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TRANSCRIPT

Mr. Robinson Good morning, everyone. Welcome to today's meeting of the Establishment and Project Review Committee. I'm Peter Robinson, Chair of the committee. Glad to welcome you all here. I'm calling the meeting to order, welcoming members of the committee and the rest of the council, participants, observers, applicants, the general public. Just a few traditional announcements that I need to make. First, with regard to webcasting, just to remind everyone that this meeting is subject to the Open Meeting Law and is broadcast over the internet. The webcasts are accessed at the Department of Health's website, https://www.Health.NY.Gov. The on-demand webcast will be available no later than seven days after the meeting, for a minimum of thirty days, and then a copy will be retained in the department for four months. A few suggestions/ground rules. We are using synchronized captioning in the webcasting. It's important that people do not talk over each other so that the captioning can be done correctly. First time you speak, please indicate your name and briefly identify yourself as a council member, member of the staff, etc. This will be important to the broadcasting company as they record the meeting. Microphones are hot. They pick up every sound. Please kind of don't make a lot of noise around them. Be sensitive to sidebar conversations because they often get picked up. Reminder for the audience, and many of you have already done this. There is a form that needs to be filled out before you enter the meeting room, which records your attendance. That's required by the Joint Commission on Public Ethics in accordance with Executive Law Section 166. That form is also posted on the Department of Health's website under Certificate of Need. You can fill out the form prior to the meeting if that works for you. We do thank you for your cooperation. As this meeting gets started, this is the first time that the requirements around health equity assessments are included in some of the applications that have been filed and are now up for review. Rather than kind of brief everybody on a single application, we're going to ask that Tina Kim from the Office of Health Equity, who I believe is... There, she is on the screen. Is going to give us a brief overview of the health equity assessment form and process and talk about how that gets integrated into our review of Certificate of Need application.

Mr. Robinson Ms. Kim, can I turn it over to you?

Ms. Kim Absolutely.

Ms. Kim Good morning, everyone, members of the committee. Again, my name is Tina Kim. I am the Acting Deputy Commissioner of the Office of Health, Equity and Human Rights. Within the Office of Health Equity and Human Rights is the Health Equity Impact Assessment Unit, which is responsible for reviewing the health equity impact assessments submitted to the Department of Health as part of the Certificate of Need application process. Tomi Akanbi, the Director of the Health Equity Impact Assessment Unit is out of office on scheduled leave. She shares her regrets for not being able to attend today. I want to assure the committee that the Health Equity Impact Assessment Unit is well represented today. I am delighted to be here with you today. Two members of my team are present in person. Ali Hamburg, Program Data Analyst from the Health Equity Impact Assessment Unit and Kacey Griffin, who many of you know, Senior Health Program

Coordinator from the Office of Health Equity and Human Rights executive team. I want to first start off with a high-level overview of the health equity impact assessment requirement. On June 22nd, 2023, the law requiring a Health Equity Impact Assessment with Certificate of Need application went into effect. Through this Public Health and Health Planning Council the department adopted and implemented regulations related to this requirement. To refresh memories, the purpose of the Health Equity Impact Assessment is to understand the health equity impacts of a specific facility project that will be undertaken, understand the impacts specific to medically underserved groups, and ensure that meaningful community engagement and assessment of various factors that contribute to mitigating health disparities are considered when a Certificate of Need application is being reviewed by the department. The key elements of a Health Equity Impact Assessment requirement, a third-party independent entity is required to conduct a facility's health equity impact assessment using the department's established template that demonstrates the independent entity's evaluation of the unintended and intended health equity impacts of a proposed project in a facilities service area, especially for medically underserved groups. It is also expected for mitigation plans and a monitoring plan to be developed by the independent entity and the facility to address any negative findings through appropriate mitigation strategies, monitor impacts, and continue meaningful engagement with the community. As part of the process, the independent entity must meaningfully engage with stakeholders and the community. The scale and depth of that meaningful engagement should be commensurate with the size, scope, and complexity of a facility's proposed project. The regulation provides a description of possible mechanisms for meaningful engagement, such as, but not limited to; phone calls, community forum, focus groups, and written statements. Lastly, the department requires that the independent entity offer stakeholders the opportunity to offer statements and provide as part of the Health Equity Impact Assessment a summary of submitted statements. Since the law went into effect June 2023 as anticipated, the department has begun to receive Health Equity Impact Assessment submitted by a Certificate of Need applications evidenced by today's agenda. Today, the committee will review three CON applications that were submitted with Health Equity Impact Assessment. Before the committee discusses each individual application, I want to make some baseline foundational remarks on what health equity is, followed by general remarks as requested about the process undertaken for the health equity impacts to be considered as part of the overall department's recommendations on the CON application. What is health equity? I am going to display here this slide shows the New York State Public Health Law definition of health equity. Health equity shall mean achieving the highest level of health for all people and shall entail focused efforts to address avoidable inequalities by equalizing those conditions for health for those that have experienced injustices, socio economic disadvantages and systemic disadvantages. From the department's perspective, it is significant and monumental that New York State Law reflects and defines health equity. Basically, health equity is achieved when no one is limited in achieving optimal health and well-being because of social position, identity, or any social determinants of health. To ensure everyone has the opportunity to achieve optimal health and well-being it is important for interventions and programs to be tailored to the different and unique needs of individuals and communities, rather than providing everyone with the same interventions, same services, same programs, and expect to achieve the same results across the population. Providing individuals with the tailored interventions and programs and services they need is what characterizes efforts to achieve health equity. Simply providing the same services to everyone is not sufficient to meet the needs of those who have been historically prevented from accessing or receiving social determinants of health. The goal of health equity is to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes. Health equity impact assessments are one mechanism. It's a powerful tool that will help inform facilities and the

department understand the health equity impacts of a project. The intention is and the hope is that that information will help the facilities develop proactive and inclusive strategies to meet the needs of the most underserved.

Ms. Kim This next slide is a great visual that myself, the Commissioner, we use all the time in our public remarks when it comes to describing and kind of illustrating health equity. Health inequities arise from systemic and structural factors that create barriers to accessing health care services and resources. As illustrated on the left, the left tree, not everyone is starting from the same place when trying to achieve optimal health and well-being. Not all people have equal access to the things that they need to be healthy. According to the health equity approach, it's not that everyone should have everything equally, and that's what it's going to take. This is where health equity comes in. As illustrated on the right, health equity is the idea that everyone, regardless of their race, ethnicity, socioeconomic status, age or any other factor should have the same opportunity to achieve their best health outcomes. It's not necessarily about giving equally. It's the idea of how we make it so that different people have what they need, what they individually need in order to achieve optimal health and well-being, considering their circumstances. This is what the department hopes that the work and expertise of the independent entity, and quite frankly, also the facilities, will help shed light on with respect to specific facility projects. With that, I'm happy to kind of go into how we evaluate information coming in. As I stated upfront, a dedicated unit of trained staff within the Office of Health Equity Human Rights reviews and evaluates health equity impact assessments based on the validity, strength, and value of the information that's presented. Similar to other review units within the department, the Health Equity Impact Assessment Unit reviews submitted Health Equity Impact Assessment concurrently with other parts of the CON application. As a reminder, the Health Equity Impact Assessment is one of several components that are considered in the totality of a given CON project and the overall CON approval process. I also want to remind that much of the scope and the contents of the Health Equity Impact Assessment is already outlined in statute. The Health Equity Impact Assessment Unit closely reviews the degree of impact of a proposed project on medically underserved groups in the facility's service area, both positive and negative. If negative impacts are identified, ensure they are properly addressed in the mitigation plan and monitoring strategies. Ensure meaningful community engagement with a variety of stakeholders. Make sure that that was achieved and discussed in the assessment. Key insights collected from stakeholders during meaningful engagement are strongly considered and incorporated in the overall evaluation of the assessment. The strength of the mitigation and monitoring strategies is offered by the independent entity and applicant. It's not realistic for us to assume that most CON projects are going to come with absolutely zero negative findings. There may be potential negative findings that will be found. Really, we also look at the strength of the mitigation and monitoring strategies to see the facility understands these potential negative findings and are proactively thinking of ways to address it, to mitigate it, to monitor it moving forward. That's part of the overall consideration of the assessment. Based on these factors, data and other information presented by the independent entity the unit makes a determination with respect to the health equity impact of a CON application on whether the proposed project will result in any significant or overwhelmingly adverse health equity impacts that could not be addressed in the mitigation plans. The design of the expectation of the Health Equity Impact Assessment requirement is that the health care facility fully understands and demonstrates understanding through mitigation plans and monitoring of the findings of the Health Equity Impact Assessment. With that, I'm happy to pause there and see if the committee has any questions with respect to this requirement. Thank you.

