NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL COMMITTEE MEETING
JUNE 29, 2023 10:00 AM
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Jo Boufford May I call the meeting to order.

Jo Boufford Good morning, everyone. Let me invite the council members to take their seats. Everybody's having a good time saying hello to each other, which is great. I'm Jo Boufford. I'm the Vice Chair of the council. I have the privilege of calling the meeting to order the Public Health and Health Planning Council and welcoming members, Commissioner McDonald, participants and observers. As a reminder for the audience viewing the public meeting via webcast, there is a forum that needs to be filled out, which records your attendance at meetings. It's required by the Commission on Ethics and Lobbying and Government and in accordance with Executive Law Section 166. It's posted on the Department of Health's website under Certificate of Need. We'd appreciate if you'd email the completed forms to ColleenLeonard@Health.NewYork.Gov. We thank you for your collaboration on meeting these duties as prescribed by law. I also want to remind the council members, staff and the audience that this meeting is subject to the Open Meeting Law and is broadcast over the internet. Some suggestions for ground rules. Members, please keep yourselves on mute when you're not speaking and they are live mics, so please avoid the rustling of papers and all of the other noises that you might make locally that you don't want to be broadcast. There is synchronized captioning. It's really important that people not talk over each other because it makes it really difficult if two people are speaking at the time. When you first speak, if you would please state your name briefly and identify yourself as a council member or department staff member. This will be of assistance with the broadcasting. I'd also like to encourage members, staff and public to join the department's Certificate of Need listserv. The unit regularly sends out important council information and notices such as agendas, meeting dates and policy matters. There are printed instructions at the reference table just outside the conference room on how to join the listserv or again, contact Colleen Leonard for assistance in joining. I want to note some shifts in the agenda today. To be sure we maintain a quorum, we've rearranged today's agenda. Under the Department of Health reports, we will hear from Commissioner McDonald to provide an overall report and then move immediately into project review and recommendations and of the establishment committee Mr. Robinson will be reporting. Then moving to regulation, Mr. Holt will present regulations for emergency adoption. I'll provide us a report on the Public Health Committee. Ms. Monroe will provide a report on the Health Planning Committee sorry, both of which met Monday in Albany, and then at the end of the meeting we'll hear Department of Health reports from Mr. Herbst on long term care and Ms. Morne on health equity and human rights, Dr. Morley on the Office of Primary Care and Health Systems Management and Dr. Bauer will provide a report on the activities of the Office of Public Health. I also need to make just an announcement about the presentation that when Mr. Robinson moves in, members of the council and most of our guests who are regular attenders of the meeting are familiar with the reorganization, and it includes batching of certificate of need applications. We always want to take this opportunity to ask members of the council if they have reviewed this batching of applications, if there are any particular applications they would like to pull out of the potential for batching for individual discussion at this point.

Jo Boufford Seeing none, I will move ahead, and we'll move ahead with the usual batching. Mr. Robinson will manage. We want to wish happy anniversary to Cattaraugus County Health Department, represented by our own Dr. Watkins, Kevin Watkins, who is here. I want to take this time to congratulate the department as they celebrate their 100th year anniversary. It is the oldest.

Jo Boufford I said that to him earlier.

Jo Boufford Anyway, it's the oldest county health department in New York State. The county health department was one of the first to receive public health accreditation in New York. Our own Dr. Watkins, of course, is a critical member of this council. On June 15th, they had their centennial celebration with Commissioner McDonald in attendance. Everybody's already clapped for Kevin in his county.

Jo Boufford Give you the mic if you'd like to make one comment about it.

Dr. Watkins Absolutely.

Dr. Watkins New York City always tells me, remember, we've been here first. We're the first local health department.

Jo Boufford They're not a local health department.

Dr. Watkins We don't consider them a local health department. We were established in 1923. I just want to thank all of the team, New York State Department of Health team that came down. Dr. McDonald, who did an outstanding job and helped celebrate that occasion with us. It was just an exciting event. I know that you were in a rush to move on to other things within the county, but just having you there really was a delight for the entire department and for the entire community. On behalf of the community, we did want to present you with a book that's called, The Health on the Farm in the Village, which talks about the creation of our health department. I just want to make sure that that presentation was given to you, although we didn't get a chance to do it at the event. I'm going to do it here. Thank you very much for all that you contributed to that celebration.

Jo Boufford For those of you who can't see it, it's a very beautiful, leather-bound book. It's really impressive.

Jo Boufford Not yet.

Jo Boufford Let's move on. I want to have adoption of the minutes.

Jo Boufford May I have a motion to adopt the minutes of April 18th, please.

Jo Boufford Dr. Berliner.

Jo Boufford Second, Dr. Yang.

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford No.

Jo Boufford Motion to adopt the 2024 PHHPC meeting dates which have been circulated before this meeting.

Jo Boufford Monroe.

Jo Boufford Mr. La Rue seconds.

Jo Boufford All in favor?

Jo Boufford It's now my great pleasure to hear from Commissioner McDonald, who will update us on the department's activities since our last meeting.

Commissioner McDonald Thank you so much.

Commissioner McDonald It is great to be with you all today. It's interesting. Since I joined you last, I moved from Acting Commissioner of the New York State Department of Health to being confirmed.

Commissioner McDonald Well, thank you.

Commissioner McDonald A little interesting little fact about it. It was thirty-three years to the day when I graduated medical school where I became confirmed. I share that a little bit because the legislature started their session on June 9th, which is when I graduated medical school. I was confirmed at 2:30 in the morning. Just in case you're curious, I told my team at quarter at ten, I'm going to bed. Expect you guys to do the same. We're here about in the morning and we did. Apparently, the way the legislature gavels in, it's recorded as June 9th. It's kind of a special day for me for a lot of reasons. It really is important to me that the confirmation occurred for a lot of reasons. One was just brought stability and predictability to the department and the state, more importantly. I think it really is just important that we kind of know where we're going forward. I want to extend a great deal of gratitude to my team. You know, Megan Baldwin, our Executive Deputy Commissioner, Laura, Chief of Staff. I have a really good staff. A lot of people say they have a good staff. My staff makes it possible for me to succeed every day. I really appreciate all the help they've given me to come as far as I have so far. I'm just looking forward to where we're going to go next. I do want to thank Governor Hochul in particular for her confidence in me. I really enjoyed working with her. I'm working with her quite a bit, as you might have imagined, almost daily this week for other reasons, but it's just great. I want to thank the Senate, by the way. My confirmation hearing, I would describe is enjoyable. It was cordial. They asked great questions. They were trying to figure out if I had the qualifications for the job and a vision for the state. They just asked really good questions. It was a very warm, engaging dialogue. I really hope that's how we interact with the legislature in the future. That's what I expect and that's what I'm used to. I thought that was really good. I want to just touch a little bit quickly, though, on how my priorities are going a little bit. I think one of the things that you heard me talk about last time was how we're planning on rebuilding the department. We did see a trough in the number of members of the New York State Department of Health in the end of 2022. We're seeing some nice increases now as we're halfway through 2023. I attribute some of that increase

to some updated lists with civil service exams. I think also we're seeing some improvement with something which is called the HELP, which is that hiring for emergency limited placement, where civil service exam requirements were lifted for more than one hundred direct care, health and safety titles for thousands of positions across the state. We're a little more successful at retaining staff as well. It's interesting. I think, you know, quite frankly, it's no secret that public health professionals had a very difficult time during the pandemic. I think many have left. We thank them for their service. Many have stayed. For those who have stayed, I'm eternally grateful. They've demonstrated good resilience. I'm very, very grateful for the staff that have stayed. One thing about me is I'm out and about quite a bit around the department. We have thirty-eight sites. I haven't been to all thirty-eight yet, but I do show up at a lot of places. It's not about management by walking around. I'm not trying to see what people are doing. That's not my style. I don't micromanage. I have staff. Great leadership team who knows what they're doing. I just want to know how people are doing. Often, I ask people their name, what they do, how long they've been there. I ask them if they like their job. I'm kind of surprised how many people just quickly say, I love my job. I understand you might be...well, you're the Commissioner. They're just going to tell you that. I don't think that's what's going on. They don't need to do that. I'm just surprised some people actually love working at the New York State Department of Health. That's part of our culture that's pretty positive. That just fills me with more optimism. When I say I've been around, I've been to a lot of sites already. It's just interesting. I mean, last week over in Albany. I'm just surprised. Some people just do wonderful work, very important work, very behind the scenes work. People just love their jobs. Just it speaks to, again, good leadership team that makes it possible. I think it's really important for people to be happy at work to the extent that we can do that. Work is work, but I like it when our team is happy. Another thing I talked a little bit about last time was forming partnerships. Partnerships are important to me. One example of a partnership that we're building. It's a little bit stronger. I've had some wonderful meetings with Commissioner Rosa from the State Education Department and her team were committed to meeting monthly, working on things that matter. The State Education Department has a pretty significant public health role. They're responsible for our social determinants of health called education. It's big. By the way, other state agencies are responsible for social determinants of health as well. I'm trying to meet other state agencies as well. The other thing about State Ed is they're responsible for a core public health value, which is a skilled, diversified workforce. Little known fact perhaps to some about State Ed and Department Health is we're really responsible for about 85% of the state budget. I just think it's imperative that we become friends, work together well. I really have enjoyed getting to know Commissioner Rosa and her team. I'm committed to being friendly, doing things together. I just think that's something I want people to know in public, that that's my plan going forward, that we're going to find common ground of where we can go and see what happens. The other part I talked a little bit about was things we're going to do at the New York State Department of Health and throughout the state to eliminate health disparities and promote health equity. I'm just going to give you a few just small, tangible examples of things we've done. One of the things we've done is we've just changed questions on job interviews to make sure that there's at least a couple questions on health equity, but that's for everybody coming in just so people know what they're getting into. We've added information about health equity to every job posting. We're incorporating health equity into our employee orientation. I say this a lot around the department. We're health equity organization that happens through public health. I just want to make sure you know that this is just a few examples of things we're doing in our organizational culture to make this more common for folks. One of the things I worry about sometimes is people talk about health equity, but I don't know if they really know what I'm talking about or what they're talking about. I just think it's really important for people to have a common understanding

