JEFF KRAUT: OK. Good morning, I'm Jeff Kraut. I'm the Chair of the Council and I have the privilege to call to order the meeting of the Public Health and Health Planning Council for April 16, 2015. I'd like to welcome the members, Commissioner, and Executive Deputy Commissioner Dreslin, participants, and observers. I'd like to remind the Council members and the audience that this meeting is subject to the Open Meeting Law, is broadcast over the internet. The webcast may be accessed at the Department of Health's website, nyhealth.gov; the on-demand webcast will be available no later than seven days after the meeting for a minimum of 30 days, and then a copy will be retained at the Department for four months. A couple of suggestions or ground rules to make our meeting successful. This is a synchronized, we do synchronized captioning, it's important that people do not talk over each other. Captioning cannot be done correctly when two people speak at the same time, obviously. The first time you speak, please state your name and briefly identify yourself as a councilmember or DOH staff; this will be of assistance to the broadcasting company recording the meeting. The microphones are hot. That means they pick up every sound. That includes try to avoid rustling of papers, and also be sensitive about personal conversation or sidebars, because the microphone will pick that up and you will be embarrassed forever on the internet. As a reminder, for our audience, there's a form that needs to be filled out before you enter the

meeting room, which records your attendance. This is required by the Joint Commission on Public Ethics, in accordance with Executive Law section 166. The form is also posted on the Department of Health's website, under www.nyhealth.gov, under "Certificate of Need." So in the future you can fill out the form prior to attending the meetings. We appreciate it in helping us fulfill our duties as prescribed by law. Before I introduce Commissioner, I would like to just make a mention, as you know, Mr. Chris Booth has resigned from the Council in February. He was a very dedicated and a valued member of this Council. He served as vice-chair of the Establishment and Project Review Committee. He was an active member of the Health Planning Committee and the Public Health Committee, and he was a kind of a voice of very structured disciplined thinking in the room and I think, you know, if the saying goes no one of us is smarter than all of us, he was one of those people that I think elevated the discussion in the room and for that we owe him a significant debt of gratitude. On behalf of the Council, Dr. Boufford and I have signed a resolution of appreciation and I just want to quickly go through that resolution. That whereas Chris Booth has served as distinction [sic] with the Public Health and Health Planning Council from 2011–2015 and during his tenure he has been provided dedicated service and served as Vice Chair on Project and Review and a member of the Planning Committee. He served in this capacity. He made countless

contributions to improving New York State's health care delivery system for the citizens of New York. And we want to acknowledge his valuable service to the Council for his term and we resolved that we convey to Mr. Booth our esteem, admiration, and appreciation for his instrumental role in enhancing the health and wellbeing of all those who reside in the State of New York and then members of this Council extend their gratitude to him for a committed service to the Council and our best wishes for many years of health, happiness, and professional achievement. I am hoping that you'll take the opportunity, if you do run into Mr. Booth, or write him an email, and just share your personal sentiments with him. As I said, we will miss him. He was a valued member of this Council and we wish him well. I'd like now, before I make some introductions—well, I'll come back to the Establishment Committee later—I'd like to then ask if I could Dr. Zuckerman [sic] to provide his report.

HOWARD ZUCKER: Good morning. Thank you very much. It's a pleasure to be here to speak with you today. The Department has been on a whirlwind of activity and I'd like to bring you up to date on some of the most important issues that we have had. I'd like to start with the executive budget, which was recently passed, before discussing some of the other topics, including DSRIP, the current flu season, and Public Health Week. I am pleased to say the Department had several pieces of good news in

the upcoming budget season, which will enable us to pursue our goals. Overall, it provides an unprecedented level of resources to support the health system transformation. So to start with, we'll begin with the capital funding for hospitals and community health centers. The enacted budget includes a comprehensive package of capital funding and short-term operating assistance that will support health care transformation, in communities throughout the state. This includes [$]285 million in addition vital access provider funds to help financially fragile health care providers continue to operate while they implement the long-term sustainability plans. We also received $700 million in funding that will go towards health care facility investments to preserve, expand, and improve the quality of services in Brooklyn communities with the greatest health care needs and most fragile providers. We are also receiving $300 million in capital funding to consolidate multiple outdated facilities in Oneida County into a new state-of-the-art hospital and medical campus. In addition, the budget includes $335 million for grants to essential geographically isolated hospitals that will support debt retirement and other initiatives that are part of the restructuring plans designed to achieve their long-term financial sustainability. The budget also includes [$]19.5 million in a community health care revolving capital fund that will be jointly administered by the Department and the Dormitory Authority. So these funds will be used to expand access to

capital for community-based clinics that are not part of hospital systems and that's one of the… so that one area is in issue with the budget, so the next part of that also is involved with the budget is the issue of the Ending the AIDS Epidemic. So the executive budget also included $10 million over two years to help implement activities to End the AIDS Epidemic. Governor Cuomo had made the historic commitment that New York will be the first state to end the HIV as an epidemic and that this will be done by 2020. The three-point plan he announced include: a push to identify all persons with undiagnosed HIV and get them into treatment; to have all those with diagnosed HIV achieve viral suppression; and to provide access to pre-exposure prophylaxis or prep medication to high-risk persons to keep them HIV negative. In addition to the $10 million, the budget includes language that will make it easier for incarcerated persons to get tested. It also contains language that removes disincentives for the use of proven prevention strategies, such as condoms and sterile syringes, among persons most likely to acquire or transmit HIV. The budget builds on the steps taken last year to move the state closer to the goal set forth by the Governor of reducing new infections from 3,000 per year that we have to 750 and active a first-ever decrease in HIV prevalence. Our vision is to make New York a place where new HIV infections will be rare and persons with HIV will live longer and healthier lives. It's a goal that with proper support we are certain that we can

achieve. On the next issue, which is children's health homes, in addition the budget provides $45 million for Medicaid health home care management services for children, adolescents, and teens. These health homes will be tailored to serve the needs of high-risk, medically fragile children, including those with multiple chronic illnesses, a history of trauma, serious emotional disturbances, and children in foster care. Currently many of these services are siloed; they do not provide continuity or integrated care, as children grow and change, and transition to different settings. Linking New York's Child-serving systems in health homes will provide a national model for better coordination of services, improved outcomes, and expanded access to care-management services. On the issue of health home criminal justice, the budget invests $55 million over two years for Medicaid criminal justice homes. The funds will help former inmates transition into communities from the criminal justice system and will reduce recidivism, as well as Medicaid multi-public health and criminal justice costs. In addition, they will improve linkages between the health homes and the criminal justice system and thereby improving the engagement of a population with significant medical, as well as behavioral, health issues. The money will facilitate projects to leverage data sharing and linkages between the health homes and the existing community-based initiatives, such as the alternatives to incarceration and re-entry taskforces, that are

in place. Our goal is identify imprisoned persons who are eligible and enrolled in health homes and make sure they are connected to health home care management in their communities when they are released. An additional one-million dollars is available to facilitate Medicaid enrollment for the highest-risk members in the population. On another issue is the issue of fluoridation. Some more good news about that, regarding to the budget, it’s going to enhance our fluoridation program. The budget invests $10 million over two years to help communities with the insulation, the repair, the upgrade of drinking water fluoridation systems. The State’s Prevention Agenda has recognized that the drinking water fluoridation program is the single-most-important intervention a community can undertake to solve dental problems. This funding helps maintain and expand community water fluoridation, which is an evidence-based public health intervention. The program will focus on communities that o not currently provide optimal fluoridation, as well as communities that have been in need of an upgrade. This will reduce the burden of tooth decay, reduce the cost of treatment to Medicaid and other health plans, and help enhance the local economic activity (the lack of funds to purchase equipment and construct adequate systems are major barriers to implementation in the community water fluoridation programs). Caregiver support. And last but certainly not least. I am pleased to announce that the Governor has committed $50 million over two

years to supporting care givers. We are all aging; we know somebody who is aging. We know someone who needs assistance with their daily lives, because it's a disability or loss of function that occurs to them, and there are millions of generous New Yorkers who spend countless hours caring for these aging and disabled friends, family, neighbors. But family members who care for aging or mentally ill or impaired relatives tend to encounter more stress than other kinds of caregivers. They themselves report high levels of depression. We need to better support these caregivers. The final budget item increases funding for respite care services, so family caregivers can continue their tireless efforts. This includes an increase in funds for the current program for the Alzheimer's disease assistance centers and the Alzheimer's Disease Community Assistance Program, or ALZCAP. Both will be expanded and rebranded as part of this overall effort. Regarding DSRIP, we have a brief update on DSRIP, as well. As you know, last spring we received the $8 billon Medicaid waiver. The bulk of those funds are being applied to our delivery system reform incentive payment program, or DSRIP, which is designed to transform our safety net providers in the health delivery system serving Medicaid patients. Last December, 25 performing provider systems across the state submitted project plan applications describing their plans for system transformation. These plans were scored and then reviewed by an independent panel of experts. We have

provided those scores to the Federal government for their final review with a recommendation to approve them all. The main goal of each performing provider system is to reduce avoidable hospital use by 25 percent. We want to shift the focus of care away from the emergency department and inpatient settings to more comprehensive care in ambulatory and community settings. This effort requires significant collaboration among the Medicaid providers, whose efforts will be carefully monitored and measured. Funding from DSRIP hinges on each PPS meeting their project performance and outcome measures. We're hoping to hear back from CMS soon on this. On FIDA. We also have some news about our Fully Integrated Dual Advantages, or FIDA. It's a program, individuals in New York City and Nassau County who are enrolled in both Medicaid and Medicare can now receive services under one person-centered health plan. As of April 1st, eligible individuals began being automatically enrolled in FIDA, which allows enrollers to receive all health services under one simple plan. The plan includes full Medicare and Medicaid coverage, long-term care, Part D of Medicaid drug coverage, and other benefits. Enrolled individuals will not pay any deductibles, premiums, or copayments/coinsurance to a FIDA plan when they use any of the covered services. We now have over 36,000 people enrolled in this. Eligible people can opt in to the program at any time by calling the New York Medicaid Choice, the enrollment broker, and select one of the 25 available FIDA plans. FIDA was

created in partnership with CMS and will improve health care by organizing care around each person's unique needs and preferences. Each individual has a care team composed of doctors, specialists, and other service providers. The team model enables an enrollee's health care providers to work together to create a optimal care plan for the patient. This helps the providers better coordinate their efforts to make sure that each individual gets the care he or she needs. Caregivers are also part of the team and can help and support enrolled love ones in making the right decisions about their care. Regarding the flu season. We recognize from the temperatures out there and the fact that nobody's wearing a winter coat that spring has finally arrived in New York, but we're still dealing with the flu season. As of the end of March, flu activity was still geographically widespread, with 52 counties, plus New York City, reporting laboratory-confirmed influenza. But there was a 15 percent decrease in lab-confirmed influenza reports over the previous week; however the number of patients admitted to the hospital or hospitalized patients with new case of flu did fall 21 percent, which is obviously good news. So the Department will certainly continue to monitor flu as we do every year; we'll give you more news about this as it becomes available. An finally, I just want to say a few words about Public Health Week, which took place last week. Governor Cuomo took the opportunity to launch a new anti-obesity campaign. As we know,

obesity is a serious health problem in New York State. One of 61 percent of New York Adults and 25 percent—one-in-four—of our children are overweight or obese. We simply cannot allow this to continue. So I took this message around the state last week and talked to community groups about the importance of obesity prevention. I went to Buffalo, to Syracuse, to Troy, Long Island, Helen Hayes Hospital—and each community connected with a county health director or the commissioner there, to cement the Department's relationship with the local public health communities. At each stop, I spoke about the ways we can combat obesity, mainly physical activity and good nutrition, and the importance of those tools at all age groups. Obesity prevention to improve nutrition and physical activity is a major component of our Prevention Agenda, the 2013–2017 agenda, and we're now entering the third year of the Prevention Agenda. Dr. Birkhead will provide an update on this later this morning. Though Public Health Week may be over, our campaign is not. We're going to tackle this problem from all ends of the state and then however we need to to improve the public health of everybody in the state. We plan to continue to get the message out there and we will drive the rates of obesity down in New York, along with all the other areas of public health that we want to tackle at this time. I want to thank you for giving me this opportunity to speak with you. I wish I could stay and listen to the other reports. I have to give a speech and that requires some travel,

so I won't be able to stay this morning, but we'll have an opportunity to hear from all of you in the future. So thank you very much.

JEFF KRAUT: Thank you, Commissioner. Are there questions for the Commissioner on this report or any other matter of interest or curiosity? Dr. Martin.

GLENN MARTIN: Given all the big issues that you raised, this will seem reasonably trivial, is my guess, but it has to do with flu season, it's vaguely tied in. From sitting on the Behavioral Health Committee, we had the opportunity to look at the regs that were finally going to be promulgated through OMH and noticed that in the last revision—which I think came through this committee, I missed it that time—that there's an exemption for hospital personnel who are speech therapists and the like (I believe this is correct), to operate without masks, even if they weren't given shots, so that they could see their mouths. This does seem important for a speech therapist, but I can argue it's the same for lots of other things. And frankly, I would think not giving infectious diseases that are potentially lethal would be equally important or more so. And I was just wondering if perhaps we could reconsider that exemption going forward, because it does seem rather odd, given the overall goal of the regulation.