Mr. Robinson Please, Dr. Berliner.

Dr. Berliner Hi. Can you say anything about the people who have been doing the evaluations?

Mr. Kraut The independent.

Dr. Berliner the independent evaluators.

Ms. Kim Yes.

Ms. Kim What I can say, and I can pass it over to Ali to give some more specifics. Generally, independent entities have been very willing to engage the department. They're eagerness to learn and really develop themselves in the face of health equity impacts is clear. I personally have been in a number of conversations with independent entities that have sought out consultation and technical assistance from the department, and I know the unit has had even more conversations with independent entities. The desire to learn and to understand kind of what the department expects is very clear. We can also say that the independent entity, you know, certainly as outlined in statute really understand kind of the intent of the law and know that the key components with respect to meaningful engagement, you know, the data, and you know the mitigation plan and strategies and really working hand in hand with the facility. They know that that's critical. Undertaking measures to make sure that they do due diligence in that respect. They're slowly rolling in. In terms of the diversity and who is in the health equity impact assessment game continues to be further developed and kind of evaluated from our end. We had kind of committed at the beginning. We said year one is going to be the first year of implementation. Many firms and entities are coming up with their bandwidth and their capacity to be able to do this service. It's definitely been a learning curve. Overall, it's been quite impressive. We continue to consult the independent entities if to whatever extent the health equity impact assessment needs clarification or additional details. They've been very willing to engage and share with our unit so that we can have a full understanding of their perspective.

Dr. Berliner Thank you.

Ms. Kim Thank you.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence I commend you. It's a pretty lofty goal that you've outlined. I guess my question is what is the measure of success for your efforts? What do you think that will look like? How will you report out on your success over time?

Mr. Kraut Before you answer that, I just want to make sure everybody is aware that in the attachments we have the health equity impact assessment staff reports. Those are available. To the public, the filing of the health equity impact analysis done by the independent evaluators are available. There is just a tremendous amount of information put out there to the public that could invite comment on. Howard, your statement suggests the quality of the analytics that are done, which I think you'd be relatively impressed by. I went on to see the actual source documents. It really was reflective of the intent, you know, as you said before. I'll let Tina comment. I just want to make sure everybody knows there's an enormous amount of information.

Mr. Lawrence Thank you for your comment, because and maybe I need to clarify what I'm asking. I'm asking about the outcomes. How do you know that you are being impactful? In fact, the people that you are targeting, and you wish to improve outcomes for. How will that show up? How will it be measured? When and how will you report on it?

Ms. Kim Thank you for that question.

Ms. Kim Thank you, Mr. Kraut. You took the words right out of my mouth.

Ms. Kim As designed in this requirement, there is the requirement to pose the health equity impact assessments in full publicly, as well as the detail that is outlined in the PHHPC committee materials. In terms of the overall outcomes, you know, I can speak very generally in terms of what the vision was from the department's perspective as we were taking this legislation, really understanding the intent of it and bringing it to life through implementation. Just this requirement in and of itself is pretty monumental. The first time that the department is going to comprehensively and systematically across these facility projects gain a ton of information with respect to health equity impact assessments. I think the hope is and I think one outcome we can just debate how it's measurable. Even just the fact that this committee can think about the nuances that come. We know that before this health equity impact assessment requirement CON applications did speak to here's the demographics, here's who we serve and give a good understanding of what the intent of the project was. The health equity impact assessment provides a lot of color and some insights that may not have been considered in the past. From the Department of Health point of view for us to be able to then begin to analyze on a macro level what the health equity impacts identified and the kind of the overall landscape of these facility projects that's definitely something that is significant for us. We would want to do our due diligence. We have been thinking about after the first year what would it look like to be able to show some of the outcomes of these analyses? That's going to take time. We do have intentions. We do want to be able to somehow later be able to show how these changes have reflected in the upcoming years. We can look at potentially less hospitalizations, less incidents of disease in that particular area. All to say, like, I think in terms of the outcomes, we really kind of hope that this council will greatly appreciate and really take into consideration the nuances that were found in the health equity impact assessment and then also that for the department we have a better sense of kind of localized health equity impacts with respect to these facility projects.

Mr. Lawrence Thank you.

Mr. Robinson Dr. Kalkut.

Dr. Kalkut Thank you.

Dr. Kalkut I also think what you're doing is crossing a threshold to gather information like this. My understanding is we're the only state in the country that is doing this. Would you consider after some period of time; a year, two years, eighteen months, something like that putting together a summary of what we have. The outcomes made, as you said, may take longer than that. There may be some intermediate outcomes that we could look at, but just what has happened over the past year? Because this information, as you said, is gathering anew. It would be great to see it summarized over a year or a year and a half.

Ms. Kim No, I was going to say the unit has already started to think about what could be possible, and what would make sense in terms of year one reporting. As you know, Dr. Kalkut, like it's been a gradual increase in submissions. We expected that because of the time that it takes for you to contract with an independent entity and to get these done and make sure that it coincides and aligns with the lifespan of the CON application. We knew that it was going to be gradual. Yes, the intention is that we want to be making available to stakeholders, to this committee and to the overall community what we're seeing. That's an active discussion. Actually, as recent as last week, we were just talking about what can we think about reporting out for year one? I know you said you had a comment.

Dr. Kalkut I just want to compliment you and your staff on the formatting of the health equity assessment in the attachments. It's five pages long. It's got data and narrative in there. It's easy to read. It's very nicely done.

Mr. Robinson Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe Ann Monroe, member of the council. Good morning. I know that you're committed through this process to patient privacy. I know that's the underpinning of all of this. Have you faced any challenges with that? Is there anything in the assessment that might, in fact, bump up against those areas like patient privacy that upon reflection you think might need to be strengthened or amended in some way or another?

Ms. Kim Thank you so much for that question. You know, from the experience of the Health Equity Impact Assessment Unit thus far...no, there has not necessarily been an incident or an issue with respect to patient privacy in a submitted HEIA. I will say to you that overall that there have been concerns and comments raised about patient privacy and specifically, PHI, protected health information. If and to what extent that does come in through the health equity impact assessment, you know, one thing is that we have implemented the ability for the facility to redact information. To the extent that the health equity impact assessment, the CON application, and the summary of statements from stakeholders to whatever extent there needs to be redactions that that be made. At the same time, we also recognize, and we want to make sure that we ensure the highest maximal protection of patient information and ensure privacy. To that end, the department is developing additional guidance for independent entities and for facilities when it comes to patient information. So, for example, we are going to recommend that a patient identifier system be used. Instead of putting the full name of a patient or the employee or the stakeholder that is submitting a statement that it's Patient A, Patient B, Employee A, Employee B, Stakeholder A. We are implementing a number of remedial measures and issuing guidance to ensure that we uphold patient privacy. I do want to emphasize that the unit has been trained with respect to HIPAA and protected health information. We want to make sure that that is protected. It's really the top lines of like the health equity findings. Not so much analysis that the patient or like kind of stakeholder level when it comes to those submitted statements. I do want to emphasize kind of the focus of the unit's evaluation is less so much on like what is individually submitted, but rather like the overall findings of the independent entity, which is then supported by the stakeholder statements. We are actively developing and finalizing guidance as well as implementing a number of remedial measures to make sure that patient privacy is upheld.

Mr. Robinson Thank you.

Mr. Kraut Mr. Kraut.

Ms. Kim Absolutely.

Mr. Kraut I'm going to take the prerogative of the last statement before we turn to the agenda. We asked Tina and the staff to come today because we didn't want to burden these applications with these discussions. We want for the council to refresh their memory, understand things. I just want to give it context. When you take a look historically about what this means, and we were all very supportive of it when the regulation came before us. We wanted clarity. If you go back and the expectation of what one thing will do, I doubt very much the imposition of a health equity impact assessment is going to move the needle alone. What it is, it's part of a process where if you go back in our history we brought in the prevention agenda. How did you align? We brought in the focus on the community service plans and what the applicant was doing in a broader context, and then the focus on community health, working with local departments. Just recognize when we look at the use of this in this room it's really to drive good data, good policy so we have a more informed decision making. We evolved with long term care applications in looking at the star ratings and bringing that into the room. Good data is helpful to make good decisions. Just remember this context of what we're doing here will also be evaluated in terms of other policy initiatives that the state is doing, most notably, and hopefully will be the most impactful will be the 1115 waiver, the development of the social care networks, because we know health equity is the social determinant aspects of it beyond just health care is really what will move that needle. Reimbursement changes, the capital transformation grants, I think all of those in context. What the council has done with adopting this regulation it's putting everybody on notice that that's an important part of the discussion. You don't come into the room here without those discussions and will be informed by this. Time will tell. Let's find out how that works.