of what we're talking about. I did talk to you a little about this earlier. I did a tour of Western New York two weeks ago. I want to thank our Deputy Chief of Staff, who is the Deputy Chief of Staff, but really had us to the minute for three days throughout Western New York. It was sixty-three hours. We went to so many different sites, but it was just really a well-oiled machine, how we moved and met with a lot of community-based organizations. I was really thrilled to meet our Western Regional Office team. I was thrilled to be at Batavia Veterans, Home Nursing Home. It's wonderful for me to be talking to veterans who were over 100 years old and telling me a little bit about their time on the Oriskany, for example. Being someone who's a veteran myself, you know, I told this to Nicole when I walked in. I said, I feel very at home here. I just love the culture that makes it so a veteran walk in and feels at home. I saw happy veterans and happy staff, which made me happy as well. It was wonderful to interact with common ground as a community-based organization. Very impressive. I was also blown away by SNUG, a community-based organization that's really working on gun violence in Western New York. My team and I left humbled by just the work that we saw being done in Western New York and very thrilled to see it. Jericho Road was another interesting community-based organization. Working on the migrant issue, people who are seeking asylum, but just wonderful work, this federally qualified health center doing to help migrants in Western New York. I want to just thank Dr. Watkins. What a wonderful host Cattaraugus County was. We just felt so welcome. It was great. We had a wonderful time. We didn't rush off to go somewhere else because of the sake of it. We went to the hospital just to take a look at what was going on down there. I felt it was important. Not only did I see University of Rochester, Rochester Regional, I was at ECMC. We did a lot of hospitals, but I really want to see a small hospital and yet I saw they weren't small at all. They had some wonderful things that differentiate themselves, the cardiac catheterization work they do, they're impressive intensive care unit and even had a hyperbaric oxygen chamber. Just great to see the folks at the hospital. I do want to talk a little bit about the budget. We had a wonderful budget. As far as the health department is concerned, I thought it was a great public health budget. Hospitals got a seven and a half rate increase for inpatient work, six and a half percent for amputee work. Nursing homes got a seven and a half increase. These are historic increases. Other things that we saw where, the primary care providers got a nice increase. We also saw adverse childhood experiences, questionnaires for children in particular. They're going to be covered by Medicaid. You get $29.00 if you do one of these. You can do it once a year. Nice project to really identify, what are the adverse childhood experiences going on in children's lives that can affect their long-term health and development? This type of primary prevention, getting at the social determinants of health really important to helping our future. Very glad that went through. Some wonderful work occurred. There is a lot of things that occurred with material transactions. The temporary staffing agency requirement went in, made me happy. One of the things I heard consistently from every single hospital was how much they were overwhelmed by agency nursing cost and how that unpredictable labor costs really affected them just being able to carry out their mission. The other. The thing I thought was interesting was over $1,000,000,000 for health care capital. That's $490 million for transformation grants, $500 million for technology and telehealth investment and $10 million for community health. There were other things in the budget, but I just feel like, you know, we were very happy with how the budget ended. I wanted to touch a little bit on the pandemic. It's funny as we're kind of emerging from the pandemic. We're moving in a new direction. I think we're seeing new vaccines being selected. You know, the XBB 1.5 is what the advisory committee and station practices voted for. Just in case you're curious, I asked our Wadsworth staff, right choice? They felt it was. Might seem kind of hubris for me to ask Wadsworth, but when you have the world's leading public health lab in your back pocket, I want their opinion. I was glad to hear that what they thought as well. I think we've really moved in an interesting direction that we're moving into where there's a posture of

personal and organizational autonomy and responsibility. If you think back to since February, the mask mandate really was lifted for health care facilities. Health care facilities can decide what's best for their health care facility. Visitations allowed in nursing homes. The pre-op procedure testing no longer something that we need to do. We're now seeking public comment on lifting the vaccine mandate, just kind of reflecting for Medicaid and Medicare services went and where the epidemiologists bring us. We'll be interested in seeing what the public comment has to say. I do think it's important, as we have a larger perspective about all this. I mean, the pandemic's been a significant population trauma for everybody. As we move forward, I think its really important people understand their own personal health risk, what affects us and what you can do about it. Just going to be right out in front with this. When there's a new vaccine coming out this Fall, I'm going to be getting first in line to be getting up to date with my COVID vaccine. To me, I think it's just very important for me, and I'm encouraging people to do that as well. I don't know whether we're going to see annual vaccines. You know, I think we have to see where this pandemic goes. I think, you know, we know there's something coming this Fall. I'm encouraging people just to say, look, this is a chance to see if we can put this thing behind us. Let's see what happens here. Having said that, I want to touch base on the air quality. If you were in New York City June 7th, you noticed the air quality. Like you didn't need to go look at the news, you looked out your window. It's interesting, as Commissioner of Health, I rarely hear the word apocalyptic, but it was stunning. I was hearing the word apocalyptic. The air looked disturbing. It was concerning to everybody. Very grateful the state moved as quickly as we did. Again, it illustrates the partnership we have with the Department of Environmental Conservation and the Governor. A lot occurred quickly. Masks were mobilized for people to access in the public. There was a great deal of messaging out right away. Getting that notion that N95 masks are important to reduce our exposure to particulate matter. Because these Canadian wildfires are things we can't control. This is something we have to acknowledge is part of climate change. It's something we're going to be living with. Interestingly enough, yesterday, again, you saw some interesting situations in Western and Central New York. Situation again today. This is something that we have to pay attention to. You know, the way I look at this is every morning I look at my phone and see what the weather is. I check the air quality. If you don't have the Air Now app, I encourage you to do that. I happen to have mine programmed to show me all of New York State. It was easy to set up, very intuitive, but I think the Air Now app just gives you a great deal of resources. When you look at those numbers, you look at where your personal health risk is, know your risk and decide if you need to be outside or not that day. If you have to be outside had an N95 mask. Make sure it fits well. Do what you can reduce your exposure as best you can. A couple of more things. We did put a web page together if you're interested about this. It's Health.NY.Gov/Wildfire. It's a fine place to start just to learn about the effect of wildfire smoke. Lastly, just want touch on, you know, we're an interesting time in medicine. I don't know if you guys have been as impressed with how far we've come with vaccines. I am. As a pediatrician who's been a pediatrician for thirty-three years. I have to tell you, I never thought I'd see something for RSV. I just got used to it. It's interesting. The advisory committee immunization practices now looking at RSV vaccines for adults. I think a little known how many people older pass away from RSV each year. Sort of a silent issue in our country to some. You really saw this last year. We talked about the triple, if you will, COVID, flu and RSV. I'm optimistic about what our future is. I'm optimistic of what the RSV vaccine could be for the elderly population. There's actually a drug coming for infants. We'll hear more about that in the coming months. I hear that they're committed to getting this resolved before the Fall, before the season start. The monoclonal antibody looks interesting to me as I see some of the preliminary data on that. Very intriguing. RSV is one of the most common reasons babies end up in a hospital. I can't tell you how many times I've seen myself at the bedside. You

run IV fluids, get some oxygen, and then you wait. There just is not more you can do to. I would love to see this go the way of other vaccine preventable diseases. That's part of what keeps me optimistic about our future. We have such wonderful science and technology being in such wonderful places. I think it's a lot to be hopeful about.

Commissioner McDonald With that, let me stop and see if there's questions.

Jo Boufford Questions for the Commissioner?

Jo Boufford Yes, Dr. Soffel.

Dr. Soffel Good morning. Denise Soffel, council member. Could you say anything about Long COVID and what the state is doing, if anything, to sort of coordinate responses to what is emerging as a pretty significant health problem?

Commissioner McDonald Long COVID is a significant health problem. It's really something we work more with federal partners on. Health and Human Services has committed a lot towards research about that with the National Institute of Health. One of the things that I think we desperately need for a Long COVID is a definition we can all live with. It's really important to have a definition. I want to be really clear about that is it depends what lens you look at when you look at Long COVID. Are you looking at it from a patient standpoint? Are you looking at it from a disability standpoint? How are you looking at it? Really just the different causes and treatments for it. Our role is really to collaborate with federal partners and see what's possible. National Institute of Health is the one who's leading research efforts on that. To me, though, it's really one of those things where it's an important public health threat because just the prevalence of people who are stuck with this and I think it really speaks to that. COVID isn't just the cold. For a lot of people, it's really a significant like thing for months and almost a year. This is where we don't really have good treatments for it. Right now, people are just finding that either they're getting better from it or they're not. It's a tough place to be. It's certainly something we're paying attention to.

Jo Boufford Mr. La Rue.

Mr. La Rue Good morning. Congratulations on your confirmation. I just wanted to make a comment about the budget. First of all, I'd like to thank the department because I know how hard they fought for the rate increases that were so justifiably needed. My comment is more towards the legislative piece of this. They just passed that three and a half hour staffing legislation for the nursing homes, which everyone is supportive of, more staffing both in the hospitals and the nursing homes. They funded $187 million for that in the prior year's budget. In this year's budget, they took the $187 million away and did give the six and a half to seven and a half percent increase, which is not even sufficient to cover the cost of the change in staffing legislation. I know today we have more staffing legislation before us in terms of regulation. I just encourage the legislature. These are important issues. We don't disagree on them. You've got to fund them. If you don't fund them, it's impossible to implement them. We are very grateful for the work the department did to get those six and a half percent. I hope as we implement the staffing legislation and work towards next year's budget, that we keep that in mind.

Commissioner McDonald Thanks for the feedback.

Jo Boufford Any other questions or comments for the Commissioner?

Jo Boufford Very comprehensive report. I think you've answered everybody's questions.

Commissioner McDonald Thank you.

Jo Boufford Thank you very much. Again, congratulations on your confirmation. Delighted to have you here.

Jo Boufford We'll move on to Mr. Robinson and turn the meeting over to him for reports and actions of the Establishment and Project Review Committee.

Mr. Robinson Thank you.

Mr. Robinson I'm just going to take a moment of privilege.

Mr. Robinson I will do that.

Mr. Robinson Thank you, Ann.

Mr. Robinson I'm usually called one reminding people to do that.

Mr. Robinson Thank you.

Mr. Robinson I just wanted to acknowledge Mr. Thomas's return to the council after the loss of his son. Jeff made some eloquent remarks at Committee Day about Evan and what a remarkable young man he was. I think at this point, it's more just glad to have you back in the family, Hugh, and just know that we've got your back.

Mr. Robinson As Dr. Boufford mentioned, we're going to batch. But the early applications because of recusals are going to be taken individually. Even though she gave you your chance to pick out applications, if anybody still does want one to be discussed separately, please feel free to weigh in.

Mr. Robinson This first application, 221200E, Suffolk Surgery Center, LLC in Suffolk County. Noting the conflict in recusal by Mr. Kraut, who's not here, and Dr. Strange who is and is leaving the room. This is to transfer a 68% ownership interest from one withdrawing member LLC to a new member PLLC. The department has recommended approval with conditions and contingencies with an expiration of the operating certificate three years from the date of issuance. The committee made a similar recommendation. I so move.

Jo Boufford Seconded by Dr. Berliner.

Jo Boufford Any questions?

Jo Boufford Comments from anyone on the counsel?

Jo Boufford All those in favor?

All Aye.

Jo Boufford Opposed?

Jo Boufford Any abstentions?

Jo Boufford No.

Jo Boufford Motion passes.

Mr. Robinson Thank you.

Mr. Robinson Please have Dr. Strange return.

Mr. Robinson Application 222258B, association to benefit children doing business as ABC Little Clinic in New York County, an interest declared by Dr. Lim to establish and construct a new diagnostic and treatment center at 1841 Park Avenue in Manhattan. Department and committee recommend approval with conditions and contingencies. I so move.

Jo Boufford Move for approval.

Jo Boufford A second, please.

Jo Boufford Dr. Watkins.

Jo Boufford Any discussions, questions from the council members?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Motion passes.

Mr. Robinson Dr. Strange, would you mind doing the perp walk again?

Mr. Robinson Thank you.

Jo Boufford It's the ethics walk.

Mr. Robinson Ethics walk.

Mr. Robinson Thank you.

Mr. Robinson Oh, you're an interest. You can stay.