HOWARD ZUCKER: I think we can reconsider that. I think that what we also should do is make every effort, particularly for individuals like that in speech therapists, to push them to make sure they get their vaccine, because here we have a situation where there's a reason that you would not want someone wearing a mask, and it's pretty tied to their, what they do to help people in the state. So let me see what we can do and we'll look into that as well. That's a good point.

Thanks.

JEFF KRAUT: Any other… yes. Ms. Rautenberg.

ELLEN RAUTENBERG: One of the things that went down in the budget was the retail clinics, urgent care centers issues— something that this Council and the Department spend a lot of time on. Was it simply because policy was embedded in the budget item? Does it come back in another way? Did… was the politics not played well? I mean…

HOWARD ZUCKER: We will look into this. We are concerned about all the issues of the clinics and I know this committee looked at this last year and actually we had spoken a little bit about next steps regarding that, as to try to figure out how to

tackle that. You're specifically talking about sort of the freestanding clinics that are out there are growing in the state.

Something that [inaudible].

HOWARD ZUCKER: Right. Well, I know Dan Sheppard will be giving a report in a little bit about that, so maybe Dan will fill you in a little bit about that. Great. Thanks, Dan.

JEFF KRAUT: Welcome to the sausage factory. Any other questions? Commissioner, thank you so much and we appreciate you coming and sharing with us an update.

HOWARD ZUCKER: Thank you very much. Appreciate it.

JEFF KRAUT: OK, now I'd like to make a motion. I'd like to move into executive session. Pursuant to New York State Public Officers Law, section 105F, to consider two cases arising under DHL section 2081-B. after that, and prior to returning to the public portion of the meeting, the Council is going to obtain a confidential legal advice from our general council, which is exempted under the Open Meetings Law requirement, pursuant to Public Officer Law section 1083. May I have a second?

Second.

JEFF KRAUT: I have a second, Dr. Berliner. I ask the members of the public, would you please exit the meeting room, as the Council will now go into executive session. We anticipate that we should be returning somewhere about 11:00am, and what we'll do is we'll wait for everybody to exit.

[EXECUTIVE SESSION]

JEFF KRAUT: We're ready? OK, I am calling back into order the Public Health and Health Planning Council of April 16, 2015. Our next agenda item is the adoption of minutes. May I have motion to adopt the minutes of February 12, 2015, PHHPC minutes?

[Second.]

I have a motion. I have a second. Second, Dr. Kalkut. All those in favor, aye.

[Aye.]

Opposed? Abstentions? The motion carries. Before we begin here's been some exciting changes to the Establishment and Project Review Committee; Mr. Robinson has been appointed to serve as its chair and Dr. Kalkut has been appointed to serve as it's vice chair. In addition, Ms. Fine has joined the committee

and I speak on behalf of the council and thank you for undertaking these new leadership roles and we look forward to working with you guys. Before we call the Committee to order, I am going to present an item of the administrative law judge reporter recommendations for establishment and construction. The application number 131347-P, Southtowns Ambulatory Surgery Center, LLC. The Department is recommending a five-year limited-life approval, with contingencies and conditions. This application was considered by the Establishment and Project Review Committee in a special meeting on April 10, 2014. A vote to recommend approval of this application was taken, but that vote failed and the application proceeded to the Council without a recommendation to the full Council at its meeting later that day. The full Council then proposed to disapprove the application and the applicant was afforded a hearing pursuant to section 2801-A of the Public Health Law. A hearing was held before an administrative law judge, and on February 20, 2015 the administrative law judge issued a report with findings of fact and a recommendation that the Council approve this application as recommend by the Department. I now move the that the Council adopt the Department’s recommendation accordingly as set forth in the proposed resolution of approval, included with the agenda book exhibit, for this application, as resolution A, which is a resolution of approval. I just want to note for the record that in the exhibit, that condition seven, the new complete

construction date is July 31, 2016. I would like to make the motion. Do I have a second?

[Second.]

I have a second. Dr. Gutierrez. Mr. Abel. Or, who is gonna… Who is going to tee this up? Who is just going to explain… Does…

CHARLIE ABEL: I can simply call the Public Health and Health Planning Council members attention to my…

JEFF KRAUT: Excuse me. Mr. Abel, I have to just… One other thing I didn't mention is Tom Holt declared a conflict and has excused himself and he has left the room. Sorry. Mr. Abel.

CHARLIE ABEL: I wanted to call members' attention to my April 9, 2015 memo, summarizing the past processing of this application, and the ALJ's recommendation, which was attached to that memo. The Department continues to recommend approval. Thank you.

JEFF KRAUT: OK. We have in the exhibit the report of the administrative law judge. That is the only item we'll take up right now. Are there any questions? Hearing none, I'll call for a vote. All those in favor for the motion, say aye.

[Aye.]

Opposed? Abstentions? The motion carries. I'll now… now should we? Do you want to go to codes first? OK, we have staff here, so I am not going to go to Project Review, I am going to go to Codes next. So let me just get my little cheat sheet. Could you ask Mr. Holt to please return and Dr. Gutierrez, if you would like to make the report of the Codes Committee.

ANGEL GUTIERREZ: Good morning, at the March 26th meeting of the Codes Committee, the Committee reviewed two proposed regulations, one for emergency adoption and one for information. For emergency adoption was the children's camps. And the first matter on the agenda at that time was another proposed emergency amendment to sub-part 72 of the State Sanitary Code, regarding children's camps. These amendments are necessary to implement the law that established the New York State Justice Center for the Protection of People with Special Needs. At the Committee meeting, Tim Shae, the Department of Health noted that there have been no changes to the emergency amendments previously approved by the council, which have been in effect since June the 30th of 2013. He indicated that the emergency amendments currently in effect will expire in mid-June, so it is necessary to request approval of another emergency adoption. Mr. Shae explained that the Department has not yet put forth permanent regulations because the Justice Center is continuing to work on regulations, and that it has asked that the Department of Health

wait to finalize the children's camps regulations until this work concludes. The committee voted to recommend adoption to the full Council and I so move.

JEFF KRAUT: I have motion, do I have a second? I have a second, Dr. Berliner. Any discussion? Hearing none, I'll call for a vote. All those in favor, aye.

[Aye.]

Opposed? One… Oh, one opposed, Dr. Martin. Dr. Bouton-Foster. Any abstentions? The motion carries.

ANGEL GUTIERREZ: For information, as a supplemental report on certain congenital abnormalities for epidemiological surveillance. Next on the agenda for information are proposed amendments to section 22.3 and 22.9 of Title X, NYCRR, which defines when and how individuals are reported to the congenital malformations registry. Currently, health regulations require physicians and hospitals to report congenital malformation that are diagnosed within two years of a child's birth. The Department's proposal will require reporting of pre-natal diagnosis of birth defects, extend the case capture period for certain defects, and require nurse practitioners and physician's assistants authorized to diagnose congenital anomalies to report diagnosis to the registry. The proposed amendments would also clarify and reiterate the requirements that clinical

laboratories conducting diagnostic testing on New York State residents submit a report to the registry. These changes will enhance the Department's epidemiologic surveillance and advance its understanding of birth defects and their environmental causes. Furthermore, the Department would more accurately be able to measure effectiveness of preventive efforts. A notice of proposed rulemaking was published in the New York State Register on February 25, 2015. It was open for public comment until February 13, 2015. The Department is currently reviewing the comments received in the public comment period. Since this was before the Committee for information only there was no vote. Mr. Chairman, that concludes my report.

JEFF KRAUT: Thank you. Are there any other questions? Thank you much, Dr. Gutierrez. I now call the Project Review Committee, under the category of project review, Dr. Kalkut will be reporting on a number of CON applications that we reviewed at the previous meeting of the Committee on Establishment of Health Care.

GARY KALKUT: Thank you. We'll start with the applications for constructions, category one. 142200C, Long Island Digestive Endoscopy Center in Suffolk County. To add pain management as a specialty to an existing single-specialty ambulatory surgery center, and bring online a fourth procedure room that had

previously been approved and constructed. DOH and the Establishment and Project Review Committee both recommended approval with condition and contingencies, maintaining the current operating certificate expiration date of June 4, 2019. I advance a motion.

JEFF KRAUT: May I have a motion? Do I have a second? [Second.] I have a second, Dr. Gutierrez. Any Department of Health?

CHARLIE ABEL: No comments at this time, thank you.

JEFF KRAUT: Any questions from councilmembers? Hearing none, I'll call for a vote. All those in favor aye. [Aye.] Opposed? Abstentions? The motion carries.

GARY KALKUT: Next in category two, we have two conflicts and recusals, Ms. Hines, who is leaving the room, and Mr. Robinson, also leaving the room. This is 121224C, HCR in Monroe County. Application is to add three counties, Livingston, Ontario, and Wayne, to the existing counties HCR currently services. The Department and the Project Review Committee both recommended approval with condition and contingencies. I make a motion to…

JEFF KRAUT: I have a second, Dr. Gutierrez. Department of Health want to make any comment?

CHARLIE ABEL: No comments, thank you.

JEFF KRAUT: Does any member of the Council have any questions? Hearing none, I'll call for a vote. All those in favor, aye.

[Aye.]

Opposed? Abstentions? The motion carries.

GARY KALKUT: We move to category six. This is an application for competitor review of health care facilities and agencies for dialysis services and construction. I will present these two together, but they will require a separate vote by the Council. First is 142261C, Faxton St. Luke's Health Care Division in Madison County. An interest declared by Dr. Baht. This is to certify an eight-station chronic renal dialysis extension clinic, including home dialysis services, to be located at 131 Main Street, in Oneida. The DOH recommends approval with conditions. The Establishment and Project Review had no recommendation on this application. The related application in the competitive review is 142183B, that's Utica Partners, LLC, doing business as the Dialysis Center of Oneida,

Madison County. Again, an interest by Dr. Baht. This is to establish and construct an eight-station chronic renal dialysis center to be located at 2142 Glenwood Shopping Plaza, Oneida, NY. Department recommends disapproval on the basis of need and the Committee had no recommendation.

JEFF KRAUT: We have motion where the Committee made no recommendation on these two projects and the Department recommended approval on the Faxton St. Luke's and disapproval on the basis of need on the Utica Partners. We will take, we will do the discussion together, but I will then call—I'll have a motion to… I have a motion on the floor and I'll take each of these separately, but so I think I'll call 142261C, Faxton St. Luke's Health Care with the recommendation of the—no recommendation from the Council and recommendation of approval by the Department. May I have a motion? Dr. Gutierrez. Microphone, please.

JEFF KRAUT: OK, I have to make—I have to make two motions. I have to make one motion and then get a motion and a second, and then I gotta make a separate. And there's no, it's not cause we want to discuss them both. We have to vote separately, but I am calling both of them for motions. So I just want a motion to call that. We're going to discuss it, but we're going to come back and vote separately on each one, but we're

discussing them together. So that's one motion that I have asked for a second.

[Second.]

Second.

Ms. CARVER-CHENEY: Yeah, just a quick question. Can we approve both or we can only approve one?

JEFF KRAUT: I think we are able to vote as we see fit.

The second is application 1428[1]3B.

HOWARD BERLINER: I am not sure you answered the question. I mean, this is a competitive batch.

JEFF KRAUT: Well, you have to decide.

HOWARD BERLINER: No, but I think the question was can we approve both, not can I individually vote yes for both of them. But if the Council votes yes for both of them, what have we done?

JEFF KRAUT: You have approved both. But why don't we ask the Department of Health that question. Could you… let me just get it on the floor to be discussed. Now, could I ask you—OK. So this the application is recommended. DOH recommends disapproval

on the basis of need. This is 142183B, DOH, the committee voted no rec. Had no recommendation. Do I have a motion? I have a motion. Do I have a second?

[Second.]

I have a second. OK. Now.

PETER ROBINSON: Is that a motion to approve or disapprove the second one?

JEFF KRAUT: The recommendation of the Department of Health is to disapprove. We are considering the recommendation of the Committee, which is no recommendation.

PETER ROBINSON: So when you make a motion for this particular application, the second one, is the initial motion to initiate the discussion? The motion is to disapprove? Or motion to approve?

JEFF KRAUT: Good question. What did I just do?

PETER ROBINSON: You didn’t… It was not clear. All I am asking for is clarification on that.

ART LEVIN: Nothing. We… there’s no clarity here, so. That’s right.

[Well, he made a motion.]

That’s right.

JEFF KRAUT: OK. I am going to do it a little differently. I am going to do it a little differently. I am going to bring both of these—we’re going to have the discussion and then we’ll entertain the motion, OK. How about that? Now, Dr. Baht, you have declared an interest and I saw… is Mr. Torres, is Dr. Torres in conflict? He’s just outside for a minute? OK, I just want to make sure he’s not in conflict. OK. There is no motion on the table yet. We’ll have the discussion and then we’ll make the motion. Is that clear? Department.