Mr. Robinson Nicely said, Jeff. I think, appreciate the context that you provided. Let's get into the business of the committee and with thank Ms. Kim again for her comments and her team is here and she's available online---

Mr. Kraut Tina's going to drop off. Her staff will be here to ask questions on the application.

Mr. Robinson Got it.

Mr. Kraut Okay.

Mr. Kraut Thank you, Tina.

Mr. Robinson Thank you for that clarification.

Mr. Robinson Calling application 232182C, White Plains Hospital in Westchester County. This is to certify twenty-four intensive care beds and 120 med surge beds and perform renovations to create a ten-story addition. More than a renovation. The department is recommending approval with conditions and contingencies.

Mr. Robinson May I have a motion?

Mr. Robinson Dr. Berliner.

Mr. Robinson Second?

Mr. Robinson Dr. Torres.

Mr. Robinson Ms. Glock.

Ms. Glock Good morning. This is Shelly Glock from the department. My comments to introduce this project this morning are going to be a bit lengthier than I typically provide. That's due to the size of the project and the fact that the project has multiple components. White Plains Hospital is a 292-bed acute care hospital and a member of the Montefiore Health System. They are located in White Plains in Westchester County. This application requests approval to certify twenty-four additional intensive care beds and 120 additional medical surgical beds. White Plains Hospital plans to construct a ten-story addition to the existing hospital that will be connected to the hospital on the first three floors. The new addition will also include an emergency department expansion, an addition of three new operating rooms in addition to the 144 additional private acuity adaptable inpatient beds. The primary service area is Westchester County. However, patients from other Montefiore System hospitals who reside outside of Westchester County are anticipated to receive care at White Plains Hospital as well. White Plains Hospital joined Montefiore in 2015 and has transformed from a community hospital to a tertiary hub, providing high acuity care to the community that is expanding to include its hospital partners and its affiliates in the system. White Plains Hospital now supports communities ranging from Newburgh in Orange County, Nyack in Rockland County through the Hudson Valley to Southern Westchester County, including Mount Vernon, New Rochelle, and Yonkers. They currently provide advanced care that is not offered at Saint Luke's Hospital, Nyack Hospital, New Rochelle and Mount Vernon currently. The project enables the Montreal System hospitals to continue to transfer secondary and tertiary level patients to White Plains Hospital instead of those patients having to travel to New York City or New Jersey. White Plains Hospital has experienced significant growth over the last decade, driven by expanding access to health care providers both geographically through the addition of new ambulatory practices and through the addition of new advanced programs and services. White Plains Hospital's goal for this major expansion project is to enhance and expand its campus, to continue to serve as the tertiary hub in the Hudson Valley for the Montefiore system while addressing the increase in utilization in the associated capacity and overcrowding issues on its main hospital campus. I want to get into a little bit the project's three key components. The applicant proposes adding the 144 private acuity adaptable inpatient beds to address current and future capacity issues. According to the applicant, many of the existing rooms are undersized and they require updates in both size and amenities. These rooms will also be able to be converted into critical care rooms if needed as future demands may dictate. Twenty-four of these additional beds will open as intensive care beds bringing White Plains Hospital to a total of fifty-two critical care beds. Inpatient volume in the med surge beds has exceeded 100%, often overflowing into other areas on certain days. The applicant states that White Plains Hospital continues to manage its rising average daily census with initiatives to lower length of stay and enhance throughput, but still experiences capacity and overcrowding that only an expansion can further mitigate. The second component of the project is a proposal to expand the emergency department by adding an additional 22,650 feet to help mitigate ED throughput and overcrowding issues. The ED volume at White Plains Hospital has grown from 66,000 visits in 2019 to nearly 78,000 in 2023. Even with initiatives to minimize unnecessary emergency department visits underway and the availability of expanded hours in several primary care practices and multiple urgent care centers in the area. The department was originally designed to accommodate 46,000 patients annually. The ED has twenty-seven semi-

private positions and thirty-one private bays, for an existing total of fifty-eight care spaces. The new proposed ED expansion will have sixty-seven private bays. The third component is the White Plains Hospital with this application, if approved will add three operating rooms to help address the increasing volume and the acuity of surgical cases. The O.R.'s are seeing higher volume, but also higher acuity cases, leading to extended surgical times. According to the applicant, White Plains Hospital's surgical volume has grown 84% between 2010 and projected 2023. Not only has the volume increased, but the complexity in the length of the surgical cases continues to increase, generating necessity for additional appropriately sized operating rooms. The three additional operating rooms will have a new private pre and post unit and an expanded sterile core as essential components of this expansion to help address the increasing volume and acuity of the surgical cases. The applicant is projecting 29,372 inpatient visits and 626,963 outpatient visits with its 18% Medicaid payer mix. According to the applicant, White Plains Hospital has experienced an increase in the number of Medicaid patients served and anticipates this will grow as it evolves as the tertiary hub for the system. The total project cost is $747,928,910. It will be met with the met with $147,928,910 in equity, fundraising of $100 million and a $500 million tax exempt bond with an interest rate of 6.5% over thirty years. There is an error on the green sheet summary that is $500 million tax exempt. That will be corrected for the full council meeting. Based on our review, the department is recommending approval with contingencies and conditions on the project.

Mr. Robinson Thank you.

Mr. Robinson Are there any questions for the department?

Mr. Robinson Dr. Berliner.

Dr. Berliner Shelly, was there any outreach to the other hospitals that might be affected by this increase in bed size?

Ms. Glock There was no specific outreach by the department. However, the department did not receive any opposition to the project. We did receive letters of support including the County Executive.

Mr. Robinson Thank you.

Mr. Robinson Other questions?

Mr. Robinson Ms. Monroe.

Ms. Monroe I have a question for the applicant.

Mr. Robinson Can we ask the applicant to come forward, please?

Ms. Monroe Good morning. Big project you're taking on.

Mr. Robinson Let the applicants introduce themselves.

Ms. Monroe Of course.

Ms. Fox Good morning. My name is Susan Fox. I'm the President and CEO of White Plains Hospital.

Mr. Cicero Frank Cicero, a consultant, White Plains Hospital.

Ms. Monroe We hear over and over about the workforce shortage. I noticed on your staffing projections you have over 200 RNs in the first year of the operation, as well as if you look at techs there's huge numbers as well. I don't know when the first year of operation would be because you've got to build this building. What thought process have you gone through to be confident that you're going to be able to staff this expanded hospital, given all of the constraints that everyone seems to be under?

Ms. Fox Thank you for your question.

Ms. Fox We have been growing over the last fifteen years very consistently. I've been at the hospital since 2010. Our number of employees have grown by 3,000 since then. If we just look at that time, we're growing about 200/300 a year. We have, as I think Ms. Glock had mentioned, we've been growing in all area's inpatient, E.R., O.R., and significantly in our ambulatory environment as well. We've been very successful at hiring. I think that goes back to understanding and having a culture of recognition and respect for individuals, communicating, making sure that we are paying market, we're providing benefits. We provide reward and record recognition to the employees. Ultimately, they really feel that they're part of the organization. I can go on about our secrets to success, but at the end of the day, our turnover rate is half of the national average. I think the national average went from 17 to 22% over the last couple of years. And for nurses and non-nurses, we're 10 and 11% right now. We're very proud of that number. We feel very confident that we'll be able to hire the people that we need. I think in terms of our clinical volume, that is there now there's a lot of people that are already there. In terms of the mix of who's year one we'll probably have a lot of building and security, housekeeping, other types of positions that have a bit more of a lift those first couple of days where the clinical will be sort of more of a natural rise as we've been growing each year. Over the last decade, on average, our volume has grown about 4.5%. For this project, we're anticipating that it'll be more conservative around 3%. Thank you.

Mr. Kraut When is the building opening?

Ms. Fox 2028.

Mr. Kraut You have five years.