Mr. Robinson 222274B, doing business as Dr. K Health Center in Queens County, an interest declared by both Mr. Kraut and Dr. Strange to establish and construct a new diagnostic and treatment center at 63-18 Austin Street in Rego Park, Queens. Department and Committee recommend approval with conditions and contingencies. I so move.

Jo Boufford Motion.

Jo Boufford Second from Dr. Watkins.

Jo Boufford Any questions?

Jo Boufford Any concerns?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Not seeing any.

Jo Boufford Motion passes.

Mr. Robinson Dr. Watkins, you're recused on this application.

Mr. Robinson Thank you.

Mr. Robinson Application 22232E, Good Samaritan Home Health Agency, Inc. Its geographic service area includes Allegheny, Cattaraugus, Erie, Genesee, Monroe, Niagara, New Orleans and Wyoming Counties. Noting a conflict in recusal by Dr. Watkins. This is to transfer 70.3% ownership interest from two Withdrawing shareholders to the three remaining shareholders. Department and committee recommend approval. I so move.

Jo Boufford Second from Dr. Berliner.

Jo Boufford Dr. Watkins has left the room just to note that for the record.

Jo Boufford Any questions or concerns by council members?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Not seeing any.

Jo Boufford Motion passes.

Jo Boufford We can invite Dr. Watkins back.

Mr. Robinson This next application includes an interest by Dr. Lim and a recusal by Dr. Kalkut, who is not here.

Mr. Robinson Application 231001C, NYU Langone Hospital, Long Island in Nassau County. Convert three med surge beds to bone marrow transplant beds and perform renovations to construct a bone marrow transplant inpatient subunit. The department and the committee recommend approval with conditions and contingencies. I so move.

Jo Boufford Second from Dr. Berliner.

Jo Boufford Any questions?

Jo Boufford Concerns by council members?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Motion passes.

Mr. Robinson Thank you.

Mr. Robinson I think one more application to do independently, although no recusals and then we'll go into batching.

Mr. Robinson Application 222270C, Precision Care Surgery Center in Suffolk County certifying the second ambulatory surgery specialty for pain management. Department and committee recommend approval with a condition and a contingency. I so move.

Jo Boufford Dr. Berliner again.

Jo Boufford Any questions or concerns from council members?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Not seeing any.

Jo Boufford Motion passes.

Mr. Robinson Thank you.

Mr. Robinson We're batching now.

Mr. Robinson Application 231016E, Advent Health Care Services LLC in New York County. Establish Advent Health Care Services LLC as the new operator of the Certified Home Health Agency currently operated by Self Help Special Family Home Care Inc and relocated from 528th Avenue, New York to 419 Church Avenue in Brooklyn. On this application, the department and the committee recommend approval with a condition and contingencies.

Mr. Robinson Application 222159E, Maples Assisted Living Facility LLC doing business as the Maples Adult Living Community. Its geographic service area is Oswego County. Establish a new licensed Home Care Services agency at 453 Park Avenue, Fulton to exclusively serve the residents of their assisted living program. Department and committee recommend approval with contingencies.

Mr. Robinson Application 222215E, Premier Upstate Properties LLC doing business as Visiting Angels. Its geographic service area is Chemung, Schuyler and Steuben Counties. This is to establish a new licensed Home Care Services Agency at 168 Miller Street B103 in Horseheads. Department here recommends approval with conditions, as does the committee.

Mr. Robinson Application 222242E, Hearthstone Care LLC. Geographic service area, Columbia, Delaware, Green, Rensselaer and Schoharie County. Establish a new licensed Home Care Services Agency at 1187 Route 23A in the Catskills. Department and committee recommend approval with a contingency.

Mr. Robinson A part of a PACE program application 231136E, Welby Health New York PACE LLC. Geographic service area is Bronx, Kings, New York, Queens and Richmond Counties. Establish a new licensed Home Care Services Agency at 5521 8th Avenue, Brooklyn to exclusively serve Welby Health in New York, PACE LLC. Department and committee recommended approval.

Mr. Robinson I'm going to stop there and make a motion to approve that batch.

Jo Boufford Second, Dr. Strange.

Jo Boufford Any questions?

Jo Boufford Comments from council members?

Jo Boufford Yes, Ms. Monroe.

Ms. Monroe Excuse me for lack of clarity, but some of these say there's contingent approval. Others say approval. I wasn't at the last meeting, so that might have been explained. What is the difference between the committee’s contingent approval and approval?

Mr. Robinson I'll just let Ms. Glock answer that question.

Jo Boufford Mr. Furnish.

Mr. Robinson Mr. Furnish is reaching for the mic.

Mr. Furnish Contingent approval means there's as the normal course of business here we do a list of contingencies getting documents executed, things of that nature before we approve CON. Approval is a flat-out approval, meaning there's no more things that have to be done to complete the process going forward. Basically, for example, a legal contingency may ask for executed documents to be completed before we'll issue the operating certificate. That's when you see that. Sometimes you see a condition and that's during the contingencies before we operate. During the lifetime they have to maintain certain levels. An approval, straight approval is just an approval.

Ms. Monroe That contingency approval doesn't relate to our role. It relates to the staff's role after we approve it.

Mr. Furnish Correct.

Ms. Monroe The word approval means you don't have any of those things outstanding?

Mr. Furnish Correct.

Ms. Monroe Thank you.

Mr. Furnish Sure.

Jo Boufford Any other questions?

Jo Boufford Comments?

Jo Boufford All in favor?

All Aye.

Jo Boufford Abstentions?

Jo Boufford Those applications are approved.

Mr. Robinson Thank you.

Mr. Robinson Next batch.

Mr. Robinson Application 222183E, Elder Care, Home Care Inc. Geographic service area is Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Rockland, Suffolk, Sullivan, Ulster and Westchester Counties. This application transfer 77% ownership interest from one shareholder to an existing shareholder. The department and the committee recommend approval.

Mr. Robinson Application 222196C, Horizons at Canandaigua, LLC. Geographic service area is Ontario County. This is to establish Horizons at Canandaigua LLC as the new operator of a licensed Home Care Services agency currently operated by DePaul Adult Care Communities Inc at 3132 State Road 21 South in Canandaigua. Department and committee recommend approval with contingencies.

Mr. Robinson Application 222254B, Greater Binghamton Surgery Center in Broome County. Converting a single specialty freestanding ambulatory surgery center to multi-

specialty. Transfer ownership interest from the sole member to one new member LLC and rename the facility. The department and the committee recommend approval with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance.

Mr. Robinson Application 231026B, Maplemere Ventures, LLC in Erie County. Establish and construct a multi-specialty ambulatory surgery diagnostic and treatment center at 111 Maplemere Drive in Amherst. The department and the committee committee recommend approval with conditions and contingencies. Also, with an expiration of the operating certificate five years from the date of issuance.

Mr. Robinson Application 231137E, Gastroenterology Care Inc in Kings County. Transferring 100% ownership interest from the sole withdrawing member to four new members. The department and the committee recommend approval with conditions and contingencies with an expiration of the operating certificate three years from the date of issuance.

Mr. Robinson Application 222133B, this is the companion PACE Application. NY PACE Facility Inc in Kings County establishing construct a diagnostic and treatment center at 5521 8th Avenue, Brooklyn to solely serve the PACE program operated by Welby Health NYC PACE LLC. The department recommends approval with conditions and contingencies.

Mr. Robinson I'm going to stop there and make that a batch.

Mr. Robinson I make a motion to approve that.

Jo Boufford Dr. Watkins, second.

Jo Boufford I wanted to ask you, just Ms. Glock, perhaps just to clarify the language in the spirit of Ms. Monroe asking for clarification, this issue of the expiration date of the certificate. Could you just address that as a process matter relative to these particular surgeon DTC applications?

Ms. Glock Sure.

Ms. Glock Shelly Glock from the department. Based on PHHPC policy, we had brought this before PHHPC and discussed to ambulatory surgery centers in PHHPC at the time by policy, had asked the department to place a limitation on the operating certificate for new ambulatory surgery centers to ensure that they would need to come back to the department at the end of five years and request permanent life to ensure that they were serving a medically underserved population by doing their fair share of Medicaid and charity care. You'll notice on some applications it says three years instead of five. That's because they're not startups. It's a transfer of ownership. It takes a couple of years to get the Medicaid numbers and the billing established. When it's a transfer of ownership, we set a three-year limitation versus five.

Jo Boufford Thank you very much.

Jo Boufford Appreciate it.

Jo Boufford Any questions or concerns about these applications?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstention?

Jo Boufford Batch is approved.

Mr. Robinson Thank you.

Mr. Robinson Application 222250B, Hope Development Inc DBA Diagnostic and Treatment Center in Kings County. Establish and construct a new diagnostic and treatment center at 340 Broadway in Brooklyn, SW2. Department recommends approval with conditions and contingencies, as did the committee.

Mr. Robinson Application 231095B, Fairview Care Center LLC doing business as Marton Care Health Center in Kings County. Establish and construct a new diagnostic and treatment center at 12 Fairview Place in Brooklyn. Department and committee recommend approval with conditions and contingencies.

Mr. Robinson 231111B, C and T Health Clinic in Queens County. Establish and construct a new diagnostic and treatment center at 74-15/37 Avenue in Jackson Heights. Department and committee recommend approval with conditions and contingencies.

Mr. Robinson Application 231126E, Form Rehabilitation Inc in Westchester County. Transferring 100% ownership interest from one withdrawing member to two new members. The department recommends approval with conditions and contingencies, as did the committee.

Mr. Robinson I move this batch.

Jo Boufford Second, Dr. Berliner.

Jo Boufford Any questions or concerns from members of the council?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Motion passes.

Mr. Robinson Finally, a group of certificates. A certificate of dissolution for the Grace Vue Manor Nursing Home Corporation, requesting consent for filing to dissolve the Grace Vue Manor Nursing Home Corporation. Department and committee recommend approval.

Mr. Robinson A certificate of dissolution for New York Congregational Nursing Center requesting consent for filing to dissolve New York Congregational Nursing Center. Department and committee recommend approval.

Mr. Robinson Another Certificate of dissolution for Niagara Lutheran Home and Rehabilitation Center Inc requesting consent for filing to dissolve Niagara Lutheran Home and Rehabilitation Center Inc. Department and committee recommend approval.

Mr. Robinson Finally, a Certificate of Amendment to the Certificate of Incorporation for Manhattan Eye Foundation Inc to change its purposes. The department and the committee recommend approval.

Mr. Robinson I move that batch.

Jo Boufford Second?

Jo Boufford Mr. Thomas.

Jo Boufford Any questions or discussions?

Jo Boufford I just wondered the geographic location of Grace Vue Manor and New York Congregational in terms of geographic location in the state, in terms of what would appear to be service reduction even in long term care. Just be helpful to have that in the agenda.

Mr. Robinson Which one are you interested in?

Jo Boufford The Grace View Manor and New York Congregation. I just wasn't clear where in the state those were located.

Marthe Ngwashi Good morning. Marthe Ngwashi. I'm an attorney at the Department of Health. Grace View Manor is located or was located in Binghamton, New York. What's the other one?

Jo Boufford New York Congregational.

Marthe Ngwashi It is also in the exhibit. If you look at the memo from the general counsel to the Public Health and Health Planning Council, it outlines where they're located. New York Congregation is also in Binghamton.