CHARLIE ABEL: Thank you. What you have before you are two applications to initiate a dialysis facility for eight stations. The Department… for Madison County. The Department has a need methodology for dialysis stations and the current need, remaining need, for the planning region, which is the county, is eight stations. We did receive two applications. They are presented here, through reviews for each for eight stations. The need methodology tells the Department that we cannot approve both, so we had to review both of these applications on a competitive basis. We established competitive criteria around

the statutory CON review criteria—which are, of course, public need, financial feasibility, and character and competence—but we also extended criteria to logical items. So our selection criteria that you might expect, for instance, regional position of the proposed dialysis center and the physical plant and how proposed and quickly the facilities could be put in operation. The need was created by the closure of the Faxton St. Luke's extension clinic for dialysis services last year and this was in the summer and as a result, we received the Utica Partners application and then an application from Faxton St. Luke's for a new extension clinic. In reviewing the standards of character and competence, and public need, we found that both applicants passed those standards. They are both proposing eight stations, which is sufficient to meet the need in the region. And both the—and from a character and competence perspective, the Utica Partners application, applicant members passed our character and competence review. As Faxton St. Luke's Hospital is a currently established provider and this is an extension clinic of that provider, we look at current compliance and the facility is currently in compliance with all Department rules and regulations. We took a look at it from a regional perspective. Both facilities are proposed to be within, located within a mile of one another. We didn't find a discernable difference with respect to the siting, proposed siting of the two facilities. There is the Faxton St. Luke's application does propose to begin

construction and operation just a matter of only a couple of months before the Utica Partners, but that really didn't seem substantial and plus, as we all know, construction dates do tend to slip from time to time. So it didn't really factor very much into our evaluation. So we looked at financial factors and we looked at the cost per unit of service. The revenues for dialysis facilities are fixed; they are really driven by primarily by CMS rates for Medicare payments, for dialysis patients and services provided to those patients. So we look at costs. And one of the reasons we look at costs is to try to determine the sustainability of those facilities. I'll tell you straight out, both facilities have demonstrated that they can provide services in a financially feasibly manner. The Faxton St. Luke's application, as submitted and reviewed, had a lower cost per unit of service—substantially lower than the Utica Partner's application. We questioned the applicant with the respect to that cost per unit of service, as did its competitor in correspondence to the Department. And I should just point out that both Utica Partners and Faxton St. Luke's have submitted material to the Department, which we have shared with you, professing the benefits of their application, and in some cases taking some objection to points in the opposition's application. We sensitized the Faxton St. Luke's application and presented that a sensitized review at the Establishment and Project Review Committee meeting some three weeks ago for two reasons: One, the

initial application as submitted proposed services for a— proposed more services, a higher volume of services, than we felt the region could sustain, so we had to sensitize for volume; and we had a sensitize because there were some costs in the application that we believed, or there were mention of some costs in the application that we believed needed to be in there. So, we took our best educated guesses at what those costs would be and we presented that material at the Establishment and Project Review Committee meeting. Faxton St. Luke's has revised their application and increased their budgeted expenses for many of these to compensate for many of these omissions and the cost of per unit of service is still considerably lower than the Utica Partners application. All other factors being comparable, the element that we focused on at the Establishment and Project Review Committee meeting and in our review, is that the Faxton St. Luke's application proposes a more cost-efficient proposal, and as a result, that we recommend approval based on that metric. And we, in response to the Establishment and Project Review Committee's Chair's request for quality data on both applications, we gave you (and you should have at your chairs) the CMS STAR data related to the facts in St. Luke's operations, for its facilities, and also and I need a note that since Utica Partners is a separate legal entity, while it does have an American Renal Associates as a to-be-established entity within that application, we, to try to bring in—well, actually it was

in response to the chair's request—we brought in other American Renal Associate affiliates with New York State experience with STAR ratings. So while it's presented here for you, I need to make clear to you that they are separate legal entities from the applicant that is being proposed here. And if there are any other questions, I am available. Thank you. The Department, just in conclusion, the Department recommends approval of the Faxton St. Luke's application, which if that is approved by this body, that will fulfill the need for additional eight stations in the planning region. As a result of that approval and fulfilling the need, there will be no need remaining per our need methodology for the Utica Partners application. So we are recommending disapproval based on lack of need for that application. Thank you.

JEFF KRAUT: Dr. Berliner.

HOWARD BERLINER: So, if… but we do get to vote on both applications. Even if the first one is approved? So, if in fact both are approved, does the decision then rest with the Commissioner? Since approving both would mean that we've gone over the need.

CHARLIE ABEL: The—while the Public Health and Health Planning Council has authority over establishment matters,

construction matters are the domain of the Commissioner. I think the answer to your question, and I'll ask Division of Legal Affairs to back me up, is that whether or not to approve the construction of one or both or none of these facilities relies the Commissioner.

JEFF KRAUT: So, we're a recommendation to the Commissioner on this matter.

CHARLIE ABEL: There is an establishment matter.

JEFF KRAUT: Oh, wait a minute.

CHARLIE ABEL: Related to Utica Partners.

JEFF KRAUT: So, OK. So that's. OK. Do you understand the difference? OK.
Yeah. Dr. Baht. Then Mr. Fassler.

DR. BHAT: Let's go back and look at this competitive way of looking at two applicants that are coming in here. I think the question was raised by Dr. Berliner and Ms. Cheney saying why can't we approve both of these. What really bothers me in this application is that Faxton just decided to close it even though they know they were running out on their lease. They knew at

least, for what, a year or more than a year. And then when… they closed it down and it caused a lot of discomfort to the patients, because some of them had to travel about 50–60 miles to get dialysis. And when there's a competition that's coming in, they are coming back and saying that we are going to be applying. That bothers me. And I do not think… I think in the last Committee meeting, we are talking in terms of saying that in home health care we wanted to have more choices. Why is it that dialysis is different from home health care? And I think there we want it to be a lot more people coming in. What will happen IF BOTH are going to be there? Having, from my perspective, I think Faxton wanted to close it down, they closed it down, and they came back about two or three months later when the competition came in they came back and said we would like to be there because one of the physicians who is on the staff there was partnering with the new entity coming in. I think that's probably not the right thing, because if Faxton will be closing down, if they COME TO the Department saying, "look, we have a problem here, we'll come back." I don't think… I did ask question once; I did not get AN ANSWER BACK FROM THERE, but in this particular case it looks to me that once the competition came in, they changed their mind, saying that now that we have space to put it in, they are coming in and competing. I don't think it's fair.

JEFF KRAUT: Mr. Fassler.

MICHAEL FASSLER: Yeah. Two questions for the Department. Looking at the financial data, Faxton St. Luke's has a deficit and this program WERE TO generate and add income. If it's not approved, how would that affect the financial security of the hospital? That's the first question.

CHARLIE ABEL: I don't believe that not approving this application is going to substantially change the financial picture for the hospital. There is some marginal excess income that this proposal is producing, but I don't think it's substantial to impact one way or the other, substantially on the financial circumstances of the facility.

MICHAEL FASSLER: And the other question, are there other providers in Madison County right now?

CHARLIE ABELL: Faxton St. Luke's is the sole provider of facilities, of dialysis facilities in the county.

JEFF KRAUT: Ms. Hines.

VICKY HINES: So, just a comment, and then a question for the Department. So it's the balance of issues that worries me

about this application. So if you put this competitive question aside, you know, three things. One is I am also bothered by the short notice that they gave patients despite the fact that they had been planning for some time. So from a patient-centered perspective, if these are folks they cared about, I would have been talking to them well before that 30-day notice. The costs changed, so they are submitting a CON, they take those applicant—or should take those applications seriously. After discussion here, they went back and revised cost estimates, so that makes me sort of question, a competency question at the beginning. And then it looks like there are still valid costs associated with dialysis operating a dialysis center, which I admittedly don't know a lot about, that are still missing. So I'll come back to that question. And then the quality, again, as I look at the quality summary results, it seems clear that the other application produces better quality than Faxton. And I did hear what you said, Charlie, about you have incorporated some other locations, right, in the Utica Partners one. So on balance, I have worries about this. My question is really centered on the cost piece. So, knowing what you all know about dialysis and probably some other members of the Council can weigh in, as well, is it a fair representation of the actual costs of running that unit? My untrained eye would say perhaps it isn't.

CHARLIE ABEL: We believe that in the Faxton St. Luke's submission to increase the expense side of their budget, there still are omissions. We have reviewed—you know, we have pretty good experience with dialysis facilities'—costs don't vary a lot and usually when there are variations there are specific reasons for that. So, we do estimate that the, there are… this is an estimate only, that there are perhaps $60 per unit of service that remains not accounted for. If we were to impute that addition expense into the Faxton St. Luke's budgets, it produces a per unit of service that is still $20–30 less than the Utica Partner's application. We have done that, you know, internally in terms of an assessment to be able to speak to you from an educated perspective to say that the Faxton St. Luke's budget still does appear to be more cost efficient than its competitor.

JEFF KRAUT: Dr. Martin.

GLENN MARTIN: So just looking over the data that you gave us with the STARS and everything, if I am reading this right—I am not sure if I'd come to Ms. Hines conclusion. So the Faxton St. Luke's health care, which you actually have ratings on five of their sites as compared to only one for Utica Partners, if I am reading that correctly. And that at least in Faxton's all of their bottom line death rates are as expected or better than expected, except in the one that doesn't have a rating. I guess

the question I have is they made an assertion in a letter that was sent that they were slated to get four out of five before they closed. Is there any independent verification of that or is that just an assertion?

CHARLIE ABEL: The material that you have before you is the latest material that we have from the CMS website.

JEFF KRAUT: Dr. Kalkut.

GARY KALKUT: I would also agree with Dr. Martin that the quality data is difficult to interpret with only one entity from Utica Partners and without the confidence limits and other better data here I think it’s a good reflection of how difficult it is to interpret the CMS data. The fact that there’s one in Faxton where the death rate is better than expected. I am not sure how to make, how to interpret that, so both the data itself intrinsically and also what’s presented here in terms of one of five of the Utica Partners, I think makes this neutral information in my mind.

JEFF KRAUT: Ms. Fine.

VICKY HINES: I appreciate a lot of the comments that have been made, but I have to ask the question directly to Charlie.

Was there anything in the review of the handling of the closure of Faxton's previous site that led you to pause on character and competence?

No.

JEFF KRAUT: Dr. Boutin Foster.

CARLA BOUTIN-FOSTER: I have a follow-up to that question. Can you just go over what caused them to close initially and then what changed?

Microphone.

CARLA BOUTIN-FOSTER: I am sorry. What caused them to decided close initially and then what change happened, aside from some, you know, someone else coming in? What change happened that can reassure us that they will not decide to close again?

CHARLIE ABEL: Well, I can summarize what we have reviewed in the application and what was presented by Faxton St. Luke's at the Establishment and Project Review Committee in really just a couple of sentences. They lost their lease. They were looking for another facility to situate their dialysis—to move their

dialysis facility to and could not locate a facility to preserve continuity of services.

So.

Just use your mic.

CHARLIE ABEL: Locate the… in this application before you, they did locate a site that was suitable, that met their needs and they believe their patients' needs, and that's the application that's before you now.

JEFF KRAUT: Dr. Baht, did you have a comment?

DR. BHAT: I have two comments. One is what Ms. Hines was asking and it is cost numbers are still suspicious, cause I know some of the… It's not like comparing apples to apples, there's a lot of costs that are burried in the hospital's budget that are reflected here in the dialysis costs. Just to say that Faxton is a low-cost facility compared to the competition, I don't buy it, because it's a lot of stuff that is not included. The other stuff that I have is about the lease part of it. Is there something that was submitted that came to the Department of Health, I think. The landlord did give the option for the facility to continue on a month-to-month basis, knew about it

for a year, year-and-a-half, that they were losing the lease, and they were not acting on it. I mean, no one who is in a business where, the dialysis business, knowing that the patients are going to be disbursed as a result of not having the lease, that probably is not going to think to look. And I am really bothered by it. Say that they knew that they were going to be losing the lease, did not do anything about it, did not go back to the landlord and work out some kind of a deal to stay there up until they could find a suitable site where they could go. It's not like a doctor's office, where you go and see the doctor once every couple of months. These patients have to go in three times a week, 50–60 miles to drive, and I don't think this is the right thing to do.

JEFF KRAUT: OK. So… Mr. Fassler and then I want to wrap up some of the conversation.

MICHAEL FASSLER: Yeah, just a question and a comment. The question is on the cost. If the costs were the same, what the Department's decisions on two applications and the reason for it?

CHARLIE ABEL: Well, it would certainly make it difficult for the Department to reach a decision based solely on the three statutory criteria. I think we'd have to move to something like

sustainability of care or continuity of care or established providers and, as I mentioned at the Establishment and Project Review Committee Meeting, selecting Faxton St. Luke's as the approved project between the two applications would seem to me to be consistent with the principles of DSRIP and I believe our recommendation would have to hinge upon those factors.