Mr. Robinson I'll have you stay here to see if there are any other questions for the applicant or the department.

Mr. Robinson Thank you very much.

Ms. Fox Thank you, everyone.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Motion carries.

Mr. Robinson Thank you very much.

Dr. Kalkut Next application is 241042C, Saint James Hospital in Steuben County. There's a conflict and recusal by Mr. Robinson, who's left the room. This is to convert two medical surgical beds to intensive care beds and certify a four-bed swing bed program with no change in total bed count. The department recommends approval with conditions and contingencies.

Dr. Kalkut Can I have a motion?

Dr. Kalkut Dr. Berliner?

Dr. Kalkut Second?

Dr. Kalkut Dr. Torres.

Dr. Kalkut Shelly.

Ms. Glock Saint James Hospital is an existing fifteen bed acute care, not for profit hospital located in Hornell, New York, which is in Steuben County. This application requests approval to convert two med surge beds to intensive care step up beds. The department does not have a special designation as step-up beds, so they will be certified as intensive care beds. As you'll hear, through the application, they intend to use them as step up and to certify a four-bed swing bed program with no change in the total bed count. Saint James Hospital will remain a fifteen-bed safety net hospital. The med surge beds will decrease from fifteen down to thirteen, and the intensive care beds will increase from zero to two if the project is approved. This project will treat patients in Steuben County. Saint James Hospital is in a health professional shortage area for dental, health, mental health and primary care. The medical surgical occupancy has grown significantly from 2020 to 2022 with further growth anticipated. Saint James also notes experienced spikes in utilization, often reaching 100%. Creating the ICU in swing bed unit will allow more flexibility for the hospital. The proposal will address complex care with the certification of two med surge beds as ICU beds. These proposed beds would be used as med surge beds when there are no complex care patients for admission. The proposal will also allow the hospital to accommodate patients in need of mechanical ventilation for up to thirty-six hours, but no more than ninety-six hours. The swing beds will create flexibility to switch from an inpatient status to a skilled care for patients needing short term rehabilitation or waiting for skilled nursing home placement. The proposal will use the existing patient rooms for the ICU beds and the skilled nursing swing beds. There will only be minor renovations to meet this higher level of care for the ICU. This renovation will occur on the second floor. No building system upgrades are proposed, which is why the project cost is such. No construction work additionally is proposed for the skilled nursing swing beds. These two medical surge inpatient sleeping rooms will be used for the swing space, and they'll remain single occupancy bedrooms. The applicant is projecting ninety-one inpatient visits in year one and 183. That's for both the ICU and swing bed. Medicare is the primary payer source, with 89% in year one and eighty-seven in year three. Medicaid is projected to be about 6.6 and 7.7 in year one and three, respectively. The total project cost of $40,264 will be matched with equity, and the HSA has recommended approval on this project, as does the department with contingencies and conditions.

Dr. Kalkut Thank you.

Dr. Kalkut Questions from the committee?

Dr. Kalkut Any member of the public wish to speak on this application?

Dr. Kalkut Seeing none, I would call a vote.

Dr. Kalkut All in favor?

All Aye.

Dr. Kalkut Opposed?

Dr. Kalkut Abstain?

Dr. Kalkut The application passes.

Dr. Kalkut Could we call Mr. Robinson back in the room?

Dr. Kalkut We're at 231323C, Saint Mary's Hospital for Children in Queens County. This is to certify eighteen new pediatric beds to construct in addition to house a new pediatric unit. The department approves with conditions and contingencies.

Dr. Kalkut May I have a motion?

Dr. Kalkut Dr. Berliner.

Dr. Kalkut Dr. Torres.

Dr. Kalkut Ms. Glock.

Mr. Furnish Its actually Mark Furnish with this. I make that mistake all the time.

(Laughing)

Mr. Furnish Anyway, I'm Mark Furnish. I'm with the Department of Health. This is a construction application, not an establishment application for Saint Mary's Hospital for children. It requests approval to increase bed capacity from 124 pediatric beds to 148 pediatric beds for a total increase of eighteen beds. It would also renovate an existing space on the fourth floor and construct a new building, which will be attached to the existing facility, which will compensate for those new rooms and some existing office space. It should be noted that Saint Mary's is only one of three residential health care facilities in New York City, serving the general pediatric population. These beds are needed. Give you an example. In May, from a time period of May 1st, 2022, to April 30th, 2023, there was a waiting list of ninety-one children and 333 children referred to the facility, and only 121 could be admitted due to the lack of bed capacity. We also want to make note that on Page 4 of the exhibit, the Medicaid access chart is wrong and will be fixed in time for the April 11th, 2024 full PHHPC agenda. Their Medicaid numbers are well above county levels. As a result, we did have a contingency number three, which we usually put in when applicants have low Medicaid access numbers that we want to remove. I'm going to read that into the record now just so everyone's clear on what we're removing. Contingency number three from the project states submission of a plan to

continue to enhance access to Medicaid residents. At a minimum the plan should include, but not necessarily be limited to, ways in which the facility will A, reach out to hospital discharge planners to make them aware of the Medicaid access program, B, communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility, and C, identify community resources that serve the low income and frail elderly population, and may eventually use the nursing facility and inform them about the facility's Medicaid access policy. We're going to remove that contingency from this project. It passes need. Character and competence are fine. Star ratings are very high for this facility. Financially, it meets our metrics. With that, the department recommends approval.

Mr. Robinson Clearly, we need more or more of these facilities in the state given the demand.

Mr. Robinson Mr. Holt.

Mr. Holt Thank you, Peter.

Mr. Holt Mark, just to that question, given the number of referrals that are being made and number of patients are able to be accommodated, those patients weren't accommodated either remaining in hospital or being transferred out of state. Give us a sense of what happens when there's not enough capacity for this unique population.

Mr. Furnish Yes, it is a concern. Some go out of state to out of state. New Jersey, they go to there. We get requests all the time to do one offs. Lately, we've got in situations due to unique circumstances where they ask if they could use surge room as a temporary bed. There's a lot of last-minute planning. They stay in the hospital. They're transferred out of state. It's a disruption to the families. It's a real concern.

Mr. Robinson Other questions for the department?

Dr. Soffel I have a question.

Mr. Robinson Please.

Dr. Soffel Good morning. Denise Soffel, council member. Mark, I want to go back to the Medicaid question because I'm a little bit confused. My understanding was that most people who are residing in RHCF facilities are on Medicaid because they're receiving long term care services. Medicaid picks up most long-term care costs in the state of New York. Yet, when I look at the payer mix for Saint Mary's that's not the case. Can you speak to their particular payer mix and why it's so low in Medicaid?

Mr. Furnish I could ask the applicant to come up and explain how they explained it to us.

Mr. Kraut Didn't you just say it's wrong?

Mr. Furnish It is wrong.

Mr. Kraut The data is wrong in the report.

Mr. Furnish There's a little... It's nuance.

Ms. Glock Can I just make a clarification?

Ms. Glock Hi. Shelly Glock from the department. The information in the exhibit that Mr. Furnish is referring to is the percentage of Medicaid at the time of admission. That's an important distinction because over time residents may become eligible for Medicaid, but the regulation is around at time of admission the percentage of Medicaid.

Mr. Robinson Thank you for that clarification.

Mr. Robinson Can we have the applicants introduce themselves?

Mr. Cicero I'm Frank Cicero, a consultant to the applicant.

Mr. Lally Sean R. Lally, Executive Vice President, Saint Mary's Health Care System.

Mr. Mead Bill Mead, Executive Vice President.

Mr. Cicero We were in touch with the department regarding this matter. What happens with the children who come to Saint Mary's is every virtually every child is covered by Medicaid. There's a small fee for service percentage. I think that's what's covered in the staff report. Every child who is eligible is enrolled in Medicaid managed care upon admission. They are eligible upon admission for Medicaid. It's 86% of the children at Saint Mary's Hospital who are on admission are covered by Medicaid. The overall payer mix is nearly 100%, over time, but on admission it's 86%.

Dr. Soffel That certainly changes the way I was looking at this. Because I was going to ask a question about health equity. I know you guys were not required to submit a health equity assessment because you submitted your CON prior to, days prior to the health equity rules coming into effect. My concern was whether children on Medicaid were going to be disproportionately limited in access to this facility, which I acknowledge is desperately needed. It sounds like that is not the case.