Jo Boufford Thanks.

Jo Boufford I do think it'd be helpful that when listed on the agenda for those of us that aren't a member of the committee.

Jo Boufford Any other questions or concerns?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Batch is approved.

Mr. Robinson That concludes the report of the Establishment and Project Review Committee.

Mr. Robinson Back to you, Madam Chair.

Jo Boufford Thank you very much.

Jo Boufford It's now my pleasure to introduce Mr. Holt, who is ready to give us a report on Codes, Regulations and Legislation.

Tom Holt Good morning. I'm Tom Holt. I'm the Chair of the Committee of Codes, Legislation and Regulations. At the June 15th meeting of the Committee on Code Regulations and Legislation, the committee reviewed and voted to recommend emergency adoption for the following two regulations for approval for council. First, we had the investigation of communicable disease. Jason Riegert and Dr. Emily Lutterloh from the department presented the investigation of communicable disease, proposed regulation to the Committee on Codes for emergency adoption and their available to the council should there be any questions of the members. I move this regulation for adoption.

Jo Boufford Second by Dr. Yang.

Jo Boufford Any questions or concerns from members of council?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Motion passes.

Tom Holt Next, we had the hospital and nursing home, personal protective equipment requirements, PPE. Jacqueline Sheltry from the department presented to the hospital in nursing home PPE requirements. Proposed regulations to the Committee on Codes for emergency adoption. Jacqueline Sheltry and Jonathan Karmel are now available to the council should there be any questions. I so move the adoption of this emergency regulation.

Jo Boufford Second?

Jo Boufford Dr. Soffel.

Jo Boufford Any comments or questions from members of the council?

Jo Boufford Yes, Dr. Watkins.

Dr. Watkins Does the department have any idea how often we'll continue to have these emergency adoptions since there is no longer a declaration of emergency from the state or from the federal government? How often will we see these emergency adoptions coming before the council?

Jo Boufford Who was in a position to answer that?

Jacqueline Sheltry This is Jacqueline Sheltry with the Department of Health. I could answer that. This latest emergency adoption would cover through, I believe, September 27th. Yesterday, we actually filed proposed revised regulations. The public comment period for those closes on August 14th. We anticipate this may be the last emergency adoption, depending on the public comments we receive based on that revised proposed rule. We'll have to reassess and of course, report back to this committee if a subsequent emergency action is required. Based on the anticipated promulgation of permanent regulation, we are, I think, coming down the end of the pipeline for the emergency adoptions. Again, depending on what the public comment period reveals, in terms of the public comments and whether or not any changes are needed to that revised proposed rule.

Jo Boufford Thank you.

Jo Boufford Any other questions from members of council?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford The motion is passed.

Tom Holt The following two regulations are presented for full adoption, the first being clinical staffing and general hospitals. Mr. Mark Hennessy from the department presented the Clinical Staffing and General Hospital proposed regulation to the Committee on Codes for adoptiaon and is available to the council should there be any questions of the members. I move the acceptance of this regulation for adoption.

Jo Boufford Can I get a second?

Jo Boufford Dr. Watkins.

Jo Boufford Are their comments from staff, health department staff? I probably skipped over that. It's a good idea to have those for these regulations.

Jo Boufford Any comments?

Jo Boufford None.

Jo Boufford Questions, comments from members of council?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford Motion passes.

Tom Holt Next, we have the inclusion of Health Equity Impact Assessment as part of the Certificate of Need process. Ms. Johanne Morne and Tina Kim and Jason Riegert from the department presented the inclusion of Health Equity Impact Assessment as part of the Certificate of Need Process regulation for adoption to the Committee on Codes. They are available to the council should there be any questions of the members. I so move the adoption of this regulation.

Jo Boufford A second?

Jo Boufford Dr. Soffel.

Jo Boufford Ms. Kim or Commissioner Morne, are you there? You want to make any comments at all?

Johanne Morne Good morning, everyone. This is Johanne Morne, Deputy commissioner for the Office of Health Equity and Human Rights. At this time, I don't have additional comments. I know that we've had the opportunity to present on two separate occasions. I have my colleague Jason, as well as Casey Griffin also on screen in the Albany office. We are here to answer any questions should there be additional questions to consider.

Johanne Morne Thank you.

Jo Boufford Any questions?

Jo Boufford Yes, Mr. La Rue.

Mr. La Rue Good morning. Scott La Rue, member of the council. Not participating in the committee meeting on this. What changes were incorporated from the original proposal? Because there was a lot of feedback specifically around CONs that were more routine in nature and didn't necessarily at least people who provided feedback felt they did not have with significant impact and should be exempt from it. Can you explain where we fell out on this?

Jo Boufford Ms. Morne.

Johanne Morne Sure.

Johanne Morne My apologies.

Johanne Morne As you've indicated, certainly there was tremendous diligence done in order to receive input both from community stakeholders as well as from providers across the state via membership associations. As a result of those communications, there were

amendments that were made to the original package, mostly aligned with ensuring that we were inclusive in our language, as well as taking into consideration the points that you have raised regarding the CON process and the various levels in which a CON process may proceed. It may be helpful if I asked Mr. Riegert just to address any significant changes that can respond to your question.

Jo Boufford Mr. Riegert.

Jo Boufford What would a meeting be with one telecommunications glitch, right?

Johanne Morne Perhaps the technology. I'll go ahead and hopefully the technology will advance.

Johanne Morne They are no longer frozen. It looks like we're unmuting.

Jo Boufford Excellent.

Jo Boufford The question of Mr. La Rue, was any significant changes made from the original draft as a result of the comment period?

Jason Riegert Can you hear me now?

Jo Boufford Yes.

Jason Riegert There are no substantial changes that would be that would require another forty-five day public comment period to the extent that we wanted to do that. We did make, as Johanne, I think, alluded to, a number of changes to the actual documents that will be utilized to make those more just sort of simplistic, user friendly, more streamlined. We are going to be working on a smaller sort of rate package based on some of the comments. That's the plan. We anticipate having that to the council hopefully at the next meeting. Some of those were including. For example, just one that comes to mind is also for the exemptions for minor construction and equipment projects, adding a 10% threshold. I think that was always sort of the intent there, but it wasn't expressly in the regulation. We received comments and feedback on that. It's somewhat of a clarifying edit but given the way that State Administrative Procedure Act works, we would have to do that as a rulemaking. I don't know if you had anything else.

Johanne Morne That was it.

Jo Boufford Mr. La Rue.

Mr. La Rue 10% of what?

Jason Riegert It's minor construction equipment projects would subject only to limited review unless such projects would result in the elimination, reduction, expansion or addition of beds or services. Setting a 10% threshold. Part of the problem, right, is that if you have a minor construction project, but it could eliminate one of one-hundred beds, that's only 1%. That's not really what we're looking at as far as a substantial change that would be subject to a Health Equity Impact Assessment.

Jo Boufford So the 10% refers to the percentage of services that are being reduced as a consequence.

Jason Riegert That are being reduced.

Jo Boufford That was his question, what was the 10%?

Jo Boufford Any other?

Mr. La Rue Yeah.

Jo Boufford Please, Mr. La Rue, again.

Mr. La Rue I think initially there was also quite a bit of discussion about the cost of Health Equity Assessments. I don't know where the regulation ended up. That it's being put forth as a no cost regulation, or is it anticipated that there would be costs related to this commission?

Johanne Morne Yes, I'm happy to respond to that.

Johanne Morne Yes, it has been determined that there is an affiliated cost, and that cost is largely related to bringing on an independent assessor. Different facilities, as well as membership associations have estimated the cost based on their own... What's the word I want? Based on their own sort of inquiry or query to private contractors. The cost is what's being suggested and what's in our guidance and documents is that that cost should be estimated and included in the estimated cost of the entire proposed construction or substantial change. As it relates to the independent assessor, there was intention on the part of New York State Department of Health to not dictate who could be brought on as an independent assessor, leaving that so that providers can broadly select as long as an independent assessor that is selected aligns with the framework of expectation, meaning that there is no conflict of interest.

Jo Boufford One of the issues having been in conversations about using the magic words impact assessment, everybody immediately relates to the environmental impact assessments, which are incredibly complicated and incredibly expensive to conduct. I think having worked on health impact assessments, I think and looking at the guidance that's been issued on the equity assessment, it really is not as complicated a process. It really builds on the community health needs assessment, which most facilities are supposed to be developing anyway and also so the form doesn't appear to be terribly onerous. I would not think it would be a significant expense relative to, you know, the overall cost of the project that's being considered.

Jo Boufford Ms. Monroe.

Ms. Monroe A question about implementation. Whenever you hear the words independent assessor, there are a lot of very good organizations that could do that job. There are also going to be a lot of licenses thrown up that they're qualified to do this. How is the department ensuring that if a provider chooses an independent assessor, there's been some either certification or a vetting of that person so that when the assessment gets to the department, there's not a question about accuracy, completeness, etc. Does the department anticipate... I hate to use the word certifying, but something so providers have confidence that this independent assessor is actually going to be able to do the job.

Johanne Morne Thank you.

Johanne Morne At this time, the department does not have intention to do certification of these individuals or of these organizations. In the guidance, there are some clearly stated expectations as to who and what experience or expertise an independent assessors should have. Again, with the intention of allowing providers to be broad in their thinking and selection, we intentionally did it this way to create parameters as far as expertise, but at the same time not limit the options of who may be selected. Certainly, as we continue to build our team and our experts as it relates to the health equity assessment process, we are happy to work with providers if they have additional questions on a specific selection. We have not placed ourselves in the position of making the determination. That determination is on behalf of the provider.

Johanne Morne Did you want to add anything to that?

Ms. Griffin No. I just believe that we are going to do our due diligence and monitoring for the first few months as well as the first year, and then we will review if there are any questions that we have and things like that. If it does come to that at the six-month mark or one year mark, we are willing to re-evaluate that position.

Jo Boufford Thank you.

Jo Boufford Any other questions from members of the council?

Jo Boufford Dr. Soffel.

Dr. Soffel I'm not sure this is a question so much as it's an observation for all of us on the council. I am very curious how many CONs came in in the final hours before it went into effect last week and whether there's sort of a rush to get their applications in before this new requirement was installed. I think that we as a council should look at those applications very carefully when they come to us for review. Does anybody know how many applications came in in the last week?

Ms. Glock Shelly Glock with the department. I can tell you that approximately seventy applications came in between June 16th and June 21st. What I can't tell you is how many of those may have been excluded from having to do the Health Equity Impact Assessment, because I would have to manually go into each application and read exactly what they were trying to do. It doesn't mean that all seventy of them would have needed a Health Equity Impact Assessment.

Dr. Soffel Understood. How many would you normally get in a week? Was that a typical number or was that not a typical number?

Ms. Glock I'm not sure there is a typical week. I can tell you that I had just pulled data from a couple of random dates, two in May and then one back in February just to kind of get a gauge. Excluding the Article 36 and 40 applications, that type of thing, that the Health Equity Impact Assessment wouldn't apply to. There were about, I would say, twenty a week. Definitely an uptick with the seventy, but that again, small sample. I only pulled three weeks.

Dr. Soffel I would like to request then that when those applications come to us for review, that there would be a little note of the date that they were received. Is that possible?