JEFF KRAUT: Well, you know, the issue about DSRIP, OK, and so here we are, we're trying to go into systems of care. We're trying to coordinate care, and we're trying to do it, you know, we're kind of in some areas we're more advanced, in some areas we're less advanced. It's very difficult to take dialysis and say it's out there alone and it's not connected to something else. And there is pros and cons here, as I hear the conversation. There's nothing that really convinces me, frankly, you know, the cost or maybe the quality. I hear, I get the same conclusion. And you kind of think of it as, you know, what's the framework to think about these things when they are competing and if we look beyond just dialysis and we say, "well what would serve the community best?" And it's a system of coordinated care. Now the countervailing course of this is Faxton St. Luke's has the majority of the dialysis centers in the community, so I am always apt for, well, competition's good. It's actually very good community DNA kind of makes people sharper and do that. On the other hand, we're dealing with individuals who, for many of

them, may be dually… not dually diagnosed, but Medicare/Medicaid. You know, they are dealing, we're primarily government payers are supporting this. We're trying to make sure… These are chronically ill people that have issues that are beyond end-stage renal disease, and we're trying to keep them in a coordinated network of care. And, you know, at the end of the day you kind of come down and say, alright, you have two competing ones. One is kind of clearly the health system in that particular community in that area, and this is an important component of that care delivery. How do you view that versus the right of another applicant to come in here and innovate and try to lead, and you know, obviously in providing good care? And I think, you know, you have to come and maybe open the aperture a little in your thinking beyond just the dialysis centers. And that's what I struggle with when I go to one of those. I would like to see where we are, so the only way to do that is to ask Dr. Kalkut to make a motion and then to vote. And then let's see where we end up and take it from there.

GARY KALKUT: On the Faxton St. Luke's application, the Department recommendation is to approve and I would make a motion to approve this application.

JEFF KRAUT: I have a second, Dr. Gutierrez. All… I am going to like to call a vote unless anybody has any procedural questions. OK. All those in favor, aye.

[Aye.]

Opposed? We're going to do a roll call. Colleen.

Dr. Berliner.

Yes.

Dr. Baht.

NO.

Dr. Boutin Foster.

Yes.

Ms. Kathleen Carver Cheney.

No.

Mr. Fassler.

No.

Ms. Fine.

Yes.

Fine. Sorry.

Yes.

Fine. Fine. Fine. Fine.

Dr. Grant.

Dr. Gutierrez.

Yes.

Ms. Hines.

No.

Mr. Holt.

No.

Dr. Kalkut.

Yes.

Mr. Levin.

Yes.

Dr. Martin.

Yes.

Ms. Rautenberg.

Yes.

Mr. Robinson.

Yes.

Dr. Rugge.

No.

Dr. Torres.

No.

It fails. We do not have 13 votes.

How many votes do we have?

Nine versus eight.

We have nine yay and eight…

Nay.

JEFF KRAUT: OK. Would you like to make a motion on the second application?

GARY KALKUT: I make a motion to disapprove the Utica application.

JEFF KRAUT: OK, we have a motion to disapprove the Utica Partners application. I am going to call for a vote. Dr. Gutierrez, before I do.

ANGEL GUTIERREZ: So the question is…

Microphone.

JEFF KRAUT: Sorry, it was stolen away from him.

ANGEL GUTIERREZ: So the first motion was disapprove. That means that there's no dialysis there.

JEFF KRAUT: No, the first motion was to approve and we could not get 13 affirmative votes.

ANGEL GUTIERREZ: So it's not approved.

JEFF KRAUT: It is not approved.

ANGEL GUTIERREZ: That therefore that proposal does not move forward?

JEFF KRAUT: Until we… yes. Right now that motion BASE stands as it is.

ANGEL GUTIERREZ: And the Department has said to disapprove the second motion and if we go along with the Department there will be no.

JEFF KRAUT: No. No, Dr. Kalkut has said to disapprove the second application.

It’s a very important distinction.

It’s a distinction. The department has also recommended approval, but the motion that’s in front of you is the motion of the Public Health Council and that motion is to disapprove. And that’s what we’re going to ask you to vote on.

I THINK THE QUESTION.

JEFF KRAUT: I don’t know, but I want to see.

[Inaudible]

JEFF KRAUT: Well, the outcome is if you vote to disapprove this, it will be disapproved. Both disapproved.

JOHN RUGGE: But would the impact then be to allow some other level of review.

JEFF KRAUT: I can have another motion afterwards, but I am just trying to find out where everybody is at and see where the vote is and we can figure out maybe where we go from here.

JOHN RUGGE: But don't we know that already? We had a…

JEFF KRAUT: Well, I want to see—this is my prerogative. I want to see where the Council is and then we'll figure out where we go next. But I am not going to give you a choice now.

JOHN RUGGE: I am… and that is fine, that is your prerogative, I am just wondering about taking a vote on the Utica Partners application may be even more revealing to know is there a choice the Council has…

JEFF KRAUT: Well, that's why I want to take a vote on the Utica Partners. So the motion is to disapprove. If you are inclined to approve it, then vote no on the disapproval. So if you wanted to see, cause then that might be the next motion, but then there could be two or three others. And you… This vote is for disapproval. If you want to see this disapproved, you vote yea. If you do not want to see it disapproved, you vote nay. Are we clear? Could I call the vote or is there any other questions? I want everybody to be clear. This is Utica Partners. This is not… I know I am being obvious, it's not Faxton. This is Utica

Partners. This is the second. This is the one that is Utica Partners, which you have correspondence from American Renal.

JOHN RUGGE: I apologize. I thought you were taking a…

JEFF KRAUT: No, I was not. I was going to the second applicant to give it its day to see where we're at. So… John.

JOHN RUGGE: I think so, but in this case a yes vote is to disapprove.

JEFF KRAUT: That's correct. That's the motion.

JOHN RUGGE: OK. OK. Thank you.

JEFF KRAUT: OK. Is there any other? It's real important, cause once you vote, you vote. Go ahead.

GARY KALKUT: I raise one other. The Department's recommendation is to disapprove on the basis of need. We now… We're just disapproving.

JEFF KRAUT: You're disapproving it. The Department's recommendation is need. The theory was that had you approved the

other one, this one… but it’s still a disapproval. All those in favor, say aye.

[Aye.]

Opposed? Please take a roll-call vote.

Dr. Berliner.

Yes.

Dr. Baht.

NO.

Dr. Boutin Foster.

NO.

Ms. Carver-Cheney.

No.

Mr. Fassler.

No.

Ms. Fine.

Yes.

Dr. Grant.

No.

Dr. Gutierrez.

Yes.

Ms. Hines.

NO.

Mr. Holt.

No.

Dr. Kalkut.

Yes.

Mr. Levin.

Yes.

Dr. Martin.

YES..

OK, Ms. Rautenberg.

Yes.

Mr. Robinson.

Yes.

Dr. Rugge.

No.

Can you repeat? No.

Dr. Torres.

No.

It’s flipped, eight...

JEFF KRAUT: It’s the flipped, eight-nine?
So both applications…

JEFF KRAUT: Alright, so there’s an issue, how do we get to consensus here. So these are the options you have. We can vote to approve the Utica Partners application. You can vote to— you didn’t vote to approve the Faxton application, so and I suspect if we voted to approve the Utica one, it could be nine-eight. So, the ramifications of this, Charlie, I just want to be sure the Department is on the Faxton, Faxton is that establishment or is that construction?

CHARLIE ABEL: The Faxton St. Luke’s application is a construction application.

JEFF KRAUT: So we can have no vote of the Council and that application then gets reviewed by the Commissioner; the Commissioner makes a determination. Am I correct as how the applicant… the application would proceed? OK. The Utica, on the other hand, is an establishment. If we fail to make a vote, that applicant is in limbo. Am I correct? So, limbo means that applicant, if we do not vote to approve or disapprove it, that

applicant has no ability to avail themselves of other… due process.

DR. BHAT: Jeff. Can I ask a question?

Yes.

DR. BHAT: I know what limbo is, but I think the question was if somebody gives their certificate back, and surrenders the certificate, they go back, is it an establishment or it’s just a construction?

JEFF KRAUT: We voted already. We’ve taken it… are you talking about Utica. You gotta.

DR. BHAT: Faxton.

JEFF KRAUT: Faxton doesn’t have to go anywhere. They could get approved.

DR. BHAT: I was just asking for clarification. If somebody surrender their certificate and then they come back and say later on come back and apply, do it have… is it an establishment or it’s not an establishment?

JEFF KRAUT: I will leave it to the Department to answer.

MR. DEERING: Because Faxton was an already-established entity and when it decertified its dialysis it was just essentially taking a service off of its operating certificate. To add it again is then a construction application.

JEFF KRAUT: OK. So, we could leave the Faxton alone. Let it proceed. I have a sense that if I ask for it to be disapproved, it would just be flipped eight-nine; I don't think there's any value necessarily in doing that. So, the only question now is because Utica is a establishment and we don't want it to be in limbo, and limbo being they can't go forward, so you have two choices there. You can get a Council, the Council can vote disapproval so they can appeal that decision, recognizing, I would think because we didn't approve the other one, the issue of need is still out there. I don't know if we've disadvantaged or advantaged. I would think it would be in the applicant's interest to have a disapproval so they could advance through the process. I would think it would be, but that's not for me to say. I can't ask the applicant because we don't ask the applicant at this juncture, but I do believe strongly that not to allow it to proceed and take advantage of whatever remedies it can is not fair to the applicant. That's a decision you are going to have to make independently. Yes, Dr. KALKUT.

GARY KALKUT: The process as just outlined would be different for the two applicants. If we disapprove Utica where the construction project, Faxton, would go to the Commissioner and the other would go to an administrative law judge. We just had one of those which took, seems like a year, little more than a year, for it to go through its process. So that difference seems relatively stark and I wonder if there's any other way to do it.

JEFF KRAUT: Well, I don't know if there is. Let me just make one point. You know, it could proceed to the Commissioner for Faxton. He could, the Commissioner could seek to approve it and therefore there's no need. Doesn't go to a… You know, then what is an administrative... you know. It's complicated. I don't think it's our job to sort through, necessarily, those issues, but Ms. Carver Cheney.

MS. CARVER-CHENEY: I was just going to say what are we even voting on if it's not establishment?

JEFF KRAUT: Well, we are voting on establishment. We would be voting on establishment in the respect of… No, no Faxton is not establishment. It's an established provider; it is wishing to construct yet-another dialysis center.

MS. CARVER-CHENEY: And we have a vote on that even though it's not our final decision. Is that it?

JEFF KRAUT: Well, we failed to get a vote. We failed to approve the application.

MS. CARVER-CHENEY: But, I guess my question is if we disapprove that, can they still go forward with the Commissioner?

JEFF KRAUT: No. Oh, yes, of course they can. Yes, cause we are not the final.

MS. CARVER-CHENEY: We're really not. It doesn't matter.

JEFF KRAUT: I think Faxton is on a path that's going to the Commissioner and I am going to suggest with an eight-nine vote, I wouldn't even… It doesn't matter. You know. I don't want to waste. Not so much waste our time, I don't think it matters. It's going up to the Commissioner right now. I think the issue is the fairness to the Utica applicants since there isn't a consensus to disapprove this application, if we don't send it to the Commissioner with a recommendation one way or the other, it can't avail itself of the administrative remedies it has to it in due process. To appeal our decision or to have it reviewed.

What I am suggesting is someone to—I am going to ask Dr. Kalkut to make a motion again to disapprove the application because we don't have consensus. And that allows the applicant to move through the administrative processes. Cause I don't think we could get—I don't think there's enough consensus to allow it to approve, you know, cause of the same reason. Yes, Ms. Hines.

VICKY HINES: Yeah, I guess I am also concerned, as Dr. Kalkut is, that we clearly couldn't draw, we're split in both. Couldn't draw the best conclusion. It seems most fair to both applicants that the Commissioner is able to weigh them against each other from a competitive perspective. And if our disapproval of the Utica application means that he has no opportunity to consider it and it has to go through ALJ, which by definition he's going to look at one and not have the opportunity to look at the other. I just wonder is there any other approach to do this, cause it seems most fair to be able to go to the Commissioner as two competitive applications.

JEFF KRAUT: We could certainly ask for a statutory and legislative change, but I think that would take equally as long. But I don't believe—let me give it. Let me not answer and… I don't believe there's an alternative procedurally unless…

Well, yeah.

You guys.

MR. DEERING: I mean, just to make a point, too, with respect to the Utica Partners application, is establishment and construction. So even though you are the final deciding body on its establishment, it still has to technically to the Commissioner to approve for construction. And the Commissioner is statutorily able to look at public need himself with respect to any construction application, including ones that have already gone through establishment.

JEFF KRAUT: Yes, Mr. Levin.

ART LEVIN: I guess I am asking for a more granular definition of “limbo.” In other words.

Microphone.

It’s one.

JEFF KRAUT: OK, so Mr. Levin is asking for what does it mean when we, when I call it limbo. You want to explain what does it mean to an applicant.

ART LEVIN: I mean, if we… if that vote stood today and…

We made no recommendation.

ART LEVIN: We made no recommendation because we could not reach the necessary majority, what does limbo mean? Could it come back? You know, does it sit around in limbo for a while.

JEFF KRAUT: Let me just define it. What does it mean from the perspective of the applicant, not the Council.

Sure.