Mr. Cicero I'll let the facility speak a little if you'd like, but I can just say this facility has not been in front of this council, I think for about ten years since the last time it added beds. This is a facility that serves everyone. It always has been and always will be.

Mr. Robinson Other questions of the applicant?

Mr. Robinson Any other questions for the department on this application?

Mr. Robinson, I think Mr. Holt underscored this in his comments, but we really as a state need much more of this kind of capacity. Really glad to see this application here. Thank you for bringing it forward.

Mr. Robinson I'm going to call the vote.

Mr. Robinson All in favor?

Mr. Robinson I apologize. Thank you, Mr. Kraut.

Mr. Robinson I've got to do my due diligence here.

Mr. Robinson Is there anyone from the public that wishes to speak on this application?

Mr. Robinson Hearing none I'll call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Thanks very much.

Mr. Robinson Application 222105E, Alliance for Health Inc. This is an application for a home agency licensure establishment and changes of ownership. This is a transfer of 100% ownership interest above the grandparent level. The department is recommending approval with a condition.

Mr. Robinson May I have a motion?

Mr. Robinson Thank you, Dr. Berliner.

Mr. Robinson Thank you, Dr. Torres, for a second.

Mr. Robinson Mr. Furnish.

Mr. Furnish Yes.

Mr. Furnish Just a reminder that we are leaving Article 28 land crossing the border into Article 36 land, so your passports are out. I'm going to make a declaration before we proceed. Article 36's are different. They have a different regs set, a different rule set. When you're looking at these applications you will see charts with grandparents, parents, great great grandparents. It goes on and on and on. The regulations account for that by looking at controlling entities. That means that through ownership or voting securities or voting rights they deem control of the facility. Any change in any of those levels you have to get established through the Public Health and Health Planning Council. Now, as health care continues to change and you get these higher and higher levels and national and international and corporations getting involved in this it becomes increasingly hard to do the character and competence, because in New York State, we like to do a character and competence of each individual person because of the natural persons. We came up with addressing that control aspect of this is we an applicant comes to us, we say, point to us on the chart where control stops. They point to that and say, well, everyone has to sign an affidavit of no control at that level or higher that they say they're not going to have any control over any of the plans, any of the finances, anything related to the Licensed Home Care Service Agency. Everyone who doesn't sign that we do a character and competence check on. I just want to make that clear as we move forward to these. Project number 22105 Alliance for Health doing business as Accent Personal Care Service of New York, which operates a licensed home care service agency is requesting a change in indirect

ownership, transferring 100% ownership interest above the grandparent entity. An affidavit of no control has been implemented above the parent entity, Accent Care Inc, where Pluto Acquisition one and organizations above this entity will refrain from exercising control by directing or causing direction of the actions, management or policies of the agencies, whether through voting securities or voting rights thereunder, electing or appointing directors, the direct or indirect termination of policies or otherwise. At that level, they have no control. It meets our character and competence review. It meets our financial review. The workforce summary has been included at your request. The department recommends approval.

Mr. Robinson Thank you.

Mr. Robinson Questions for the department?

Mr. Robinson Ms. Monroe.

Mr. Robinson Thank you.

Ms. Monroe I appreciate the genealogy chart that we're seeing. I'm wondering if there might be other ownership kind of parallel to the one that you show that is relevant to this. Do you understand what I'm saying? If you've got this guy or these folks' way up at the top, then they have this cascade of ownership here. Do they have cascade of ownership of other organizations that might be relevant to this? Is there another that falls under another path as opposed to this path? Is that relevant at all?

Mr. Furnish The next project has the same ownership struggle, different LHCSA, same set of conditions. They have to follow the same rules. They could own several LHCSAs, but they all have to sign affidavit of no control for each of those.

Ms. Monroe When you look across from one genealogy chart to the next. Are there important relationships that need to be disclosed or at least understood this way as opposed to this way?

Mr. Furnish Yes. We asked them for a full character and competence review. We look at all of that. If they're going to take control of the LHCSA in any way, shape or form, then they have to disclose all that to us.

Ms. Monroe I think I understand you.

Mr. Robinson (Laughing)

Mr. Robinson Please.

Dr. Soffel Mr. Finish, if I am understanding you correctly, because my question was what's the relationship between this application and the next one, since they both are related to Accent Health or whatever they're called. What you're saying then is that it's the great great grandfather that is Accent, but they are not the one, the entity that's being evaluated on character and competence because they have said they have no operational responsibility.

Mr. Furnish Correct, and they waive their right to operate this LHCSA in any way, shape or form at that level or higher based on their affidavit of no control.

Dr. Soffel Thank you.

Mr. Robinson Other questions?

Mr. Robinson Questions only.

Mr. Robinson I'm assuming the applicants in the room.

Mr. Robinson Thank you.

Mr. Robinson Hearing none, I'm going to call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Motion carries.

Mr. Robinson To Ms. Monroe's point Application 222160E, Accent Care of New York Inc. This is a long list of the geographic area for this application. Again, a transfer of 100% ownership interest above the grandparent level. The department is recommending approval with a condition.

Mr. Robinson Motion, please.

Mr. Robinson Dr. Berliner.

Mr. Robinson Thank you, Dr. Torres, for a second.

Mr. Robinson Mr. Furnish.

Mr. Furnish Yes.

This one is Accent Care of New York, which operates two LHCSAs is requesting a change in indirect ownership, transferring 100% ownership interest above the grandparent entity. The same affidavit of no control has been implemented above the parent entity Accent Care Inc, where Pluto Acquisition One and organizations above that entity will refrain from exercising control over the LHCSA by directing or causing direction of actions, management or policies of the agencies, whether through voting securities or voting rights thereunder, electing or appointing directors, the direct or indirect to termination of policies or otherwise. Those that are left in the chain that didn't sign that meet character and competence. They meet our financial review. Workforce summary has been included in the exhibit, and as such, the department can recommend approval.

Mr. Robinson Thank you.

Mr. Robinson Questions for Mr. Furnish?

Mr. Robinson Applicant questions only.

Mr. Robinson Anybody from the public wishing to speak on this application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson Motion carries.

Mr. Robinson Application 222111E, Allen Health Care Services doing business as Elara Caring. Again, a broad geographic area listed on the agenda to transfer indirect ownership interest above the parent level. Department is recommending approval with a condition.

Mr. Robinson Motion by Dr. Berliner.

Mr. Robinson Second by Dr. Torres.

Mr. Robinson Mr. Furnish.

Mr. Furnish Project 222111E Allen Health Care Services doing business as Elara Caring is seeking approval of a transfer of ownership interest above the great great great grandparent level. The affidavit of no control has been implemented above the great great great grandparent level Elara Holdings LLC, whereby all entities and persons above Elara Holdings LLC and others will refrain from exercising control over the LHCSA. The same laundry list that I read earlier applies here. As such, they meet the character and competence. They meet the financial review. The workforce summaries have been included at PHHPC's request. I do want to point out in one of the exhibits you can see an example of when they do still want to exercise control the lengthy list of reviews that we have to look at. It goes on for pages and pages. That's what happens when they want to maintain control of the LHCSA. We do this comprehensive review. With that, we recommend approval.

Mr. Robinson Thank you.

Mr. Robinson Questions for Mr. Furnish?

Mr. Robinson Applicant questions only.

Mr. Robinson Anybody from the public wishing to speak on this application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson Motion carries.

Mr. Robinson Application 222108E, All Metro Home Care Services of New York Inc doing business as All Metro Health Care. The geographic area noted on the agenda. Transfer indirect ownership interest above the parent level. Department recommends approval with conditions.

Mr. Robinson A motion please.

Mr. Robinson Dr. Berliner.

Mr. Robinson Second, Dr. Torres.

Mr. Robinson Mr. Furnish.

Mr. Furnish All Metro Health Care Services of New York doing business as All Metro Health Care request approval to transfer indirect ownership interest above the great great great grandparent level. An affidavit of no control has been implemented above the great great grandparent level, whereby Motivic Care Inc and all members above that will refrain from exercising control over the LHCSA. Using the same laundry list that I've given earlier. It meets character and competence of those remaining. Meets financial review. The workforce summary has been included at your request. As such, the department recommends approval.

Mr. Robinson Questions for Mr. Furnish?

Mr. Robinson Applicant questions only.

Mr. Robinson Anyone from the public wishing to speak on the application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Calling application 231232E, Jewish Senior Life LHCSA doing business as Jewish Home of Rochester Licensed Home Care with a geography as listed in the agenda. This is to establish Jewish Senior Life LHCSA Inc as the new operator of a licensed home care services agency currently operated by Embrace Care LLC at 221 South Winton Road in Rochester and add Wayne and Livingston counties to its service area. The department is recommending approval with a condition.