Ms. Glock We've talked about that internally, because on the exhibits we put the acknowledgement date. We won't change that. Under the Health Equity Impact Assessment, we're thinking about putting a little section there. If there was not a requirement to do it, would say, not required per statute or regulation for those that came in that don't have them attached. They came in prior to the 22nd. We'll put a little something in there that says, the application was received on such and such date prior to the effective date. You'll be able to see that in the exhibit.

Jo Boufford It would be clear which ones would have been assessed, would have been expected to have an equity asset.

Ms. Glock Because the acknowledgement date doesn't tell you.

Jo Boufford That's great.

Jo Boufford Thanks.

Jo Boufford Denise, is that okay?

Jo Boufford Any other questions or concerns?

Jo Boufford All in favor?

All Aye.

Jo Boufford Any opposed?

Jo Boufford Any abstentions?

Jo Boufford None.

Jo Boufford Motion carries.

Tom Holt Lastly, for information, we had the removal of the COVID-19 vaccine requirement for personnel of covered entities, the removal of the COVID-19 vaccine requirement for personnel and covered entity proposed regulation was presented to the committee for information only and will presented to the committee and the full Public Health and Health Planning Council for adoption at a later date.

Tom Holt This completes the agenda of the Codes, Regulations and Legislation Committee.

Jo Boufford Thank you very much.

Jo Boufford We'll move on to committee reports. We're moving at a good pace. We have good time for a good discussion of these reports. I'll start out with a report from the Public Health Committee that met on Monday in Albany, and then Ms. Monroe will follow up with the Health Planning Committee. This was the third meeting of the Public Health Committee. Since the post COVID, I guess in terms of our timeframes, we sort of revisited the pattern of the Public Health Committee, which has been having our major responsibility to oversee the what it will now be over the next months, the revision of the prevention agenda and potentially implementation of the prevention agenda to come back to one of

we have been in the practice of identifying a significant public health concern for the state that we also worked on at the same time we were working on the prevention agenda. We wanted to go back and revisit maternal mortality, which had been the really the last one we had dealt with. The council had produced a white paper sort of in 2016, which laid out a set of recommendations for addressing maternal mortality, which had really ended up after a terrific set of presentations across the Department of Health, really had recommended special attention to the early and easily available family planning, understanding that significant number of pregnancies in New York State were unplanned, and many of those ended in a poor maternal outcome. Secondly, to emphasize the availability of good screening for potential high-risk mothers in early referral to subspecialty obstetrician gynecologist services. We did this because so much of the rest of the department activity has been focused on the in-hospital risks for maternal mortality in terms of infection and thrombosis and high blood pressure. We got an update on that. I think Jeff had implemented a request for what's called a Deputy Commissioner Executive Report in writing, which was circulated before this meeting. A lot of this to summarized. Kristin Siegenthaler, who's the Director of the Division of Family Health, gave a really terrific report on progress in addressing the issue of maternal mortality in the department, Family Planning and Abortion Services as well, and also relative to the specifics of the council white paper, but also gave us a progress report on the Governor's commission recommendations, which had more to do with diversity of workforce, cultural competency, compensation of doulas and others, which has been moving very well in addition to that. I think the committee asked a lot of good questions. It was satisfied with the report and invited Dr. Siegenthaler to come back to the next meeting. We'll carry ongoing briefings on maternal mortality, which is such a huge, significant issue in the state. Obviously, there has been a continuation of the huge gap between Black and white maternal mortality, which had been improving, that gap had been closing. It is not now. Although everyone is improving, that gap is still there. It's something that we want to be very attentive to. The other longer presentation we had was from the Deputy Director of Commissioner Morne's Office, Office of Health Equity and Human Rights on the Health Equity Impact. We had a really good conversation and description about that. It was explained in considerable detail. There were a really nice set of slides. If people want to go on and take a look at the details of those. People were encouraged, I think, and felt it was a very reasonable approach. Dr. Soffel commented. She was there. Dr. Bauer and Shane Roberts and Zahra who are the staff. Shane and Zahra are the staff now in the Office of Public Health Practice. Dr. Bauer, of course, Deputy Commissioner for Public Health, presented really the results of her meeting with a number of leadership folks at leadership level within the department looking at the current prevention agenda, changes that might be made, especially around the new emphasis in the department on equity and community engagement, as well as multisectoral involvement on broader determinants of health, all of which had been areas that we had been interested in and emitted to, but had not been able to really implement in the way that we would have liked before COVID. Obviously, nothing has really... No changes in either the priorities or objectives for the prevention agenda or the metrics have been made since 2019. That's part of the revision process that's underway. Usefully, Dr. Roberts and Zahra have been looking at the sort of state health improvement plans, which is what our prevention agenda is across the country, to see where there might be lessons to be learned from other states and good practice. They presented a little bit of that. We're going to get a more granular level presentation going forward. We did talk about involving the sort of beginning to shape an agenda for the next meeting of the Ad Hoc Committee, which will be on July 13th in Albany, and I think Buffalo, is that right? We will do this as a hybrid meeting, I think going forward we'll help to have the Ad Hoc Committee meet in person as we move in. We also agreed in principle to have set up another meeting. We had set up follow up meetings of the Ad Hoc Committee for

November and January to sort of finish that sort of engagement and advice process. We felt it would be useful to have an additional meeting in September of the Ad Hoc Committee so that we can really take on board the more granular analysis that will hopefully, and the discussion will come out of July going forward.

Jo Boufford Let me invite Denise. Do you want to make any comments?

Dr. Soffel I just want to say I really appreciated. Tina Kim gave the presentation to the committee. I really appreciated her acknowledgement that we are all going to be learning about the HEEIA and that it's going to take... We're going to use this for several months and year to sort of all collectively get a better understanding of what we are asking and what we are learning and how that's useful. I think that the acknowledgement from the department that this is a brand-new turf that we're covering and we will together figure it out was very encouraging to me. I want to congratulate on this, because I think it's an enormous achievement for the State of New York.

Jo Boufford Dr. Lim, you were present as well. Any comments?

Jo Boufford You don't have your mic on. Maybe you can put your mike on so they can have it on the record.

Dr. Lim I'm so sorry.

Dr. Lim I just want to echo what Dr. Soffel said and what everyone else. I think what I was just saying is that it's an uncertain time, but it's a good uncertain time. That's how we learn and do better.

Jo Boufford Dr. Watkins.

Dr. Watkins Every comment that was made. It was a very informative meeting. We have a long ways to go, but I think we're getting there.

Jo Boufford I guess just finally two next steps that we asked Dr. Siegenthaler to prepare for us for the next meeting of the Public Health Council had to do with the question of consolidation in loss of maternity beds across the state, wanting to understand more about that because we see those applications coming through and I think we're all concerned when it happens. We want to hear what the impact is. Similarly, dealing with rural access to adequate prenatal care and the implication of midwifery run birthing centers, availability of midwives in rural areas. Those will be two areas she'll be talking about going forward.

Jo Boufford That's the end of my report.

Jo Boufford I'll turn it to Ms. Monroe for the Planning Committee.

Ms. Monroe Good morning, everybody. John Rugge wasn't able to be here today as Chair, and so I'm giving our report as Vice Chair. The Health Planning Committee hadn't met for a very long time and didn't really have a project like you have had in Public Health to sink their teeth into. John Rugge and John Morley put their heads together and came up with what is a serious presenting problem, and that is the backup of ambulances at hospitals and the cost of that to the system. We took that and began to talk about it. One of the things that contributes to that is the number of people utilizing the emergency room for things that really don't require that level of care. We identified two major reasons for

people who do not have emergency room level needs. We really have dug into those. The first is behavioral health. Emergency rooms are seeing lots and lots of people with behavioral health issues who really do not need to be in the emergency room. I can't give you numbers because I don't have them with me today. Trust me that it's a serious problem and it's backing up the emergency room and therefore backing up the ambulances that are going on truly unnecessary trips. The second, which was a surprise to me and I believe it was the surprise to most of us was dental. That 17% of the unnecessary visits to emergency rooms are for dental reasons. There again, you think, wait a minute, what happened to dental services out in the community? There are a lot of reasons why we see this happening, but we have asked for more data from the department. Who are these people with dental and behavioral health problems? Where are they? Where are the problems most severe? We identified a group of questions through the committee that we submitted to Dr. Morley and to Dr. Sullivan at OMH to come back to us with some answers about the current situation that go beyond kind of generalizations or anecdotes, because we'll need that in order to look at what might work. We had our meeting on Monday. We kind of narrowed in on what we were looking at. I want to especially one to recognize Dr. Morley and Shaymaa Mousa, who did tremendous work in summarizing all of this conversation over the meetings. I think what we have are kind of three buckets that I'd like to share with you. The first bucket we're calling accountability for current programs. What is currently happening to reduce or to increase diversion and how effective are they? That's part of the request for information from the department. What are the dimensions of the problem? How effective are the programs that already exist? What standards and measures do these programs have for quality, access and equity? Should we put a priority on improving what's already there rather than supplementing or replacing what's already there? That's kind of the first bucket is accountability for what's already happening. The second bucket is innovation. Should we have some pilot programs? There were some great examples of things that could be expanded. I had no idea that in five counties EMS has a relationship with 911 and with behavioral health agencies to divert individuals from the emergency room. Is that working? Should that be expanded? I asked the man who was in Rochester about the cost of that. He said, well, it's a lot cheaper than taking somebody to the emergency room. If a person says, well, I have no way to get to the FQHC or whatever. He said, we'll provide an Uber, and we'll even pay for it because it's a lot cheaper than sending the ambulance. There is an idea that might be able to be expanded. There was also discussion about paramedics, about dental therapists' kinds of things that could be new ideas that could be piloted in areas where that problem is particularly severe. That's why we need a lot of data out of the first group is to help us see where these problems are most severe. The third area after accountability and innovation is the whole idea of long-term system reform. Heslin told us about a new ten-year demonstration of which New York is part called Making Care Primary. That is something that we want to look at in terms of long-term reform, but we also have to look at for this backup in emergency rooms, diversion is only one aspect of that. Other aspects of that get us into systems, much larger systems like the nursing homes don't have any beds anymore to take people from the emergency room. Hospitals can't discharge. Those are not on diversion targets as much as they are system wide targets. That's the third piece. It means stepping back from individual ideas and individual cases and looking at what needs to happen to really improve the circle of care of ambulances, hospitals, nursing homes and primary care in the community. That's really the longer-term thing. One of the things that I think we talked about, John and I and a couple of other folks, and it's unclear to me is what is the role of PHHPC or of the Planning Committee in this? Do we direct the department to do certain things? Do we ask the department to do certain things? Do we do them ourselves? It's unclear to most of us what the role of PHHPC is in addressing some of these problems. That's kind of our next

iteration is to get clarity about the relationship and the role of the department in moving these things forward and also beginning to say we're going to tackle some things today that we might be able to improve on, but that what we're really going to need in the long term is a step back and looking at this circle and saying what has to happen for that to be smoother, for that to be more effective for people and more efficient and cost saving for providers.

Ms. Monroe I'll stop there.

Ms. Monroe Denise.

Dr. Soffel Oops.