MR. DEERING: So for the applicant it obviously means that there is no approval and there's no disapproval, so if there were a disapproval then that would mean that the applicant would have the right to seek a hearing under Public Health Law section 2801A, and so if there's neither an up or down, the applicant is in a scenario where it can't do anything and it's stuck.

JEFF KRAUT: Yes. Dr. Berliner.

HOWARD BERLINER: This is getting more confusing. If in an establishment and construction application, the Commissioner can approve the construction, but then what happens with—does

the establishment then come back here as a separate matter or is it all…

MR. DEERING: Well, establishment goes first. So, in the case of an establishment and construction application, it would go to the Council first. If the Council then votes to establish it or approves the establishment of the applicant, then it can go on to the Commissioner to determine whether there is a need for the construction of the facility.

HOWARD BERLINER: So essentially if we were to vote to approve—as Jeff is suggesting to get something…

JEFF KRAUT: I am suggesting the disapproval.

HOWARD BERLINER: Out of limbo. Because it’s a construction, it would still go to the Commissioner. Basically we would be punting this thing to the commissioner and he would still get to choose between the two applications.

MR. DEERING: If you voted to disapprove the Utica Partners application, it would not go to the Commissioner. Not at all.

No.

MR. DEERING: The Commissioner can only review construct applications from established operators.

JEFF KRAUT: It has to go through this other process. The fact of the matter is on one hand this is just the process. You know, and it’s unfortunate that we can’t get to a consensus on these tough projects. It’s unfortunate that here we’re dealing with another applicant in two, you know, two in one year, where we’re unable to reach a consensus and we’re sending it to an administrative law judge potentially to do the work of the Council. And that’s just the PAR process and we have that right, so when we can’t do this, so we have to… that’s why it’s so important that, one, the applicants applications and activity is top-notch and, two, we have, you know, all the analytic question answered because, you know, that’s part of, I think, the confusion here. This was not as tightly packaged by both the applicants and some of the analytic work. The Department can only do what it can do and has did everything it normally does. It’s presented with information, it organized it, and if that information came in dribs and drabs and wasn’t packaged well, well this is the result of that activity. It’s not a Department failing. They’re playing the cards that they’ve been dealt in the application process. Yes.

HOWARD BERLINER: Jeff, another question. So, if this were to go to an administrative law judge and that judge were to rule that we had disapproved it for the wrong –

JEFF KRAUT: No, we do a finding of fact.

HOWARD BERLINER: I mean, meanwhile, just play this out for a second for me; so Faxton goes to the Commissioner. Let's approve the Commissioner approves it. They start operation.

JEFF KRAUT: And the need is gone.

HOWARD BERLINER: A year later, the administrative law judge says wait, you made a mistake on Utica. What happens then to Utica? Because the need is now satisfied?

MR. DEERING: Well, so then the recommendation from the administrative law judge would come back to you for your decision?

JEFF KRAUT: We could say yes or no. We still have to rule. The administrative law judge is not the final say in these matters. It is a step in the process. That it would return back to the Council.

HOWARD BERLINER: So then if it was just following through the scenario, if it was presented back to the Council and the Department in their recommendation said but there's no need in that community, so we recommend disapproval –

JEFF KRAUT: On the basis of need.

HOWARD BERLINER: Which is back at the same place.

JEFF KRAUT: That's right. Well, no, actually –

MR. DEERING: You would look at it on the record from the administrative law judge, so you'd look at that record. So I think the point is –

JEFF KRAUT: But Dr. Berliner, there is an advantage to that, because as we may have all reached on the previous application that was reviewed, that judge has an opportunity to do a more thorough vetting of these nuances that we were uncomfortable with, they could do a different level of fact finding, and if that was convincing your reservations or your support could shift one way or the other based on that process. I don't see that as a failure, necessarily, even though in light of my other comments, but it's just, this is part of the process and we're uncomfortable and this is what happens.

JOHN RUGGE: Jeff I'd –

JEFF KRAUT: And I have no problem with that as an outcome, per se.

JOHN RUGGE: It just seems to me as a practical matter, failure to come to a positive from one application to the other provides, as it happens, a pathway for Faxton to be approved, thereby eliminating any basis for the administrative law judge to go back. There's no fault of anybody, it's a quirk in terms of how the decision-making goes, in terms of our vote. It's a consequence that we can't avoid. That's all.

JEFF KRAUT: Right. And Dr. Rugge, I don't think it's up to any of us to presume that might have weight with the judge or not. I have no idea. And it's not – you know, we don't know how that'll happen. Dr. Bhat and Ms. Hines then I want to call the question.

DR. BHAT: It's just for clarification Mr. Abel. Faxton application since they're already in the business, it's not an establishment in retrospect, if it had gotten administrative approval would it have been better?

CHARLIE ABEL: If we did not have the Utica Partners application –

JEFF KRAUT: it would have been administratively approved.

CHARLIE ABEL: Or another competitive, another applicant creating a competitive situation and it was only the Faxton St. Luke’s application we had in front of us, it would be approved as an administrative review.

DR. BHAT: Afterwards, right? The Faxton application came after the Utica Partners filed application.

CHARLIE ABEL: In terms of sequence the Faxton application was submitted after the Utica Partners application.

JEFF KRAUT: Ms. Hines.

VICKY HINES: So, I may just now be confused about the complexity, but don’t we have a remedy to have the commissioner look at both if we agree to the Utica application from an establishment perspective, and then he has both of them in front of him, right, because he still have to approve the construction

piece. So that's a remedy to get them both to the commissioner? Or am I missing that?

JEFF KRAUT: Listen, if we approve it and we've not approved the other application, then there's no need, the other one – the Department could approve it, I guess. OK. I'm going to ask Dr. Kalkut to make a recommendation.

GARY KALKUT: I make a motion to disapprove the Utica application.

JEFF KRAUT: Do I have a second? I have a second, Dr. Berliner. Could you do a roll call? So, let me just say something; if we disapprove this, we allow the applicant, because we are clear we couldn't approve it we allow the applicant to avail themselves of those remedies. I wouldn't presume the sequence of events, how the Commissioner would act, just give the – I'm suggesting we should give the applicant, afford the applicant the availability of moving through the appeals process. That's all for hearings. That was the point of this disapproval. Even though many of you feel it should've been approved. Just suggesting that that's it.

A 'yay' vote means disapproval to permit the applicant to move through the process. It's a terrible way to describe a

disapproval, but it’s unfortunate. I’m going to try it by voice first. All those in favor aye?

[Aye]

Opposed? One abstention, two abstention, three – opposed to – everybody yay?

[Yay]

Nay?

[Nay]

I was right. It’s Dr. Boutin-Foster, Dr. Bhat, Dr. Grant. Any abstentions? One abstention. No, OK. Hold on. What’s the vote please?

[15 – we have 18 members present]

We have 18 members present, I have 15 affirmative votes. The motion carries. The Utica partners application is disapproved. Dr. Martin.

GLENN MARTIN: Now that I know administrative law judges actually read our transcripts and occasionally care why we vote, I just want to put into the record I voted yes because I wanted to deny it. I didn’t do it because I want to get them out of limbo. This is a vote consistent with my previous vote. That I do not believe it should’ve been approved and when it gets reviewed in a year they should have that fact.

JEFF KRAUT: So, I'll take a cue from Jimmy Fallon and I go, I want to write a note to the administrative law judge. "Dear Administrative Law Judge: With respect to…" I don't know who it's gonna be… "with respect to Utica partners, there was a vote of eight to disapprove the application, nine not to disapprove it, and we have sent this to you because we have been essentially split. Please take that into account as you review this application." Respectfully, the Public Health and Health Planning Council.

DR. BHAT: Did Dr. Martin vote for the disapproval? Was it disapproval?

GLENN MARTIN: I voted yes. To disapprove –

DR. BHAT: I want to change my vote to yes.

JEFF KRAUT: No. We voted already. No, seriously, cause you know, we start reopening votes, the – but I understand why you wanted to do that. We'll note after the fact that you would've changed it, but I'm not permitting you to change your vote. Dr. Kalkut can you continue with the committee report.

I'm sorry. So you're going to leave. So now I'm going to call this one.

We're going to call application 142213B, the New York Proton Center, New York County. There was a conflict declared by Dr. Kalkut and Dr. Martin who are leaving the room.

Slowly. They have left the room. This application is to establish and construct a proton beam therapy diagnostic and treatment center to be located at 225 East 126 Street in New York. The project amends and supersedes CON 101151. DOH recommends conditional and contingent approval with an expiration of the operating certificate 10 years from the date of issuance was recommended. The establishment project review committee was unable to reach a recommendation due to a lack of quorum. Let me just make the motion. Do I have a second? Second Dr. Berliner. I would just say before the Department's thing is there is a non-binding vote of those members who were present who all voted affirmatively for this application but because of a quorum requirement we were unable to officially due so. Mr. Abel.

CHARLIE ABEL: Thank you. You'll see a March 17 note from me expressing the history of this project. We went into great detail at the establishment and project review committee meeting in background, so I'll defer to the chair as to how much you'd like me to –

JEFF KRAUT: I mean, unless any – let me just suggest this; if any member wishes to, those of you who were from the previous time when we did the proton beam, we went through this extensively, if anybody would like to go into greater detail I'd certainly encourage you to ask if there's any questions or any concerns.

PETER ROBINSON: So this really represents some change in membership and ownership. It's not really a change in the project. So I just have a comment about it. Not necessarily an objection to it. So, this proton beam thing has been going on interminably and as a demonstration project and it is thus far gotten nowhere, and I think technology has evolved and there has been a, some greater proliferation around the country of this technology, not necessarily any evidence that has come forward that suggests much more efficacy than was originally described when the demonstration project was approved. So more a statement that I'm assuming that the useful life of this demonstration project continues to be the 10 year horizon that we put on this thing? Is that correct?

CHARLIE ABEL: I think – the 10 year limited life was part of the legislation that created the solicitation for competitive and applications.

PETER ROBINSON: OK. Thank you.

JEFF KRAUT: So, Mr. Robinson, I would just also add that that was a point that we did have a lot of conversation about with the applicant, recognizing that one, the technology has evolved, they're using the newest generation, but most importantly they went into detail about the research protocols that they would be participating in and one of the things that's happening now that hadn't happened when we first considered it is a randomized clinical trial. A double blind randomized clinical trial that will answer some of the key questions about the efficacy of this treatment as compared to IMRT or other modalities. And I think in that respect they recognized that if it turned out not to be efficacious, their business model – there still would be for certain type of tumors and given the consortial approach they were fully prepared, it has been proven for certain limited ones.

PETER ROBINSON: And I think that makes good sense, and it's a very positive development that they're going to get into that. That kind of approach since it is a demonstration project and it might as well have some scientific validity to it. But the other thing I think is that there is some growing pressure to actually move in this direction. I think certainly I'm hearing a lot of noise upstate about the fact that there is a

growing interest and this technology is almost moving in the direction of having an economic development dimension to it as well as a healthcare dimension. And so I'm kind of raising this question more because of the fact that I think we need to be cognizant of the fact that there's likely to be more groups that will start to come forward given the time lag already between initial approval and this and that we need to anticipate how we're going to handle these other applicants should they come forward. That's my only comment, and I'm happy that we're going to see the change –

JEFF KRAUT: Fine. And we'll take them up if and when they do. Any other questions? Hearing none I'll call for a vote. All those in favor, aye?

[Aye]

Opposed? Abstentions? The motion carries. We'll now as Dr. Kalkut and Dr. Martin to return and he'll continue the presentation.

JEFF KRAUT: OK. He's going to call the home healthcare ones. That's going to take about two minutes just to get them through.

GARY KALKUT: continuing with applications for construction of healthcare facilities, category one. These are – I'm sorry, we're on home health. Thank you. I got it. Home health agency, we're going to put these altogether and let me start;

2063L, 2249L, 2216, 2354, 2290, 2367, 2357, 2277, 2233, 2395, and an interest declared by Ms. Hines, 2345, 2255, and interest by Ms. Hines, 2308, 2312, 2271, interest by Ms. Hines, 2341, 2227, 2360, 2284, 2156, 2248, 2269, 2234, 2194, interest by Ms. Hines, 2301, 2387, 2297, 2278, 2383, 2171, 2358, 2569, 2281, interest by Ms. Hines, 2473, 2378. 2377, interest by Ms. Hines – I think I stopped there. The –

JEFF KRAUT: Do I have a motion? I have a second, Dr. Berliner. There was an issue that had been brought up when we discussed this at project review and I'll ask the Department to respond to the question raised by Ms. Hines.

CHARLIE ABEL: Yes, so, Ms. Hines and other member or two had asked for information relative to CHHAs and LHHCSAs and I think some of that discussion trickled into the concern over the vote and Deputy Commissioner Dan Sheppard would like to address those concerns.

DAN SHEPPARD: So, thank you. And this is a little shifted around. I had intended to do this as part of my Deputy Commissioner report at the beginning of the meeting but as we've moved the agenda around, I'll break my report out and do this piece now and you'll hear the rest of it from me later.