Mr. Robinson Motion by Dr. Berliner.

Mr. Robinson Second by Dr. Torres.

Mr. Robinson Mr. Furnish.

Mr. Furnish Yes.

Mr. Furnish Jewish Center Life LHCSA Incorporated doing business as Jewish Home of Rochester is asking to be the new operator of Embrace Care LLC. Seeking to expand the services to include Wayne and Livingston counties, which have identified as counties with presumed need. That goes again to our need, our new regulations, which say that the department determines counties with need for LHCSAs and without need. They're looking to expand in counties with need. Therefore, it meets our need review. They meet our character and competence review. Financial review and workforce summary has been included at your request. As such, the department recommends approval.

Mr. Robinson Thank you.

Mr. Robinson Questions for the department?

Mr. Robinson Applicant questions only.

Mr. Robinson Anyone from the public wishing to speak on this application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson Motion carries.

Mr. Robinson Thank you.

Mr. Robinson Application 231047E, SIAL Acquisition doing business as the Verandah Assisted Living. Again, a generic geographic service areas noted in the agenda. To establish SIAL Acquisition LLC as the new operator of a licensed home care services agency currently operated by Bellwood LLC at 110 Henderson Street on Staten Island. The department is recommending approval with a condition.

Mr. Robinson Motion please.

Mr. Robinson Dr. Berliner.

Mr. Robinson Second, Dr. Torres.

Mr. Robinson Mr. Furnish.

Mr. Furnish Yes.

Mr. Furnish SIAL Acquisition doing business as the Verandah Assisted Living is requesting to become the new operator of Plan and Partner Home Health Care an existing LHCSA. Need is met. It's a transfer of ownership to LHCSA that's currently serving twenty-five or more patients. They meet our character and competence review and our financial review. Workforce summary has been included at PHHPC's request. As such, the department can recommend approval.

Mr. Robinson Thank you.

Mr. Robinson Questions for the department.

Mr. Robinson Applicant questions only.

Ms. Monroe Did you say that you do a need analysis of whether a county needs more LHCSAs? Did I hear you say that, or did I misunderstand?

Mr. Furnish The need analysis is pre-cooked into the regulation. Before we change the regulation there was no need for LHCSAs, but now there is a need methodology, I should say. What we do is we look at counties that have five or more LHCSAs serving twenty-five or more patients. If they have that in the county they're considered counties without presumed need. They have to come to us with a rebuttable presumption, saying, I know we're a county with no need. However, based on these set of circumstances, we think we serve a special community. If we agree, we'll bring it to PHHPC for your approval. There are counties with presume need, which have less than that, less than five. They automatically are considered to have need. That's how we look at need for licensed home care service agencies.

Ms. Monroe And the ones that you brought today, what category were they in?

Mr. Furnish Most of these were all transfer of ownership. If the LHCSA they're acquiring currently serves twenty-five or more patients, then we consider that the passes the need. That's how we get around that.

Ms. Monroe In the future you'll flag for us ones that are in no need but special circumstances versus counties with need.

Mr. Furnish We have not had any instances where we've done a LHCSA in front of you where there's no need county with special circumstances, but I will highlight those when they do come.

Ms. Monroe Thank you.

Mr. Furnish Sure.

Mr. Robinson Other questions?

Mr. Robinson Applicant questions only.

Mr. Robinson Thank you.

Mr. Robinson Anyone from the public wishing to speak on this application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Application 231300E, Community Health and Home Care Inc. Again, a geographic service area is noted on the agenda. This is transferring 100% ownership interest to one new not for profit corporate member. The department is recommending approval with a condition.

Mr. Robinson Motion by Dr. Berliner.

Mr. Robinson Second by Dr. Torres.

Mr. Robinson Mr. Furnish.

Mr. Furnish Yes.

Mr. Furnish Community Health and Health and Home Care Incorporated is requesting to transfer 100% ownership interest to Cayuga Health Systems Incorporated. They will become the sole member of the LHCSA. Twenty-five patients or more in this existing LHCSA. Therefore, it meets need. It meets our character and competence. Meets financial review. The workforce summary has been included. As such, the department can recommend approval.

Mr. Robinson Thank you.

Mr. Robinson Questions, please.

Mr. Robinson Applicant questions only.

Mr. Robinson Anyone from the public wishing to speak on this application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson The motion carries.

Mr. Robinson Thank you.

Mr. Robinson We're moving now to applications for ambulatory surgery, establishment and construction beginning with 232143E, Saratoga Schenectady Endoscopy Center LLC in Saratoga County. This is transferring 8.33% ownership interest to one new member. Department is recommending approval with a condition and a contingency.

Mr. Robinson Motion by Dr. Torres.

Mr. Robinson Second by Dr. Berliner.

Mr. Robinson Doctor. Berliner, miss. Clock.

Ms. Glock Saratoga Schenectady Endoscopy Center is an existing single specialty ambulatory surgery center and specializing in gastroenterology. They are requesting approval to transfer 8.33% membership interest to a new member. The center is submitting this application for a change in membership, as this change will exceed the 25% threshold limit for the past five years. There will be no changes in services offered by the ASC. Currently, there are eleven equal members that you can see in the staff report with an ownership interest of 9.09% each. Through this application Dr. Christopher Brown would be added as an 8.33% owner, with the existing members ownership percentage also decreasing to 8.33%. The department has determined that the individual proposed member has met the standard for approval under Public Health Law. The department is recommending approval with a condition and a contingency.

Mr. Robinson Thank you.

Mr. Robinson Questions for Ms. Glock.

Mr. Robinson Anyone from the public wishing to speak on this application?

Mr. Robinson Hearing none, call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Don't jump up all at once.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson Motion carries.

Mr. Robinson Thank you.

Mr. Robinson As you'll note, Mr. Kraut is recusing himself and leaving the room.

Mr. Robinson Application 232173E, Long Island Center for Digestive Health LLC in Nassau County. This is transfer of 19.88% ownership interest from three withdrawing members to one new member LLC. The department is recommending approval with a condition.

Mr. Robinson Motion please.

Mr. Robinson Dr. Berliner.

Mr. Robinson Second, Dr. Torres.

Mr. Robinson Ms. Glock.

Ms. Glock Long Island Digestive Health, which I'll refer to as LICDH is an existing single specialty freestanding ambulatory surgery center which specializes in gastroenterology. They are located in Uniondale, Nassau County. They are requesting approval to transfer a 19.88% membership from three existing members to a new member, PE Health Care Associates, which I will refer to as PE Health Care Associates LLC's has current health care ownership in New York State, as shown in the staff report. The current membership, which you can see on Page 3, consists of five physician owners totaling 25.71% interest, three non-physician owners with a 19.88% interest. Northwell LICDH ventures LLC with a 51% membership interest. The center is not proposing to add or change any services. It will continue to utilize Dr. Stern as the Medical Director and continue its current transfer and affiliation agreement. You can see from the exhibit that PE Health Care Associates and the five individuals in that LLC would acquire a 19.88% ownership interest if approved. The department has reviewed the application and has determined that the individuals meet the standard for approval under Public Health Law. We are recommending approval with a condition.

Mr. Robinson Thank you.

Mr. Robinson Questions for Ms. Glock.

Mr. Robinson Applicant questions only.

Mr. Robinson Anyone from the public wishing to speak on this application?

Mr. Robinson Hearing none, we'll call the question.

Mr. Robinson All in favor?

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson Motion carries.

Mr. Robinson Have Mr. Kraut return, please.

Mr. Robinson I want to note that Application 232243E, Advanced Surgery Center in Rockland County has been deferred at the applicant's request.

Mr. Robinson Moving on now to diagnostic and treatment centers. Application 232201B, FJ Community Family Core doing business as FJ Community Health Center in Queens County to establish and construct a new diagnostic and treatment center at 54-08 74th Street Number 3A in Elmhurst. Department is recommending approval with conditions and contingencies.

Mr. Robinson Motion Dr. Berliner.

Mr. Robinson Second Dr. Torres.

Mr. Robinson Ms. Glock.