Dr. Soffel Hi. I just wanted to add one thing to Ann's summary, which is we had an interesting conversation about where accountability lies and what's the role of the managed care plan and what's the role of the primary care provider. When we're talking about the fact that people are not connected to dental care or are not connected to a behavioral health provider. Whose responsibility is it to make sure that people, in fact do have access and a connection to a dental provider or to a behavioral health provider so that their situation does not spiral out of control, and they end up in the emergency department. We don't have an answer. I think it's an important question for us to be thinking about, what is the role of the health plan, what's the role of the PCP and what's the role of the individual?

Ms. Monroe Thank you for that, Denise. I did forget to say that, but we did have conversation about the fact that the department gives money to the Medicaid managed care plans, and dental is one of the services that's paid for by the department. Yet we know that 17% of people who come to the emergency room for pain, for which their pain is treated don't go to a dentist. They come back for more pain treatment. Where does that accountability lie in that first sector of accountability?

Ms. Monroe Thank you, Denise.

Jo Boufford I think there were... I'm trying to remember there were any other members of the committee that were at the meeting that might want to comment.

Mr. La Rue Thank you for the report.

Mr. La Rue I just wanted to comment on the dental, because being an operator. Well, at least in the short term here for a Medicaid managed long term care plan and a PACE program that cares and coordinates care for a lot of Medicaid beneficiaries. It's almost impossible to find a dentist that is willing to provide dental care to Medicaid beneficiaries because the reimbursement that they receive is not making it a priority. We ended up partnering with the Columbia School of Dentistry. We fund a mobile dental van with students on it in order to get dental services to our Medicaid beneficiaries. It is a real problem. I was surprised to hear that 17% of E.R. visits are driven by teeth, because I've never sat in E.R. and saw someone say, Oh, my God, my tooth.

Ms. Monroe That 17%, I believe, of potentially diverted people.

Jo Boufford Avoidable visits.

Ms. Monroe Is that right?

Dr. Watkins 70% of patients that go to the E.D. do not end up with something that requires emergency treatment. That's the first level. 70% of people who go to the E.D. do not require an emergency. Of that 70% who don't need emergency level care 17% are dental.

Ms. Monroe It's not 17% of everybody who shows up. It's a significant number and one that who is, as Denise said, who's accountable for that? You went and got an arrangement with the School of Dentistry for a mobile van. What else do people need to be doing in order to make that happen?

Jo Boufford Dr. Berliner.

Dr. Berliner Let me just say, this is not just a Medicaid problem. We had a visitor placed in a rural county who woke up with great pain in her tooth, thought it was an abscess, called the two local dentist, none of which would see her because she was a new patient and because it was a Saturday. Went to the emergency room to try to get some care, whereby the way, she was misdiagnosed, but that's a different story. It happens. I mean, you can't find dentists who are going to be open on weekends or after hours and hence the emergency room. Also note, I mean, historically, the dental profession is the most conservative of all the... We think of the AMA as being really super conservative. American Dental Association makes the AMA look like socialists. They fought Medicare. They fought Medicaid. They refused to participate in Medicaid. I mean, the dental problem is a really big, big issue.

Jo Boufford I think one of the interesting conversation was someone from the New York State Dental Association who had some sort of opaque responses to that question. I mean, I think the...you know, just anecdotally, interestingly, I work with a group of colleagues in the dental profession. I've got you down for next group of colleagues in the dental profession who have been working for four years to get a Medicare benefit to get dental care in a Medicare benefit and had a coalition going, national coalition of all the major dental organizations. At the sort of final hour, the ADA pulled out. The department wouldn't go forward with it. CMS wouldn't go forward with it. It just reinforces Howard's comment.

Ms. Monroe Well, I was just going to say, I think we have to start where we can. However, just as an aside, I believe that Medicare leaves the whole head out. There's no hearing, there's no vision, there's no dental. If we put the head in Medicare, we might have a better program.

Jo Boufford Commissioner Herbst is going to do that in the master plan. He'll come up with it.

Ms. Monroe I'm glad.

Jo Boufford Ms. Soto.

Ms. Soto I know that the committee's work is statewide. New York City has now set up a system when people call 911 and the individual, the incident is because someone is having some sort of mental health breakdown that instead of sending the police that they or teams to do the assessment rather than the police showing up. Some of this has

accelerated to someone being murdered because the person is acting erratic. They're telling people, don't be yelling at them and so forth. That's something that's going on. My other concern is if someone legitimately has a mental health issue that needs to be hospitalized, to be stabilized and maybe transferred, it is what is the availability? Due to someone very dear to me being very sick and visiting an ED maybe twenty times in eighteen months, knowing that in this particular facility that the mental health, the psychiatric portion of it was very small. Just in terms of keeping that person possibly in the ambulance because they're trying to do an assessment, it isn't like, you know, as many beds as whatever reason the person is there. Lastly, I called my dentist last week, a week ago today, and they've yet to return my call to set up a routine examination. I'm going to have to go in person. That's what I've done in the past.

Ms. Monroe I just want to make a comment on that.

Jo Boufford Please, and then I've got two other councilmembers and then Dr. Lim, and then I'll come back.

Ms. Monroe One of the things is that OMH Commissioner Sullivan has, through the budget, received a significant amount of money for behavioral health and they're putting pieces in place. Again, it's an issue of what is PHHPC accountable for? We can work with OMH. What we need to focus on here is what are the things that can be improved to reduce the ED visits? Having a robust, effective behavioral health system is one of those, but we have to work to that through that rather than directly from here.

Jo Boufford Let me move on here, Dr. Strange and then Mr. Lawrence and Dr. Lim.

Dr. Strange I was at that first meeting with behavioral. It wasn't at the dental one. I am in a hospital as the Chair of Medicine at Staten Island. We do have a dental clinic. We do see a large number of patients. Last night, I can tell you three patients who came in with dental procedures, one of which needed to be admitted going to the dental clinic today and will be discharged. That being said, workforce, I believe, is the key issue here. We train more doctors in this state that go around the rest of this country and provide care and we can't retain them. We have more doctors. I don't know the dental areas. I'm not attuned to that. Who leave this state for many reasons? Whether it's their own cultural reasons of wanting to live in a warmer environment, whether it's the whole issue around big cities today, whether it's let's talk about malpractice reform and other states having a better way for physicians to feel comfortable with that. Reimbursement, we just spoke about that. It all comes down to workforce. There is no access. I can tell you on Staten Island in the county of Richmond, there is no psychiatrist in the community. I mean, I can count maybe three. For sure doesn't fill up my hand. The dentist, to your point, Dr. Berliner, have been immune from all of the talks and all of the reforms that we've gone on in government. I don't blame them. It's a business. They're immune to this. What is our role as a Public Health Council? If our role is to be that of ensuring that every single person in the state has access to care? Well, first, you have the access. I was just telling Mr. Thomas, one of the best business models right now for emergency rooms is to have a couple of urgent centers built right near them. We've increased the number of people coming to emergency rooms, so we've probably tripled, quadrupled the cost of health care, because I can tell you about every day from the local set up right up the block from one of our hospitals. We get five to ten referrals a day right from the region. That wasn't supposed to be the case. It was supposed to deflect that. They can't handle the behavior. Some of those patients go to that center and they say, I can't handle it. I'm not sure you're suicidal or not. I'm not sure I can handle this. We have a workforce problem. I think it all starts at a workforce problem. The

question is why? Is it malpractice? Is it reimbursement? Is it of cost of living? Cost you $20.00 to get off the island. We need to fix that. We need to know why we can't retain our young medical students and residents here in Staten Island as opposed to going to Texas, in North Carolina, Delaware. I can tell you where they're going. I have 129 residents in my hospital. I retain five to ten a year. Five to ten. Why? I know why. I mean, I asked them why every year. I think that's the biggest issue.

Jo Boufford I think this council has been deeply concerned about workforce for a number of years. This came up again in the Monday conversation. I think we need to get someone here to really address the workforce issue. We were advised Monday, I think that there is a group working on it, but I think we need to hear about it because it comes up all the time. I think it also relates to Commissioner McDonald's earlier statement about his efforts to befriend the Department of Education, because obviously scope of practice issues, which are huge in dentistry as well as and workforce issues for physician, you know, surrogates and others is definitely.

Dr. Strange As a Primary Care Doc, we've been pushed to the limit now being told we have to practice psychiatry. There's an uncomfortable with this is how much psychiatry, right? We don't practice gynecology anymore in New York City areas because the standard of care is that a gynecologist should be doing that. We've pushed the envelope for primary care is treating depression beyond what they should be doing. That's a huge issue right now that makes physicians and providers feel very uncomfortable. That's because of access. Who else is going to do it? We're embedding social workers in our office to help deflect some of that and maybe get to the next point. I think social determinants of joining with the Department of Education, joining with the Housing Department, joining with others to help solve this problem. This needs to be a partnership.

Jo Boufford Really important.

Jo Boufford Mr. Lawrence.

Mr. Lawrence I'm not surprised that you found the dental cases and patients in the emergency room. It's an issue. It's a pretty complex issue that we have been dealing with in our neighborhood for some time. I think one, reimbursement, obviously. When we are looking at our budget, we are often saying how much are we prepared to lose providing dental services. We are committed to the mission. We just added six opportunities. The phones were ringing off the hook to schedule appointments. We had an incredible challenge and I think just recently we probably retained two dentists, but that's a challenge of workforce. In a neighborhood, no one is willing. No dentists on the private side of things are prepared to work in the city or underserved neighborhood. You could find a bunch of them doing cosmetic dentistry in other neighborhoods, but not doing Medicaid work and serving underserved people in our neighborhoods. With regard to the managed care plans, I guess the big elephant in the room is rosters, especially in primary care. There are rosters with patients who in fact are on rosters, but they are not showing up for care. That's in primary care, that's in the medical side. It's even worse in terms of the dental, because there are patients on dental rosters, and they don't show up. They don't even know who they're assigned to. You have the added burden of trying to track them down. No way of getting in touch, no numbers. The phone numbers don't work. I think there's a lot of work to be done on the managed care side of the equation to really connect patients that are on their roster with their PCP and with their dental provider. I think the workforce issue, I don't know if there's a dentist across the state program. If there isn't, there should be one. The issue of workforce I think is a structural problem in the delivery system. My sense is that

clinicians are looking for a higher quality of life, which has something to do with the health care system, but a lot to do with how they feel they live in for instance, in New York City or in other areas. Dr. Strange, if you are having problems retaining clinicians in Staten Island, imagine what I am feeling in Brownsville and East New York in Brooklyn. That's an issue. The reality also is that when we look at workforce salaries, 30, 40% and at least for us rates have not gone up to to match that. That's a real challenge. There are some structural problems here that long term need to be worked out, but in the short term, what do we do to get people into care? Get them, divert them from the E.R., which is much more costly.

Jo Boufford Yep.

Jo Boufford Thanks.

Jo Boufford Dr. Lim.

Dr. Lim Thank you.

Dr. Lim I could probably spend five council meetings just talking about behavioral health, but I'll try to sum it up just three or four points.

Jo Boufford We'll give you a chance in a future meeting to go into more depth. I can tell this is going to be an important recurring issue.