So, in response to Council Member Hines' comments, I just wanted to offer the following information and some data. I think one of the, I think, important kind of threshold bits of information is to understand the PHHPCs approval is only the first step. So, when the Council acts to approve a LHHCSA that doesn't, a licensed agency, that in and of itself does not mean that the agency can open it's doors. There are a number of steps that take place. It's a legal review of the application by the Department's Council's office, a policy and procedure manual review, obviously very important to make sure that everything that the agency should be doing is clear and in writing and acceptable to the Department, and of course the pre-opening survey. So, this really represents a very thorough process that ensures that every LHHCSA that opens meets all the same operating requirements. I think also some data now that Council Member Hines hopefully is responsive to the discussion at the committee meeting on the 26th, that although 210 new LHHCSAs have been approved by PHHPC since 2012 through January of 2015 so the period January 2012 through January 2015, the overall number in operation has only increased by about 134.

That's from 1122 to 1256. So in terms of the number of LHHCSAs, the gross amount approved doesn't equal the actual increase in operating agencies. So I just as responsive to part of the discussion at the committee meeting. Also, Council Member Hines commented on LHHCSA surveillance activities and again, just want to emphasize that because of the process I just described, no LHHCSA opens without a proper pre-opening survey. And then we also prioritize monitoring and investigating complaints to ensure that any urgent issues are promptly investigated.

So, now, overall, cause every process and you know, we can always all do better, overall, we're working to improve the efficiency and effectiveness of our LHHCSA surveillance capacity by expanding the lean process improvement work we've begun in other surveillance programs in supporting best practices to the LHHCSA program as well as exploring alternative tools and methods for assessing agency compliance. So, again, I hope, Council Member Hines that's responsive to your very good questions and comments on the 26th.

VICKY HINES: So, thank you. I appreciate the – you certainly comforted me telling me that the total number we approved does not equal to the total new number in operation. I do remain, and I lump it in with the CHHA question and I know that the Department is committed just as the Council is to really take a hard look at the homecare industry and understand

need, understand financial impact, understand impact on the new system, so I would simply ask that we continue to commit to that and move forward. But this is very helpful. Thank you.

DAN SHEPPARD: Thank you. No doubt, I think much of what we're trying to build through DSRIP and our broader healthcare agenda is very dependent on the care in the community and so it's a very high priority for my office and the Department as a whole to make sure that that network is effective and efficient and meets patients' needs.

JEFF KRAUT: Thank you. So, without ado, all those in favor, aye?

[Aye]

Opposed? Abstention? The motion carries.

GARY KALKUT: There's one additional home health agency. There's a recusal by Ms. Carver-Cheney. She's leaving the room. This is 2242L, and HDA LLC, Kings County, Queens, Bronx, New York, and Richmond. This is the only other one. Can we make a motion? Motion to approve?

JEFF KRAUT: We have a motion to approve. I have a second by Dr. Gutierrez. Any comment from the Department? Any questions? Any comment on this?

CHARLIE ABEL: No comment.

JEFF KRAUT: Any questions from the staff, from the Council? Hearing none I'll call for a vote. All those in favor, aye?

[Aye]

Opposed? Abstention? The motion carries. Could you ask Ms. Carver-Cheney to return?

GARY KALKUT: Moving on. Category one ambulatory surgery centers establish and construct 142272E, Specialist One Day Surgery Center in Onondaga County. 1511035E, Saratoga Schenectady Endoscopy, Saratoga County. The Department recommends approval and

JEFF KRAUT: So we have a second, a motion a second Dr. Berliner. Dr. Berliner.

HOWARD BERLINER: Just a question on the specialist one day surgery. Are there any orthopedic surgeons in Syracuse who are not part of this?

CHARLIE ABEL: I assume that's rhetorical but if it isn't, I do not know.

JEFF KRAUT: Well, it certainly seems to, we opened the floodgates here and we've approved all of these transfers, so. Any other questions? Hearing none I'll call for a vote. All those in favor aye?

[Aye]

Opposed? Abstentions? The motion carries.

GARY KALKUT: Next, establish and construction, D&TCs. 142006B, 142133B, 142212E, 1422257B, then residential and healthcare facilities; 131349E, 141079E, 141153E, 141207E. Motion to approve.

JEFF KRAUT: I have a motion to approve and I have a second, Mr. Fassler. Does anybody want to remove any item out of that batch just to make sure we're all comfortable? OK. Department, is there any comment on any items that you need to bring to our attention?

CHARLIE ABEL: No additional comments.

JEFF KRAUT: Is there any questions from any member of the Council? All those in favor aye?

[Aye]

Opposed? Abstentions? The motion carries.

GARY KALKUT: There's a certificate of dissolution, Guthrie Same-Day Surgery Center. Project review recommended approval and certificate of amendment of the certificate of incorporation, the applicant, The Hortense and Louis Rubin Dialysis Center, Inc., again, recommends an approval from the committee. Motion to approve.

JEFF KRAUT: I have a second Dr. Gutierrez. Mr. Abel, any comments?

CHARLIE ABEL: No additional comments.

JEFF KRAUT: Any questions? Hearing none I'll call for a vote. All those in favor aye?

[Aye]

Opposed? Abstentions? The motion carries.

GARY KALKUT: Category two; acute care services. Establish and construct 1511027E, and 142197B. Both recommended with contingent approval and I make a motion to approve.

Oh, my apology. And Dr. Rugge is recused from 142197.

JEFF KRAUT: Dr. Boutin-Foster has left the room. Do I have a second? I have a second, Dr. Berliner. The Department want to make any comments on these?

CHARLIE ABEL: Just that at the establishment and project review for project 142197, Surgical Pain Center of the Adirondacks, LLC, the EPRC asked that three additional conditions be added to those projects and for the benefit I'll read them into the record. One; no additional specialties beyond pain management may be approved for the facility without full review and recommendation for approval by the PHHPC; Two, no additional physicians may be added to the ownership of the facility without a full review and recommendation of approval by the PHHPC; and number three, no additional operating rooms or procedure rooms may be added to the facility without a full review and recommendation of approval by the PHHPC. And those are satisfactory to the Department. They've been added as conditions to that project.

JEFF KRAUT: Any questions on this? OK, Hearing none I'll call for a vote. All those in favor aye?

[Aye]

Opposed? Abstentions? The motion carries.

Could you ask Dr. Boutin-Foster and Dr. Rugge to return.

GARY KALKUT: That's it. There are no other applications in any of the other categories.

JEFF KRAUT: That concludes the meeting of the project review and establishment committee. I'd now ask Dr. Berliner to give a report on the activities of the ad-hoc committee on freestanding ambulatory surgery and charity care.

HOWARD BERLINER: Thank you Mr. Chairman. It was a great pleasure to be able in Mr. Robinson's absence to –sure, it was a great pleasure to be able to chair the ad-hoc committee on ASCs and charity care in Mr. Robinson's absence. The committee's main activity at this meeting was to hear from representatives. New York State Association of Ambulatory Surgery Centers, and from operators of ambulatory surgery centers who had undertaken special efforts to reach the uninsured and underserved. This included presentations by endoscopy ambulatory surgery centers participating in a joint endeavor with the city and the American – City of New York Health Department, and the American Cancer Society to work with FQHCs and other providers to reach Medicaid and uninsured clients for colon cancer screening. The committee heard from speakers on the practical aspects of reaching and serving uninsured and Medicaid clients including the need for active outreach to these groups and a vital role of a patient navigator or similar position in ensuring that patients referred to ASCs are able to follow through on actual appointments and receipt of services. Some speakers also recounted difficulties in

contracting with Medicaid managed care plans because of the plans preference for working with hospital-based ASCs and reluctance to enter agreements with multiple freestanding providers. Other speakers describe relative success in connecting with Medicaid plans and clients but persistent difficulty in finding and controlling uninsured individuals for charity care. This recalled discussions from the committee's earlier meeting where it was agreed that ASC application should be evaluated according to the totality of a proposed level of service to the underserved whether Medicaid, charity care, or a combination of the two. How to address this more specifically is probably going to be taken up at the next meeting of the committee in May. Without questions, that ends my report.

JEFF KRAUT: Do you have, any members of the Council have questions for Dr. Berliner? I would just make a comment that I attended that meeting for a portion of it, and given the attitude that the requirements that we've been insisting on and I think we may have thought that this was a relatively simple and straight forward issue of a reluctance to engage in charity care and access to Medicaid, from the brief conversations that I witnessed, it's much more complexed and nuanced than I might have originally given it consideration, so I just want to put it down there. if you have the opportunity the next committee day, maybe just to sit in and listen, it might help shape our

thinking as we kind of develop policy on this. It was really well done, very divergent point of views, and different levels of ability to engage or understand how to engage. It's almost, you have to marry up these organ – it's not going to happen naturally, to marry up to the FQHCs and the things like that. really, everybody has it differently. It was very well done. Whoever put the data together, I give you credit. I found it illuminating. Then I would thank the Department of Health and Chris and your staff.

CHRIS DELKER: Well, I think we were fortunate also in having a lot of operators and the advocates from the city and the cancer society to make the trip, and we had also been contacted by the state association who are very supportive of this notion of charity care. I think what that gathering illustrated was as Jeff just said, some of the difficulties of the day to day mechanics of making that happen.

JEFF KRAUT: It did help me. Yes, Dr. Berliner.

HOWARD BERLINER: I mean, just one thing, as it's moving a little bit off of you know, just how do we get, make sure that places do the amount of charity care and Medicaid that they promised in their applications, is the growing issue of bad debt stemming from new insurance policies –

JEFF KRAUT: High deductible plans

HOWARD BERLINER: And to what extent we in licensing these places have an obligation to deal with that, if any at all, which we may not, but I think it's worthy of discussion going forward.

JEFF KRAUT: Thank you. I'm now going to call on Mr. Sheppard to give us an update of the Office of Primary Care and Health Systems Management.

DAN SHEPPARD: Thank you. OK. Sorry. Just picking up where, with a portion of Dr. Zucker's presentation report at the beginning of the meeting, I just wanted to expand on a couple of items in the budget, and how the Department is proceeding with them.

As Dr. Zucker mentioned, the budget had a substantial additional capital commitment for healthcare facility transformation, and also amended a program that was enacted last year, and let me start with that. So, you may recall in some earlier reports in the fall that we talked about a program called the community restructuring financing program or CFRP [sic] it was $1.2 billion of capital funding enacted in last year's budget primarily for support of the capital component of

DSRIP projects. We issued the RFA in November but in the budget that was enacted on you know, on March 31 into April 1, there were changes to that program that necessitated that we reissue the RFA. Those changes had to do with insuring that funding was allocated in a broad regional way. The language specifically indicated that to the extent practicable funding from the program should be allocated in proportion to the applications received. The regional alloc – in this context in terms of intent, it's a New York City rest of state allocation, so we made some conforming changes to the RFA and reissued it last Friday with a short turn around time for applicants and we expect to – well, we've asked in the RFA that the responses be submitted to the Department no later than May 6. So, it's overall we don't expect it to delay awards by more than up to two months. So, by the end of the summer is our goal.

A new program in the budget but in some ways also a continuation of funding from the current year, was a program that we've named the vital access provider assistance program, or VAPAP. Again, many of you recall that as part of the DSRIP – as part of the Medicaid waiver the DSRIP waiver there was a pool of funds called IAAR, interim access assurance funds I believe was the acronym, and that was for safety net providers meaning the non-large publics. There was $250 million available. The intent of those funds was to sustain fragile providers through the DSRIP period. Well, there's really no magic to March 31 and

DSRIP's just getting rolling so many of those providers are still quite fragile, even though some of them did take some significant steps during the past 10 months to begin to get on the path of sustainability. The VAPAP program is $245 million of state Medicaid funds, again, to help these financially fragile providers statewide continue to operate while they implement their long term sustainability plans as well as their DSRIP related responsibilities which are certainly intertwined. Again, the majority, we expect that the majority of the recipients of these funds will be the former IAAF recipients. So the program was modeled very much on the IAAF criteria most importantly a strict cash need requirement that they could have no more than 15 days cash on hand. Another important element of this program is that funding received after September 30 is going to require that the recipient have a DOH multiyear sustainability plan and those plans need to align with DSRIP goals and objectives and we expect that many of those plans will involve formations of new affiliations and partnerships as part of that long term sustainability.

Again, just timing wise this program was enacted just really a couple of weeks ago. There are many hospitals that had an immediate cash need so what, thanks to the hard work of Charlie and his center we provide, we developed and provided an expedited application process that we rolled out almost immediately after the budget was enacted that would provide an

initial amount of money for April and May based on the IAAF need from the last state fiscal year. There were about 23 hospitals that took advantage of this about $52 million of this expedited two month assistance. Detailed financial submissions from those 23 hospitals and any other ones that want to apply under a non-expedited fashion are due at the end of the month and those will be used to calculate the total annual award amounts for the VAPAP recipients and we can report back to you as that process unfolds.