Ms. Glock As stated, FJ Community Family Core is seeking approval to establish and construct an Article 28 diagnostic and treatment center in Elmhurst in Queens County. The primary service area is Queens County. They will provide primary care, other medical specialty services, physical therapy, and behavioral health services under the 30% threshold as allowed. They are located in a known primary care health professional shortage area, as well as a mental health professional shortage area. The proposed owner of FJ Community Family Core is Kevin Wall. Dr. Abdulla will serve as the Medical Director. The applicant is projecting Medicaid at 60% and charity care at 2%. The department is recommending approval with conditions and contingencies.

Mr. Robinson Thank you very much.

Mr. Robinson Questions for Ms. Glock?

Mr. Robinson Applicant questions only.

Dr. Soffel I have a question.

Mr. Robinson Oh, please ask the question.

Dr. Soffel Yeah, I see that you're projecting 60% Medicaid. I was wondering whether there had been conversations with the Medicaid managed care plans that serve the Elmhurst community, so that those relationships can happen as soon as this facility is operating.

Mr. Robinson Do you want that for the applicant?

Mr. Robinson Can we have the applicant come forward, please.

Applicant We really can't have conversations with the Medicaid care plans until we have an operating certificate to negotiate those contracts. We know that in the area in Elmhurst there's a high Medicaid volume of clients there. Mr. Gallagher also operates a LHCSA, where he has a very high percentage of Medicaid recipients.

Mr. Robinson Thank you.

Mr. Robinson Other questions of the applicant?

Mr. Robinson Thank you very much for coming up.

Mr. Robinson Is there anyone from the public wishing to speak on this application?

Mr. Robinson Hearing none, I'm going to call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson The motion carries.

Mr. Robinson Thank you.

Mr. Robinson This is an application for a midwifery birthing services center. Application 232163B, BSD Birthing Centre of Rockland in Rockland County. This is to establish and construct a midwifery birth center at 84 Route 59 in Suffern. The department is recommending approval with conditions and contingencies.

Mr. Robinson Motion, please.

Mr. Robinson Dr. Berliner.

Mr. Robinson Second, Dr. Torres.

Ms. Glock.

Ms. Glock BSD Birthing Center of Rockland LLC is requesting approval to establish and construct this midwifery birth center in leased space in Suffern New York. The new center will convert an existing PC practice to an Article 28 midwifery birthing center. The center will provide prenatal, childbirth, postpartum care, and primary reproductive health care to low risk patients. Services are provided during pregnancy, labor, and delivery for those who require a stay of less than twenty-four hours after birth. As part of this application, the applicant will seek certification for birthing services and primary medical care on the operate certificate. The center plans to serve all women in Rockland County but anticipates that its primary patient base will be Orthodox Jewish women. The proposed Medical Director will be Thomas Martin, M.D., who is a licensed OBGYN. The applicant has started initiating conversations with Good Samaritan Hospital for the required transfer and affiliation agreement, which is approximately 0.5 miles away. The closest regional perinatal center is Westchester Medical Center, which is about just under twenty-three miles away. The proposed members of BSD Birthing Center of Rockland are in the exhibit. A licensed certified midwife. I'm sorry. Jacob Engel. Rivka Friedman and Chava Schwartz. The applicant is projecting 180 births in year one to 121 in year three with a 95% utilization in Medicaid for both years. The department has determined that the individuals meet the proposed standard for approval under Public Health Law. The project cost of about $1.3 million is going to be funded with equity. I did want to point out that contingency number six listed in your exhibit, which is requiring submission of accreditation survey visit to the department should be a condition, not a contingency, meaning it would remain as a requirement for the life of the project. The applicant has stated, provided information to the department that they have started the accreditation process and the legislation, the

midwifery legislation, which was passed in 2022 does allow for accreditation in lieu of a Department of Health survey similar to what we allow for hospitals with Dean status. The department, upon review is recommending approval with contingencies and conditions on this project.

Mr. Robinson Thank you.

Mr. Robinson Dr. Kalkut.

Dr. Kalkut Actually, my question is for the applicant. I don't know if we want to do...

Mr. Robinson We'll first go to questions for the department.

Mr. Robinson Ms. Monroe, go ahead.

Ms. Monroe I appreciate that they haven't negotiated an agreement with the transfer hospital since they don't have approval from us yet. You have added that into that condition. How does that work? When they do have a transfer agreement in place they submit that to the department, and you approve or not approve it? Until that point they can't be operating. Is that how that works?

Ms. Glock It's actually as a contingency on the project. It says number two, submission of an executed transfer an affiliation agreement acceptable to the department. They would not be able to operate. They would not get final approval from the department until they satisfied that contingency.

Ms. Monroe I was looking at conditions and three and four are also referred to that. That's what I thought you were talking about. It's both a contingency and a condition.

Ms. Glock The contingency under two is the transfer and affiliation agreement. The conditions are formal arrangements for both obstetrical care and pediatric care with a transfer hospital should one of their patients require that additional care.

Ms. Monroe Well, I'm not sure I understand the difference, but that's not important at this point.

Ms. Glock Well, the conditions would stay as a condition on the project for the lifetime of the project. The contingencies must be satisfied prior to the department issuing a final approval.

Ms. Monroe You're saying they have to show you the agreement before they can start, and then they have to maintain agreements throughout the operation?

Ms. Glock Correct.

Ms. Monroe I get it now.

Ms. Monroe Thank you.

Mr. Robinson Dr. Soffel.

Dr. Soffel Hi. I have a question about the character and competence review. As I read it, the proposed manager Jacob has no experience managing a health care facility. The proposed office manager has no experience managing a health care facility. I'm sort of curious how the department determines that they have demonstrated competence to manage a health care facility.

Ms. Glock The department, Yetta Engel, who is part of the operating membership is a licensed midwife in New York State. She currently practices a private practice. Jacob, manager, I believe, is a family member. I believe it's her husband. I believe the two of the individuals who are sitting at the table are licensed nurse midwives who actually do the management of the practice. The competence, specifically to your question as a licensed midwife in New York State would meet the competency.

Dr. Soffel I'm sorry, Shelly, to be clear, I'm not questioning the clinical competence at all. I'm questioning the operational competence.

Ms. Glock He currently operates a private practice, which I think she can speak about providing birthing services as a licensed midwife.

Mr. Robinson Are you are you asking the department or the applicant?

Dr. Soffel I also have a question on the health equity impact assessment. Is that a department question?

Mr. Robinson You can start there.

Dr. Soffel Okay.

Dr. Soffel My question is I read in the health equity summary that 10 of 11 engaged stakeholders indicated support for the project. Does that mean that they only talked to 11 stakeholders as the entire health equity assessment?

Ms. Glock Question to our Office of Health Equity and Human Rights.

Office of Health Equity and Human Rights That's correct.

Dr. Soffel That satisfied your requirements for stakeholder engagement in the process?

Office of Health Equity and Human Rights That's correct. We did continue to work with the independent entity when we gave them an additional time to reach out to more stakeholders. They attempted to contact more but they were unable to get a response.

Dr. Soffel The standard then is that we talked to eleven people in a community, and that will satisfy the departments saying that they have received meaningful stakeholder input?

Office of Health Equity and Human Rights It's commensurate to the size and scope of the project. Given where the size and scope were, as well as we're also willing to have the applicant discuss further about their engagement strategies, because that was something that was worked with.

Dr. Soffel I do have one additional question, which is, the health equity assessment talks about increasing access for Black and Hispanic women to birthing services, which is a

wonderful goal. Given that this center is designed specifically to meet the needs of the Orthodox community, I'm not sure that that's a relevant observation.

Mr. Robinson I think that's a question for the applicant.

Dr. Soffel Okay.

Mr. Robinson Let me ask that you introduce yourself and the applicant.

Mr. Black Sure.

Mr. Black Good morning. Andrew Black, consultant to the applicant. They are certified midwives. Lauren is an office person and administrator. I'm just the consultant. With respect to the health equity impact assessment, the independent entity reached out to, I believe thirty-five different parties. Ten of them, I believe are what responded. It's similar respectfully to get an email and returning the survey. They went out with certified mail on a lot of different forms of different approaches to get a response and having our conversations back and forth with the independent entity on making community outreach. We were able to receive, I think ten or eleven back from the community, but thirty-five were approached.

Dr. Kalkut Good morning. I notice in the project proposal your expected to be open between 9:00am and 4:00pm. I don't know if that is five days, six days or seven days. What happens when there's a mother in labor or delivery off hours but not between 9:00am and 4:00pm? The write up says that you have out on call midwife. You need more than that.