Dr. Lim Just a few comments and I think this will be in line with what Ms. Monroe and Dr. Soffel and others have said in terms of I think some points, I think with the council to consider and for DOH to consider, I think, number one, behavioral health is not a monolith, right? There are major differences primarily in prognosis and interventions. I think one of the big things that we have to recognize is not only sort of in sort of our data collection, recognizing the differences in people who are coming in for primary psychiatric diagnoses, mental health diagnoses. I think we're sometimes forgetting about people who are coming with primary substance use disorder diagnoses. We've got two different systems of care. There's increasing integration, but there are two different systems of care if you have a primary mental health versus an SUD diagnosis. I think in part of the data collection, we need to look at that, not just look at just the OMH data, so to speak. I think the other big piece is that we know and Ann, you talked about really looking at looking at the whole continuum of care. An important, very important piece in the ED diversion piece is, what are the behavioral health crisis services that are available? The interesting thing is there is actually, and I've talked about this in that meeting where there's something called the CPEP model, which is a great model, but it's not adopted by every hospital. There are fewer hospitals who have CPEPs than not. I think it's important to look at how we can expand the crisis system, which I believe OMH, and Oasis are doing, but if we're only looking at the crisis system and if we're only looking at inpatient beds, in my mind, it sort of is like we're focusing on when people are so sick that they're either trying to commit suicide or they've overdosed. Part of it has to be what is the rest of the continuum of care? I think when we're talking about continuum of care, it's got to be not just how many and what services there are, it's how are they interconnected, right? How do they communicate with each other? How can people navigate the system? I think New York State has in terms of Medicaid benefits for behavioral, it's probably the richest in terms of Medicaid benefits for behavioral health. I think the challenge is that there's so many different types of services it's confusing to navigate. We have to figure out how to sort of integrate them and connect people functionally together. The other piece to that, I think would be really helpful if we can look at the usage and access and delay issue, sort of like what Dr.

Strange was talking about on a regional and sort of hyperlocal level. There's a vast difference in the services that are available in Manhattan, for example, versus Staten Island versus Westchester versus another county. I think if there were at really sort of more hyper local assessment of what are the service availabilities, that would be really helpful instead of just sort of a general sort of an overview. The last point I'll make is I think the workforce issues, the access issues, all of the things. I think one of the things that needs to be spoken more about more explicitly is the fundamental disparity in reimbursement that behavioral health services are paid under. The methodology for which how the health care system in general, not in New York just entire in the entire country, it does not recognize or necessarily value the kinds of services and the interventions that are required for many of these. It's just fundamentally different. Until we tackle more concretely this disparity, when we talk about mental health disparities in the Mental Health Parity Act, it doesn't talk about reimbursement disparities. It's sort of more complicated than that. I think if the council could sort of focus on these kinds of issues in terms of getting the right level of data collection, what is a regional and hyperlocal needs basically for behavioral health and just really sort of focusing on how we can integrate this continuum in a meaningful way. That might be helpful, at least from my point of view.

Jo Boufford Important comments. I think just in the interest of time, I'm being passed notes over here on the left. Dr. Morley, I think has a hard stop at noon. We're going to jump to him after this.

Jo Boufford Let me see if Dr. Heslin has any brief comments. I think we don't have time for a full presentation of the pilot that Ann mentioned, but I think we would want to come back to it. Importantly, anything that boasts primary care, we want to talk about as much as we can.

Dr. Heslin Just a couple of very brief comments. Ms. Soto brought up mental health. Just to scale the New York City program, we met with them yesterday at EMS. They have six units that support all of New York City in that pilot program that they are currently running. They do about 120,000 mental health transports compared to a total of 1.5 million transports. We recognize that EMS doesn't transport. Hospitals get much more than EMS. About half their business is in transports. Just to scale of the problem, these are pilots, and they are being used. In terms of workforce, I think Dr. McDonald spoke very well about that and that our partnership with the State Education Department. We can regulate people, we can finance people, but we actually don't have the ability to provide more workforce. That's not a Department of Health role. The Department of Health, the Department of Education's role is to make sure that we have appropriate workforce through licensure and through scope of practice and through developing those pipelines because they're the educational system. We are desperate to work with them and to partner with them so that our partners can make sure we have enough workforce for the system to function. In terms of with Dr. Strange's comment, there's a quality-of-life survey that's done every year for all fifty-one jurisdictions. Puerto Rico is the other jurisdiction. We rank between 49th and 50th every year in that in terms of quality of life and reasons why physicians stay where they are.

Jo Boufford That's the position survey.

Dr. Heslin This is a physician survey.

Dr. Heslin There's a variety of reasons. It's a long list. They go through about ten or fifteen different metrics that they use in terms of why people practice, where they practice. We're always 49th to 50th. We've been that way for decades. The final thing I just have to say,

Dr. Lim, you're 100% right. Mental health has never been supported like physical health. Primary care has never been supported like procedural medicine. We have structural issues in terms of how we function and what our goals are versus what our reimbursement system is. We do have to, through what Ms. Monroe said, have to address those issues in a holistic way to make sure the circle of care as described is going to be actually supported and invested in properly. I think that Mr. Herbst is going to speak a lot to that in the report that he gives out because that is going to be key to how we actually function as we move through the silver tsunami that's coming at us.

Jo Boufford I think we'll need to wrap up this area.

Ms. Monroe I just wanted to say I think the Health Planning Committee has a lot to do. If anyone else wants to join us, you're more than welcome.

Jo Boufford Thank you.

Jo Boufford These are really, really rich issues. I think the workforce question, the only time it really has been coming forward is largely around the health care delivery system issues, hospital based, and they're huge issues and obviously they're very related to prevention, scope of practice and others around avoiding hospitalization or avoiding coming to the emergency room, etc.

Jo Boufford Mr. Lawrence last comment, please.

Mr. Lawrence You know, I guess my concern about the workforce is that I've never seen it like this. I don't know if it's a blip. It seems like there's a paradigm shift. If it's a blip, that would be a great thing, because then we'll see some return to normalcy at some, maybe a higher level. It just seems and feels different across the board for almost everyone in the workforce.

Jo Boufford I think that's an important issue. Having been involved in these kinds of things for a really long time, I think we've forgotten about a lot of... Ann put some really nice buckets on this, the accountability innovation. A lot of things that would not be new because they've been proven. The evidence base is there for things like broader scope of practice, other kinds of professionals, etc. that could deal with some of this. This pressure has seemed to have been lost in the shuffle. We need to come back to it. And then, as Jean said, following the money is always probably the most important way to see where the incentives are financially for addressing some of these issues. It's an important area. We'll make sure something comes on our table around this broader workforce question.

Jo Boufford I've got Dr. Morley and Dr. Herbst both going like this. I'm going to have to leave. I don't know if we can do a... Adams says to let John go.

Jo Boufford John, give your report briefly. And then again, referring everyone to the deputy commissioners written report, which produces a lot of work and then we'll move to Dr. Herbst.

Dr. Morley Thank you for the referral to the written report, because if it's going to be much longer than my report. For Dr. Strange, I just want to quick comment that if you think that there's concerns about internists doing psychiatry, talk to the pediatricians. OMH does offer a consult line once a week. There's a pediatric psychiatrist that offers a phone service to pediatricians across the state. It's a full conversation and discussion and consultation. In

terms of highlighting my report, the EMS memorial was held, and eight additional names were added to the wall for the EMS memorial. For the Bureau of Narcotic Enforcement, they have released an update to the prescription monitoring program that's intended to improve safety. I invite you to read further on that. Related to telemedicine, as I've mentioned before, they continue to work to align with the federal agency, the DEA, and remind folks that while a physical exam is required before prescribing controlled substances, it can be done through telemedicine. That was not always the case. DOH announces a website and a call center for the take back system. For anybody that wants to be bringing back medications, you can go to the DOH website and there's a dedicated site or a phone number. Eastern Niagara Hospital closed on June the 17th. Catholic Health Services did open up an off-campus emergency department to provide some coverage until the Micro Hospital, as we're calling it, opens up in Lockport in hopefully mid-September. Richmond University Medical Center suffered a significant cyber-attack. I've mentioned cyber-attacks a few times. That's gotten the attention of the Governor's Office. We are working and making calls to hospitals to assess how much is being done by hospitals to avoid cyber-attacks or to address them and to prevent them. There'll be more coming up on that. I want to thank Ann for her tremendous summary of a lot of discussion and a lot of work that went on at the Planning Committee and looking forward to there's a huge amount of interest in it. Thanks to everybody that's participating. There's going to be a lot more on that.

Dr. Morley That's it.

Dr. Morley Thank you very much.

Dr. Morley Any questions?

Jo Boufford Dr. Soffel.

Dr. Soffel I have one comment and one question that come from having read your written report. My comment is, as hospitals are closing across the state, it once again raises for us as a council the question of who reviews hospital closures and whether there should be a role for PHHPC in those decisions, because it seems like the impacts in terms of access and quality are quite enormous. My question is, you also mentioned in your written report that you are working with forty financially distressed hospitals. Can you say something about what are you working with them? What does that mean?

Dr. Morley The issue about closures, I certainly understand the interest of the council on that, and that's going to be a much bigger discussion at another time. The issue of the financially distressed hospitals. We have a section within the Office of Primary Care and Health Systems Management that just works with addressing financially distressed hospitals. There is money that is put into our VAP program, vital access provider. We have money that's put into the VAP program. I forgot what it is, but there's two. One is that federal money with it in addition to state, that's VAP. There's the VAP app, which is just state money. Then there's a program that goes through Medicaid for additional. It's only specifically qualified institutions, but the DPT program, I believe it's called, and that goes through Medicaid. There is funding. Requests come in from hospitals that are distressed, asking us to look and to consider them for a VAP application or for a VAP app depending upon what their needs are. We work with them. Significant amounts of money have been distributed across the state through those programs. That's not inclusive of the other series of programs known as statewide health care transformation 1, 2, 3. We're about to be issuing over the Summer 4, and 5 has already been written into law by the legislature.

We've got a fair amount of money in those programs as well. Those are for transformation projects. It's reimbursing them for programs. That obviously assists the hospitals that are unable to do that without additional support.

Dr. Soffel Just to be clearer about my question, I'm really sort of interested in how we are addressing the underlying structural issues that lead hospitals to continue to be financially distressed year after year after year after year. What we are thinking creatively about how to change the underlying structural problem that these hospitals are facing.

Dr. Morley That has been the source of more conversation, I think, than any other within the department and between the department and the Governor's Office over the last few years. It was something that Paul Francis and it's a name I know everybody. He recently retired from the department. He led those conversations. They're continuing to evolve as we look at the programs and how we will support hospitals going forward.

Jo Boufford One of the things I think that's being teed up by the Planning Committees response report as well as some of these questions, Dr. Morley and maybe we can talk about this. I think one of the reasons Jeff had wanted to have the Deputy Executive Director written a report was to provide more time for the kinds of conversations we've been having here and dispatching. All these roads have been leading to the opportunity of having sort of topic area presentations and discussions, not merely reports. I will take counsel with Jeff and others to see if we can begin to put those things on the agenda, because these are systems review things and we want to answer the question, what can we do? What can we not do? We can certainly be a public platform for discussing issues that are important. We know we can do that because we've been doing it historically. .

Jo Boufford Thank you.

Jo Boufford Any other questions for Dr. Morley before he leaves?