And so another program in the budget that I think in many ways programmatically ties, well, certainly ties in with all of our goals for to achieve patient centered regionally based systems of care and assist financially fragile hospitals to participate in and become sustainable as part of that process, there's a program that provides, going to provide $355 million for rural upstate and other geographically isolated hospitals. And the purpose of this program, many, one of the big barriers for small and medium sized fragile hospitals for joining systems and finding partners are their balance sheet issues, and very often as you all know, potential partners are reluctant to establish durable affiliations, deep affiliations with struggling hospitals for fear of their own fiduciary responsibilities to the legacy institution. So their institutions. So what this program will allow for is to help, we "clean up the balance sheets" so support debt retirement and

other purposes that are going to assist in restructuring efforts aimed at these financially sustainable systems of care throughout the state. We'll be issuing the request for applications for this program later this spring.

Two other more regional – more community, more region focused funding programs, capital funding programs in the budget was a $700 million prog -- $700 million amount of capital for health facility transformation investments in Brooklyn and this is to preserve and expand the quality of services in communities with the greatest health needs and the most fragile providers. So just to emphasize, this is the greatest health needs within Brooklyn and the most fragile providers within Brooklyn. I think this was in the executive budget and the legislature supported it and I think it's really a generational opportunity to have, to be able to put a critical mass of funding into an area with significant health disparities and needs and try to do what in a constructive way what has been tried before, and had mixed success just because of the pressures and deeply held interests and importance of people of providers, and I guess what I kind of like to look at this is we've only been able to have but for these funds, we've only been able to have these conversations about healthcare transformation in place in Brooklyn and other places. I guess this really goes for all of this funding. We've only been able to talk about this in terms of what we're taking away and I think the outcome of those kind

of discussions when you're talking about what you're taking away to make something, a facility sustainable you know, can be predetermined. This is really an opportunity to have a discussion about what we can build and what we can provide, and I think it's a very exciting opportunity. Sometime I'm sure we'll be reporting back to you on the RFA for this program will also be going out in the spring.

There's another $300 million for, in capital to consolidate facilities in Oneida County to create a state of the art medical campus. It's in Utica, the statute speaks to the major metropolitan area and in Oneida County Utica is the major metropolitan area. And to build a state of the art hospital and medical campus there that will create a strong regional system of care in an area that needs it. And again, the RFA for this will be later this spring.

Finally, as Dr. Zucker mentioned, there, in the final budget there was a program established for a revolving loan fund to support non-hospital based community providers. It's a revolving loan fund to support capital needs. It's a new program. We'll be doing it in partnership with DASNY. It's going to be administered by a community development financial institution. These are federally chartered institutions that provide access to capital to community-based organizations and again, we'll be working with DASNY to develop program details on that and I don't have an exact estimate of when we'll have the

RFA out for that, but we're work with all due haste. It's an important program and will be beneficial to community-based clinics throughout the state.

I guess finally just one not on my prepared remarks but Council Member Rautenberg brought it up, I guess a comment on retail clinics. You know, I guess just, your question was what happened? I guess what I can report is that I think there's still a lot of questions about how those types of clinics would fit into integrated systems of care. I think you know, we put forward we're confident that they do I think more education is warranted and we hope that process continues.

[what happens next?]

Well, I think we've got to do a bit of sort of a hot wash on sort of what happened in this budget and think about that in terms of next year.

ELLEN RAUTENBERG: You meant educating—

DAN SHEPPARD: I mean, you know, yeah. Well, I mean, again, it's, you know, it's what, we know what we proposed, what we're kind of drilling down on what were the issues. There were a lot of efforts between last session and this session to try to address some of the concerns – obviously it's not a new issue.

But we'll keep working on it. I mean, it fits in – we think it fits into the fabric of a healthcare system and we'll continue at it.

JEFF KRAUT: Dr. Kalkut.

GARY KALKUT: Dan, thanks for the report. Couple quick questions.

DAN SHEPPARD: I'd rather -- ….any questions on the budget, I have one more piece to get to.

JEFF KRAUT: Let Dan finish the report then we'll take questions please.

DAN SHEPPARD: So then I'll – this is also very important but I'll be brief and you know, Dr. Rugge, Council Member Rugge and myself and some key staff at the Department have been having some discussions over the past several weeks, maybe a month or two, sort of about formulating an agenda for the planning committee. So an 18 month agenda. And you know, by no means this is a final list, but we're centering on a couple of themes. One is post-acute care services. There are some very pract – as some of you know, the nursing home needs methodology is expiring in 2016. We need to as just a matter of business spend the next

months, year, talking about what that new methodology might look like. But there are also other methodologies, CHHAs, Hospice, specialty services, and all of these things I think fit very much into this health system of the future that we talk about with patient-center regionally integrated care and so I've been thinking about these very practical issues which we need to address but also think about them in a policy context about how they fit into an effective long term care strategy I think will be a fruitful area for us to talk about and work with the planning committee on. The other areas integration of primary care and behavioral health services, I mean, clearly again, this is essential for DSRIP and broader goals. I think we have an opportunity to leverage some of the overlap between the behavioral health services advisory committee and PHHPC, there's some member overlap. This is already something that we're deeply exploring and actually have rolled out DSRIP regulatory waiver related decisions on, but I think looking beyond DSRIP, how do we kind of set the framework for not just all of the healthcare system, but beyond DSRIP in this area. And then finally, I think we'll continue report back to the planning committee on our overall progress and regulatory waivers and as I said, I think the first time I spoke to you last August, the regulatory waiver process is really I think a great test bed or gateway to broader discussions about broader regulatory streamlining and reform. So I think those three rather meaty topics doesn't

preclude us coming up with another one or two, but just so that is sort of the framework for an agenda where Department and PHHPC can work together. Dr. Rugge, if you had any –

JOHN RUGGE: Just say, obviously I think these are very important topics and themselves need a bit of exploration by the committee rather than scheduling one of our marathon all day committee meetings as a next step or looking at using committee day and spending an hour together fleshing out a bit the agenda, timeframes, staff support, and how we will address post-acute care as yet another part of the healthcare system which is stressed, and yet we can't succeed in the other parts of the system unless we have a vibrant and successful and sustainable long term care system. So all the questions that Vicky Hines has raised will come up I'm sure, and we'll deal at the planning level rather than the project level.

With that I would also by way not of sour grapes going back to the retail and urgent care clinics, everything that we anticipated is indeed happening. These are sprouting up and I think this is the moment in which New York has an opportunity to shape the system and envelope these new modes of care into emerging regional systems, and it'll be a shame if the legislature can't find a way to come look at this and agree on the need for not heavy handed regulation but instead a way to

make those new modes of care really vibrant and really integral part of everything we're trying to do.

DAN SHEPPARD: So that's the end of my report. So if anybody has any questions.

JEFF KRAUT: Mr. Levin and then Dr. Kalkut.

ART LEVIN: So, just following up and following up, it's sort of a process question, was this in the budget, in the Governor's budget, fell out of the budget? Right?

DAN SHEPPARD: It was proposed in the executive budget and was not concluded in the enacted budget.

ART LEVIN: OK. So it fell out at the legislative level, at the conferences. So how do we – what is our responsibility to really push these things that we think are really important for the public's health? How do we sort of follow up – what is the follow up here. Do we try to educate the legislature? I mean, that's always one approach to say this may be in part – I mean, we're part of the Department. I don't know what we're permitted to do in terms of public education. I'm not talking about lobbying. I'm talking about having a day where we explain

what this is about and why we think it's important for the public's health to move in a certain direction. So, --

DAN SHEPPARD: Well, I think, Mr. Kraut may have some comments as the chair of this – I mean, I think, as I said you're part of the Department. There is a process. I mean, what this committee does informs the Department's agenda and then through a process, things make it into the executive budget or program legislation and then there's a negotiating process then we all have a responsibility to, in that process to educate and try to persuade people to our view. Sometimes we're successful. Sometimes we're not. And you know, I think it's important that we analyze each time why something might not have happened and come back. And so, I guess that's a generic description of what the process is with respect to how this body engages specifically in that.

JEFF KRAUT: I'll give you an unsatisfactory response possibly, but as we heard today and we discussed earlier, we're part of the Department of Health. The Department of Health has to speak with one voice, and we get a chance to influence that voice, we have a chance as Mr. Sheppard said, we can influence policy, and I think we've seen numerous occasions where things that came out of here made it's way through that process into a budget, a program bill, legislative things, and I can think of

probably more things that have that have not, and I would say on things that we as individuals feel strongly about, I think there's other venues we're informed, but I'm always cautioned to speak in any venue as the council, because the council meets as a whole, and we as individuals may have opinions but we don't speak for the council. I think what we can do, and I think it's very helpful when we do do things we write down our rationale, we have a report, it makes it into our industry, and I think it does influence it, but I'm not sure if we have an independent voice of the Department on legislative priorities of the Department.

ART LEVIN: First, follow up question. What happened to the OBS recommendation? They crashed and burned as well?

JEFF KRAUT: No, I believe we have a committee -- we have a committee actively meeting. I think at the next cycle they're going to come back and report to us on the OBS.

ART LEVIN: OK. But they didn't make it last year. these are the recommendations from last year?

JEFF KRAUT: That's correct.

ART LEVIN: On changes to the reporting requirements and the kinds of anesthesia? Right, there were recommendations? Did not make it last year?

JEFF KRAUT: I believe so.

ART LEVIN: Didn't make it this year? No?

JEFF KRAUT: Well, there was some changes made.

DAN SHEPPARD: There were some changes. There were some changes –

ART LEVIN: Some were made, some were not made.

JEFF KRAUT: But Art, we'll ask them to come back and kind of recap for us.

ART LEVIN: I guess I'm frustrated when it's budget-neutral. We're talking about pure public health measures. And we sort of you know, it sort of disappears. It's so easy to shoot it down, then there's really no constituency to fight for this. Again, it's budget-neutral so it has no money involved but there's influence involved, and people who don't want certain things to happen in certain ways make their voices

heard, and I'm wondering where is the public health voice. And it isn't very loud. I mean, we have a meeting, we agree, we pass it, we approve it, whatever, and then it's sort of gone.

JEFF KRAUT: I think we have the ability – it may not be – we have the ability to amplify it when we get behind something and I think if we feel that way we have things. As I said before, I think we have an unusual soap box, and sometimes maybe we don't use it to the fullest extent we could, but I think we should just pick and choose the issues and when we really feel passionate about something, it's like a dog with a bone; we just won't give it up. And we should just continue to do that, but I think you have – we are part of something, we have a process, and we have to – sometimes we can create a problem by trying to solve one and I think we just have to figure out the right process and path, but I'm all for doing that. And particularly for public health because it doesn't always make it to the top. And it should. Particularly when you're the Public Health Council. That should be our rationale. Dr. Kalkut, you had a question.

GARY KALKUT: I had a couple of questions about budget particulars. In the early announcements about the allocation of $700 million to Brooklyn there was pretty explicit language about it being directed towards a new hospital or construction

of a new hospital. Is that changed or been in the RFA or is that the focus of the RFA?

DAN SHEPPARD: So we haven't obviously finalized the RFA yet. I can describe for you, if it's helpful, how the statute is structured. It's obviously first and foremost it's limited to Kings County. If you think about it like a funnel. The next criteria are for communities with, I'll summarize a broad set of criteria listed in the statute, but essentially health disparities. Income disparities that are relatively worse than other Brooklyn communities and then funneled down in those communities, hospitals that are either financially struggling or hospitals that aren't financially struggling but maybe – not maybe, are willing to provide services of greater scope, breadth, and quality in those communities. And the RFA will obviously reflect those criteria and will review the applications that come in in response to that.

And that could involve, obviously in some communities and those communities are largely central in East Brooklyn if you run the numbers even intuitively, Central and East Brooklyn, and there are hospitals in those communities that are extremely financially distressed, extremely physically challenged in terms of their infrastructure, and in that discussion as people envision what that money might go for a new hospital could be

part of that and we've certainly heard enough that would be one of the applications.

GARY KALKUT: And the second question was about VAP, not VAPAP but VAP funding and where that stands and my understanding is applications are currently not being accepted for that, and so the question was when that might open up and what sort of funding was available.

DAN SHEPPARD: So, I'm hampered by not having my colleague from OHIP here. I think the way we did the meeting today conflicted with some people's schedules who intended to be here. So I can't tell you specifically about that program. My office doesn't administer it. It's obviously an important program. Their – I believe subject to some confirmation that the funding – there are funding commitments from that program. I think that probably exhausts most of the available resources that are there. There may be some others, but I think probably the best thing for me to say to you, to Dr. Kalkut is we'll get back to you on that and we'll report back. But I don't, I can't give you a precise estimate of how much funding is left or what the plans are for that.

GARY KALKUT: OK. Thank you.

PETER ROBINSON: So, may I? Jeffrey?

JEFF KRAUT: I'm sorry.

PETER ROBINSON: Don't be –

JEFF KRAUT: I didn't see you.

PETER ROBINSON: So, a broader question around HICRA and where that might be headed and in particular how the State is going to be looking at graduate medical education on a going forward basis. Is there just generally a strategy or a process unfolding for that that since it is going to I think the current version is going to expire shortly.

DAN SHEPPARD: I'm going to give you an unsatisfactory answer here again. HICRA is not a budget item that is in my purview.