Applicant There's always a midwife on call 24/7, and there's always a backup midwife on call. There are always two midwives that are answering phones and ready to go to the birth center or hospital where we have privileges or home wherever someone's in labor.

Dr. Kalkut Do they deliver at the birthing center?

Applicant They will, yes.

Dr. Kalkut There's other staff either present or on call.

Applicant There's always a birth assistant and then a backup birth assistant. They're often nurses, registered nurses.

Dr. Kalkut Because that leads to a second question, which is your staffing is 8.75 FTEs. Actually, when you look at the description of that staff, it's five clinical people. How do you cover 24/7 with five clinical people?

Applicant There are three. There are three midwives. We cover 24/7 with the three midwives. We have a series of how many birth assistants? Four or five, six birth assistants that share a call.

Dr. Kalkut They're on call 24/7, seven days a week. Usually for 24/7, seven days a week for a single FTE. Let's say it takes five people. It's just the staffing seems quite low for that.

Applicant Every full-time midwife is usually employed to work forty-eight hours. That means two full days a week in addition to one a weekend a month. If you calculate seven days every midwife has 48 hours. That fills up six days of the week plus part of the weekend. Three full time midwives actually cover a whole week and a whole month. We also have a backup midwife as was mentioned earlier. If there are two ladies going into labor at the same time, the main midwife gets the first call and then the second once she's on call the phone will reach the second midwife on call. This is how we cover our practice. This is not a big hospital practice. This is a small practice. We have a maximum between fifteen and twenty women per month. It is growing. We are looking at hiring more staff, but for the moment we are doing a very good job at covering what we have.

Dr. Kalkut Thank you for that. But just again, for other staff, I realize the midwives are covering 48 hours.

Applicant Correct.

Dr. Kalkut Other staff.

Applicant The other staff for the birth itself is birth assistant. We have about five birth assistants now. That is quite generous because we are only three midwives, and we have five births assistant. Every woman in labor has two trained providers attending the births, one licensed midwife and one birth assistant.

Dr. Kalkut Again, thanks for that. The numbers, though, just worry me a little bit.

Mr. Kraut We're just trying to understand the clinical model. You just made a good point. The 221 births you expect is four births a week just to put it in context. Will you be open on the Sabbath as well so all individuals will be able to go seven days a week, 24/7 coverage.

Applicant Yes.

Mr. Kraut Are you safely staffed to do it? You're basically saying on an average of four deliveries a week you have ample both staff and you have backup. We're not going to get into the math vacation, sick days, federal holidays. You might not have factored that in.

Applicant They've laid it out where they have a sixty-day work calendar in advance.

Mr. Kraut It's just that these are new to us. We have no basis to kind of compare you to. When you see eight FTE you to scratch your head. Nothing comes in here.

Applicant Some of them on the on the assistant side may not be working full time.

Mr. Kraut No, I understand. It's headcount versus FTE. I get it. Obviously, there's big support in the communities that you're going to serve for this because and look we have been trying to support well thought out quality birthing applications. This is one of the few that we've gotten to see. Thank you.

Dr. Kalkut It's very helpful to know how that schedule worked. Thank you for that.

Mr. Robinson Mr. La Rue.

Mr. La Rue Good morning. Scott La Rue, member of the council. My question is for the health department. It's really for my educational understanding. Do we know what the mortality rate is at a birthing center versus a hospital?

Ms. Glock I believe we do, Scott, but I don't have that off the top of my head for you.

Mr. La Rue Again, that's for my education, a birthing center. That's where someone voluntarily chooses that method to give birth to their child.

Ms. Glock That's correct. It's not for everyone, but for women who choose that as a birthing option. The midwifery birth center provides an option for low-risk women. I can say generally that the mortality rates are low, and they're considered a safe alternative. That's why the departments passed legislation and brought regs to the committee to establish these in New York State.

Mr. La Rue Thank you.

Mr. Kraut, I mean, they triage high risk out of the practice.

Mr. Robinson Is there anything that you all want to add to that?

Applicant The mortality rates are lower. The C-section rates are lower. Again, it's low risk.

Mr. Robinson Dr. Berliner.

Dr. Berliner In the work that you've been doing, how many transfers have you had to medical facilities?

Applicant As the director of midwifery for the practice, I collect all the statistics. For last year, I think we had 160 births and there was a 3% transfer rate. Those were for moms who maybe the fetal heart rate was questionable or some concerns. We transfer to the hospital. Two of us had privileges at two hospitals. I had privileges at three. If a woman needs a hospital birth, we transfer there and we still provide care.

Mr. Robinson I just want to make sure everybody had a chance to check in on this.

Mr. Robinson Well, we thank you.

Mr. Robinson Is there anyone from the public that wishes to speak on this application?

Dr. Soffel I've been asked to re ask my question about health equity and how this birthing center will improve access to care for Black and Hispanic women.

Applicant Where most of our clients right now are Orthodox, Jewish women, our doors are open to everyone. It's not exclusive to anyone from any other ethnicity. There are several communities nearby the birth center that are mostly Black and Latino that would definitely benefit from the birth center.

Dr. Soffel Do you have any plans to do outreach to those communities?

Applicant Yes, we do. We have affiliations with some of the groups in Spring Valley, which is nearby the birth center. There's also a Haverstraw, which is a very big Latino population there that we're going to be in contact with.

Dr. Soffel Because I know there's a huge desire for birthing center experiences for women across many communities.

Mr. Robinson Thank you.

Mr. Robinson Mr. Lawrence and then Dr. Berliner.

Mr. Lawrence Thank you. You know, I think a birthing center is really great when they work. I think Dr. Kalkut indicated that the risk usually is triage. You really are looking at patients are Moms who don't necessarily are of a high risk. What are some of the postpartum care and services that you offer to your patients? How long do you do that?

Applicant The typical postpartum course of care would be a twenty-four-to-thirty-six-hour postpartum home visit where we go do a full assessment on Mom and baby. That's when we perform the hearing screening, congenital heart screening, PKU, the newborn metabolic screening, full check up on the mom. We then have a one-to-two-week postpartum visit with the mom. They come back for a four to six week postpartum. Lactation consultants do home visits to help with breastfeeding.

Mr. Robinson Ms. Monroe.

Ms. Monroe Are you affiliated, or do you have an affiliation with a pediatrician? I mean, I appreciate all of the postpartum care, but that's really focused on the mother after the first visit, I would assume. Do you have a pediatric practice that you work with?

Applicant Well, first of all, midwives are scope of practice. We're licensed to care for newborns and provide all care until six weeks postpartum. That's part of our training and our certification. Second, we have a neonatal nurse practitioner on staff. The Moms often bring the babies for that one-week checkup with the neonatal nurse practitioner. The midwife does a checkup with the mom. We also have relationships with pediatrics at the various hospitals. I have hospitals at three privileges. We have relationships with the neonatologist at all of those hospitals as well. Several different pediatric practices in the community that we work with.

Mr. Robinson Is anybody from the public that wishes to speak on this application?

Mr. Robinson I'm going to call the question.

Mr. Robinson All in favor?

All Aye.

Mr. Robinson Are there any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson Motion carries.

Mr. Robinson Congratulations!

Mr. Robinson This is a certificate of amendment of the certificate of incorporation for Ezra's Home Health Center Inc.

Mr. Robinson Did I pronounce that right?

Mr. Robinson Thank you.

Mr. Robinson The department recommends approval.

Mr. Robinson May I have a motion?

Mr. Robinson Thank you, Dr. Berliner.

Mr. Robinson Second, Dr. Torres.

Mr. Robinson Anybody have anything to say on this application?

Mr. Robinson Any questions?

Mr. Robinson All in favor?

Mr. Robinson Any opposed?

Mr. Robinson Any abstentions?

Mr. Robinson The motion carries.

Mr. Robinson With that, I do want to extend my thanks to the department. Notably the people that have worked so hard on all these applications; Ms. Glock, Mr. Furnish and the folks from the health equity group for showing up here. We're going to need you probably on a regular basis. Thank you for joining us today.

Mr. Robinson With that, we are adjourned.

Mr. Kraut I just want to remind everybody that meeting of the full council is going to be on Thursday, April 11th, here in Albany. It's important that we have a quorum for a variety of reasons that are obvious to all. Please, make an effort to be here. I want to just wish everybody observing Ramadan they have a meaningful observance. Those celebrating both Good Friday and Easter the same. We'll see you back here in April. Thank you very much.