JEFF KRAUT: SO, maybe the next time, we were supposed to have a few other people here that I think would've asked those questions, so, but if you have anything on the drinking water – oh, Dr. Birkhead left. Where is he? Oh, God. Alright, Alright. He was just here. I stand corrected. Next time we'll hopefully we'll have full complement. I know there were some

conflicts today which prevented some of those individuals from attending. We recognize that. Thank you, Mr. Sheppard. And before I call the last meeting, I just want to call to your attention, if you go to page 265 of our 596 pages we were given to read, you'll see there's the annual report of Certificate of Need and I just wanted to point out and commend the Department on the median processing time has continually declined for administrative full and limited reviews, and it's quite an admirable improvement year over year when it's looked in it's totality and recognize there's different ways to measure time, but this particular measurement because there's a lot of things that happen after the Department processes it that are not under the control of the Bureau. So I just want to commend you on that, and you know, processing close to 1000 applications including notice letters totaling some $3.2 billion. It's a substantial activity. We've paired away some of the activity. We've lightened it. But the ones that have the resultant is a little, it's not so much we diluted it, it's more concentrated analytically because the threshold to get to a CON, so I just want to commend the Department with the resources that you're given that you've created operational improvements that have really been helpful, and I think you're demonstrating that. So if you guys take a look at that, it's on page 265 of our agenda. And I'd like to now end the session by asking Dr. Birkhead to

provide an update on the activities of the Office of Public Health.

GUS BIRKHEAD: Thanks very much Mr. Chairman. I've got a set of slides I'm going to run through and you should have them at your desk. Two topics; one is an update on the Prevention Agenda and second is an update on the domain for DSRIP population health activities.

So, I think people are aware of the Prevention Agenda. For our new members, it's our State Health Improvement Plan for the State and it began in 2013 with a planning year for hospitals and counties and 2014 was the first active year, and what I'm going to do is give you an update on what happened in the first year. We asked each of the hospitals and county health departments to give us an update on it. This map simply shows in each county the primary projects that were undertaken. The Commissioner asked each hospital and county to work together on at least two projects from the Prevention Agenda. One of the five priority areas which are chronic disease, mental health and substance abuse, women and infants and children's health, environmental health, and preventable infections. And I think you can judge, see from this many of the counties suggested chronic disease. Actually, I think all but one county selected the chronic disease area and 30 selected the mental health substance abuse area. Although mental health and substance

abuse is not under the purview of the State Health Department. When you talk about health issues and health planning at the local level, mental health and substance abuse comes into play. So the health department partnered with the Department of Mental Health and the –excuse me, the Office of Mental Health and the Office of Substance Abuse, OASAS, to work on those areas and it proved very fruitful.

So we did survey and ask for a report from each county and each hospital at the end of the first year, 2014. And as of March this year we received 181 responses. All local health departments and 123 hospitals responded, and we had the total number of interventions, what they were working on jointly was 362 of those. And the information that we have focused on what the interventions were. The status of efforts, which disparities were being addressed, who the partners are that are participating and the partner organizations. And then some of the successes and challenges.

So, I'll quickly just walk through. This first slide shows the area, the response for each and on the left you can see that most counties and most hospitals so the counties are in the red, hospitals in the blue. 95 percent selected the chronic disease area as one of the areas. The next, the environmental, maternal child health, mental health and substance abuse came in as sort of a second, and the preventable infections were last. So, in the reports, the county health departments and hospitals are

working in these areas and just moving very quickly, the chronic disease interventions, this highlights what particular projects they were working on. Excuse me. So in the chronic disease area, chronic disease management classes linking participants to community resources, healthy food procurement and delivery, preventive services. And we lost the end of that one, sorry, "in the community" is what it should read. So you can see that while there – a number are working in very specific areas, we have a big "other" category, almost half report "others" and we're going to go back and dive more deeply into that because we're very interested in having counties and hospitals work with evidence-based interventions in all of these areas and when something falls into an "other" category we have to look a little more closely to be sure that it's actually an evidence-based type of practice that's going on. So this is the subject of ongoing technical assistance that we're providing to the prevention agenda folks out there working on this.

Here is an example in the mental health area of what people have been working on. Suicide prevention is a prominent one. SBIRT is a brief intervention in a clinical setting to detect alcohol and substance abuse and other types of screening programs, so that was more prominent in the hospital setting, clinical settings than in the county health department settings. And then mental health and anti-stigma campaigns were important and these are the areas their working on. And again, we have a

pretty big area of “other” category so again, with our partner agencies are looking back at what are actually being – what’s actually being done at the local level around these areas, and is it the best evidence-based types of practices and working with the hospitals and counties to be sure that they are following that.

A lot of partnerships are going on out there. This shows the numbers of different kinds of partners that both local health departments and hospitals involved in their planning and implementation coalitions. So we have local coalitions, community-based organizations, FQHCs and community health centers, social service organizations, media. If Dr. Boufford were here she would be pleased with this slide because her mantra is you really got to get everybody involved in the community. The media, faith-based organizations, business, schools, colleges, universities, so, if nothing else this activity has engaged a lot of partnerships at the local level which we hope will also have spillover benefit in the other areas of DSRIP and are SHIP grant where partnerships is really the name of the game.

We did also follow up and ask the hospitals whether the prevention agenda interventions that they were undertaking were part of their DSRIP application because as you’ll see at the end of my talk, the domain for population health aspects of DSRIP are the Prevention Agenda priority areas, and I think it’s great

that almost half of the hospitals reported, yes, they're prevention agenda intervention is part of their DSRIP application. A few reported 'no' and a few reported that they were unsure. And I think we again want to cycle back on that. It may be that the people who filled out the Prevention Agenda report were not tied into the DSRIP application process. And a very few had reported no DSRIP application. They were not part of a DSRIP application. So, this was interesting information in trying to continue the linkages between the Prevention Agenda and the other departmental initiatives, and I'll say more about that.

And then there's a new IRS requirement, maybe not so new but in the last few years, to report on the community benefit from the hospital on the IRS 990 Schedule H form, I think people are familiar with this. And we asked the hospitals whether they did indeed report their prevention agenda interventions which are community interventions should count towards the community benefit on their IRS schedule H form. Sorry. And 14 or so percent said they had reported one of their two and a number more reported that they had reported both of their Prevention Agenda interventions on their IRS 990. So, again, we're encouraging hospitals to really look at their community benefit, make it meaningful evidence-based types of activities and it should be, you know, should be eminently reportable to the IRS on these forms.

A few, some hospitals reported that they had none and some were not sure, so we want to cycle back. It may be that the people filling out this form were not the same ones. Lots of forms to fill to various locations. So, if there's not good communication you may be missing something. But I think in general we were pleased that there was, that these activities were being recognized and counting toward the community benefit and think there's ways to go to be sure everybody is taking advantage of that in their IRS reports.

So what's next? We're cycling back with the local health departments and the hospitals to really work through and understand what are the interventions as I've mentioned that they're undertaking. Excuse me. Are these evidence-based practices? And then in particular what measures are being used to track progress. I think in the first year some people were using specific numeric measures but I think many were still trying to work through the issues there and we need to help folks to understand how you set up sort of a quality improvement approach and pick some measures and work towards those measures. And as part of that – that that's, you can target populations if you know what the population is, you can count that. That can become a measure. Looking at health disparities. The Prevention Agenda has a number of health disparities measures in it. Even counting things like the number of partners engaged, etc. So we will be then also diving more deeply into the

successes and the challenges and are collecting stories, essentially success stories, vignettes, to showcase efforts and doing a lot more hopefully with social media and other things to promote the types of activities that the prevention agenda has engendered out there.

So, I'm going to shift gears now. This slide, little hard to read up on the screen, but I think if you look more closely at it can see that this is an attempt to help you through the alphabet soup of programs that the Department is now undertaking and how they fit together. So the Prevention Agenda in the upper left is our community public health improvement plan, but it meshes very distinctly with our DSRIP program in the lower left. Our SHIP grant, State Health Innovation Plan in the upper right, and the population health improvement program, the PHIP program in the lower right. And in fact, the Prevention Agenda really is the population health aspects of all of the Departmental efforts, so really made an effort to try and align these programs to improve population health, transform healthcare, and eliminate health disparities being the underlying principles. So there's more that can be said, and we're constantly needing to think through and explain even to ourselves how these programs all work together and be vigilant to opportunities for these programs to be working together.

So I just wanted to provide an update on the DSRIP, where the population health aspect, what they are and where they are.

So within domain four of the DSRIP applications you'll see a focus on these areas; tobacco cessation, access to preventive care, and management of chronic diseases, decreased HIV morbidity and reducing premature births. So these are the domain for population health areas that many DSRIP plans selected to work on which we are now working with them on, and the measures for these are prevention agenda measures.

So, very quickly, tobacco remains the leading cause of preventable premature mortality, morbidity and mortality in New York. So, this is low hanging fruit in terms of trying to reduce illness and stopping smoking immediately reduces heart attack and other kinds of short term acute processes which should fit very nicely with reducing hospitalizations which is the overall arching goal of the DSRIP program. So you can see here the overall objective and the target populations. The particular target population is, low socio-economic status but also serious and mental illness. Persons with mental illness have very high, the highest rates of tobacco use in any groups that we've seen. So again, this fits right in with the linkage with behavioral health that the DSRIP is trying to promote as well. And this map shows you the geographic locations where tobacco use cessation was a DSRIP priority, a part of their plan. We encompass many, many areas of the state, large population areas, particularly in New York City and upstate, but downstate as well. So I think this is great for the DSRIP.

It's great for our public health priorities to really try and make further inroads and impact on tobacco use.

A second area project 4BII, so if you're in the DSRIP you have to get the nomenclature down here, but access to high quality chronic disease preventive services and management in both clinical and community settings. And these are targeting mostly chronic diseases that are not included in the domain three area such as cancer, is a domain four one where it's not as highlighted in the domain three. So again, a lot of the DSRIP applicants selected this chronic disease project. You can see a large part of the state lights up here including many areas in New York City and you can look at these maps at your leisure to see which of the PPSs are engaged in these.

HIV morbidity. We are in the midst of a campaign announced by the Governor to end the epidemic, in other words reduce new HIV cases below replacement value so we actually see a decline in the prevalence of HIV in the populations for the first time in the epidemic. So a great milestone and a number of PPS selected this. A couple of them early access to and retention to HIV care is critical and as I mentioned, this fits right in with our end of AIDs initiative. And this was selected primarily in New York City which is the focal point still of the HIV epidemic, about 80 percent of the epidemic in New York City. We are working with some of the PPSs elsewhere in the state on HIV but the primary focus is within New York City.

A few selected reducing premature births. Premature births are expensive. They have life-long impact on children who may suffer brain damage or other problems from prematurity, and so reducing this, and it really gets, you need to get out in the population to be sure you're dealing with the social determinants of health, homelessness, drug abuse, alcohol and other things which lead to premature birth, as well as deal with targeted populations where prematurity is very high and deal with families experiencing stressors and assuring access to contraceptive services and other interconceptional care, preconceptional care, very important. As well as smoking. So it all kind of ties in together.

Several areas in the State selected this as a target, and these are areas which have among the highest infant mortality rates in the State on a par with some other countries it's so high. So we're pleased and really be focusing with them to try and get into this.

And then finally, the mental health and substance abuse area, I think this slide shows you how important this one is. Almost the entire state selected -- the PPSs in the entire state selected these, this general area and we again will be working very closely with OMH and OASAS around implementing this.

So, happy to answer any questions. This is an exciting time where public health really is being integrated into these

health system changes, health system transformation that's happening in the State now.

JEFF KRAUT: Thank you Dr. Birkhead. Questions? You know, the challenge here of converging and aligning all of these programs, you know, we've heard in the last year or two on the committees and from different parts with all the different incentives to make sure that, you know, we'll be interested you know, how the needle moves. That really is the objective. I was with a group of doctors last night and I have to tell you at least from a DSRIP perspective how engaged they were. They were actually talking through in their community about smoking cessation and some of the measurements around there, and it was really interesting to listen to these are all community-based primary care ones that were activated in a completely different way than historically I've ever seen them. So it was pretty impressive, and hopefully it's going to manifest itself in something positive for the health of the State.

I think if there is no other questions, I think that's it for the day. Hold on. I'm sorry.

ELLEN RAUTENBERG: I was just going to make the comment that one of the other things that bit the dust in the budget was the 15 percent across the board cut to prevention programs in

the Health Department. So a number of us are very happy about that.

JEFF KRAUT: Well, and that's where our voice has to get heard.

[inaudible]
Mr. Levin. Mic, mic.

ART LEVIN: [no mic]

JEFF KRAUT: OK. If you need a ride to the station see—
If we're – a motion affirmative is to approve the ride. Alright. I just want to remind everybody that the next meeting of the Public Health and Health Planning Council is going to be on May 21 in New York City and the full council will convene on June 11 in New York City. It is very, very important if you're serving on project review that you attend. We need to have a full committee in order to deal with some issues so we don't lose a quorum and we have the ability to act on the agenda. I'll now have a motion to adjourn.
[so moved]
So moved. We are adjourned. Thank you so much, and thank everybody for all the presentations and hanging in there during the day.

[end of audio]