Jo Boufford Mr. Lawrence.

Mr. Lawrence I'm just curious, what are you finding is some of the underlying structural reasons for these troubled hospitals? I mean, sort of I'm sitting here like forty, and then there's got to be some common thread that you're looking at that you see across.

Dr. Morley The top three, and you could say the top ten are staffing, staffing and staffing. The travel cost had a huge impact. There are some other things, but COVID. Many hospitals were helped by federal funding for that, but it didn't help everyone uniformly. There were some differences across the system. Between the impact COVID, the reduction. The engine that drives most hospitals for revenue is the operating room and elective surgery. COVID had a profound effect on elective care and particularly elective procedures, which is where the revenue tends to be generated. Between staffing and a reduction in revenue and the increase in costs. The costs didn't go up just for nurses, let's be clear about that, too. Everybody thinks about that first. There's good reason. There's a lot of nurses out there. We depend heavily on them. They're the backbone on which health care is delivered to patients. Other salaries have gone up. Other costs have gone up. People that had sent in CONs in estimates of projects that they wanted to do prior to COVID. During COVID, those estimates turned out to be a little bit of an underestimate.

Mr. Lawrence Thank you.

Jo Boufford Ongoing discussion.

Jo Boufford Anyway, let me now turn to Deputy Commissioner of the Office of Aging and Long-Term Care, Adam Herbst. I think he's probably the hardest working guy in health policy in the state right now.

Adam Herbst Good morning. Thank you very much. Adam Herbst, Deputy Commissioner for the Office of Aging and Long-Term Care. I'll be speaking today primarily about the New York State Master Plan for Aging, where I have the opportunity to serve as the Chair of this committee. I know we have a deck up in front, so if everyone can just follow along in the room and online. It'd be great to have you view that. Just give some primary points before we get into the deck today. Governor Hochul established the Master Plan for Aging with the Executive Order Number 23 on November 4th, 2022. The EO was inspired by the opportunity to build on success that we've already had in the State of New York in making sure that New York implements policies that make it a better place for aging New Yorkers to live and to age. When the AARP named us New York State, the first age friendly state in the country, they said it was partly because of the prevention agenda, which I'd like to speak about a little bit today, and also some of the intersecting priorities of this body, the PHHPC with the Master Plan for Aging. Now, that we have an opportunity to take the ideas from the prevention agenda and translate them into some other factors related to the Master Plan for Aging. We're talking about social determinants of health. One important element that I'd like to convey as we go through the deck today is that the Master Plan for Aging is not exclusively looking at health care. We have several people on the PHHPC today who serve on the committees for the Master Plan for Aging. I'd like to thank them. I encourage everybody on this body and everyone listening today to reach out if you are interested in participating in the New York State Master Plan for Aging. Ultimately, we're only going to be successful in this process if we are completely engaged with all stakeholders across the state.

Adam Herbst Next slide, please.

Adam Herbst The important element with respect to the Master Plan for Aging is that we start from the basis and the Governor thought about the master plan looking ten years out. New York is currently home to nearly five million people over the age of 60, and that is twice as many as it was in 2010. New York will be a home to many older adults in ten years from now. As we look at the growing seismic changes demographically, we see that this will have an impact in many ways in the state from the structures of our families to the communities that we live in, to the drivers of our state's economy. The next generation of older New Yorkers will be significantly more diverse, will live longer, and will contribute to our state in untold new ways, making our state a more vibrant place to age. As our state ages, we will look at new challenges that the Master Plan for Aging is hoping to accomplish. Many of these challenges will present new opportunities as well. That's where the engagement of all the people across the state that I'll speak about today is critical to the success of this enterprise. Certainly, workforce is a challenge. Dr. Morley referred to this in the hospitals. We see this across aging and long-term care. We see that people are enjoying less economic security as they age than in past decades. This is a critical element to what we're considering as part of the process.

Adam Herbst Next slide, please.

Adam Herbst The Master Plan for Aging is tied in many ways to the work that we're doing at the Department of Health and our partner agency, the State Office of Aging. In the DOH,

we have developed this new office, the OALTC, which I have the privilege of serving currently as the Deputy Commissioner. Our vision and our mission in this new office is tied in many ways to the success of the Master Plan for Aging, as is the State Office for Aging and many other elements within the cross sections between the various entities and agencies that are participating in the Master Plan for Aging. You can see that our vision and our mission as we built out and developed this new office, was critically looking at quality services and having the opportunity to help aging New Yorkers live independently and in place for as long as possible with dignity and looking at it through a lens of equity. That is something that we are certainly thinking about every day in our jobs in the Department of Health. It's something that we have intertwined in this Master Plan for Aging.

Adam Herbst Next slide, please.

Adam Herbst Thank you.

Adam Herbst The important element that I want to convey is that we are looking ten years out as part of the process. The plan is intended to be a living document. We're looking at all of these different components that are not exclusively related to health care. As we look ten years out, it's important that we do look at this as a living document. I'll mention in a few moments what the process is going to include as what we're going to deliver to the Governor, both in a preliminary way and in a final way within the next year. As we focus on these different elements and these intersecting priorities for the master plan, we will continue to update this plan over the next ten years to ensure that the plan is consistent with the different changing elements in New York State. We'll produce an annual report that will put improvements together and also ensure that the strategies that we develop in this plan over the next year are still relevant that we want to pursue over the next the course of the next ten years. I believe that is the best way that we can ensure an age friendly New York that all of us deserve. We can see as we put these intersecting priorities together. There are so many elements that we discuss in this body, things that you consider on a daily basis when you meet and when you think about your roles on this PHHPC and what other stakeholders that are participating in the Master Plan for Aging process are talking about as part of our subcommittees.

Adam Herbst Next slide, please.

Adam Herbst The Governor's Executive Order required a structure that again, started with the two agencies that are chairing and vice chairing the process, the Department of Health and the State Office of Aging. We're including a public body, which is many people that sit on this committee and also other state agencies in the executive branch and our partners in the legislature. As part of the many people who have reached out, which is gratifying to know. Many people are very passionate about this in the state of New York. We broke up the work into different eight different subcommittees, which are the pillars of what we're focused on. Long term care services support, home and community based services, caregivers, health and wellbeing, housing and community development and transportation, economic security and safety, security and technology. All within the framework of looking at aging New Yorkers. Below each of these different pillars, these different subcommittees that we've created. We have hundreds of people who are working together on workgroups. These workgroups are where we're really doing the work and focusing on the priorities that we'd like to accomplish as part of our preliminary report that's going to be due in July and ultimately the final report due next year. We're working across different sections of the state to ensure that we capture all different perspectives, New York City, Upstate, Western

New York. Every community has been participating regionally, different communities within different areas of the state, again, to ensure that this is an inclusive process. I believe that we have captured nearly every aspect of the state's priorities and perspectives as part of the process. Again, if you're listening today and you feel like you'd like to participate, we continue to encourage people to reach out and join us on the journey. Again, the Governor's Executive Order and framework is to ensure that this is an inclusive process. That's why we built this structure, as you see today.

Adam Herbst Next slide, please.

Adam Herbst This refers back to some of our state partners. Again, I will just reference this very quickly because there are so many different elements that go certainly beyond health care and public health. We have included all of these different state partners at the state level. We have also included partners at the local level regionally, and our partners at the federal level. By extension, to this, New York is not the first state that has implemented a Master Plan for Aging. Other states have recently done so as well. We've reached out and corresponded with them to find out lessons they've undertaken. It's critical that we work together, not only in New York, but across the country, because many of these things that we're going to talk about today solely relevant to New York. That's why we continue to work with state partners, local partners and national partners.

Adam Herbst Next slide, please.

Adam Herbst I mentioned the subcommittees. We have eight subcommittees and how they work together. People have been focused on much of the work here that accomplishes very challenging things. This process is certainly not going to be easy, but we have people who are dedicated, specific experts in each of the different areas here. Participation is critical to ensuring these subcommittees are successful.

Adam Herbst Next slide, please.

Adam Herbst Just very quickly, the timeline I mentioned, the Governor signed the Executive Order last year in 2022, in the Fall. We've had several stakeholder meetings take place and work groups going on. Again, many people in this room are participating on those. The next big milestone is in July. We're approaching that milestone imminently. We will be producing a preliminary report which brings the workgroups and the subcommittees very hard work, thoughts, questions and ideas together and framing those preliminary recommendations. These are not final recommendations. These are framing where we'd like to go over the course of the next year to develop final recommendations. As we put a preliminary report together to deliver to the Governor, we have an ambitious schedule to implement the work in this preliminary report. In July of 2024, we hope to put together that final report for the Governor that will be shared statewide, become a public document. Again, we'll be revisiting that over the next ten years and updating it, implementing many of the priorities. Some are low hanging fruit. Some are going to be very challenging. Looking at the structure of aging and long-term care in the State of New York.

Adam Herbst Next slide, please.

Adam Herbst This is something I'd like to really focus on, and I'm sure there'll be some questions that I'd love to address today. This body, PHHPC body plays a critical role with public health, the prevention agenda, things that are critical to the success of the Master Plan for Aging. I really would like to focus on your role. The question has come up today

several times on the role of PHHPC visa vie the Department of Health and other state agencies. The Governor's Initiative for the Master Plan for Aging does require your input and your participation, whether you're on the committees in a formal way or as this body meets and discusses public health and the prevention agenda. I encourage you and I implore you to participate and discuss many of the priorities that we've discussed in this report today and things that I'd like to bring in my future reports to this body over the course of the next year. This is a successful relationship with your work, together with the committees on the Master Plan for Aging. I'm happy to take questions at the end of this presentation.

Adam Herbst Next slide, please.

Adam Herbst Again, the prevention agenda is critical as well. I mentioned that a few times already. You can see that we've identified many things that have been discussed in the prevention agenda and the overlapping work with the Master Plan for Aging.

Adam Herbst Next slide, please.

Adam Herbst I mentioned that I'd like to come back to this body, this PHHPC body, and give updates periodically on where we are with the Master Plan for Aging process. I mentioned where we are in July and I hope at the next PHHPC body meeting, I can bring some additional viewpoints and perspectives on where we are with the Governor's report. The Governor is certainly dedicated to the success of the Master Plan for Aging. Again, your participation is critical to making that successful.

Adam Herbst I think that's it.

Adam Herbst I'll end it there with respect to my report on the Master Plan for Aging. I'm also happy to take any questions with my report today. I know time is short and we're behind schedule, but I'm happy to end there and open it back up.

Jo Boufford We don't need a quorum anymore, so we want to have a good, rich conversation since we have you here.

Jo Boufford Anyone have questions or comments for Mr. Herbst?

Jo Boufford Yes, Ms. Soto.

Ms. Soto In the slide that you had in partnerships, do you have a contingency, a group of individuals who are looking at the cultural and ethnic groups, how they view aging and their needs and also in terms of a city or a state, rather, that is so multilingual, like in terms of rolling out some of your services and opportunities and benefits that people have. Is that better than what you presented?

Adam Herbst Thank you for that question.

Adam Herbst The short answer is yes, absolutely. The longer answer is that we have hundreds of people that are participating. That lens is critical to the success of the Master Plan for Aging. It's something that we are focused on from an equity lens and, you know, including everybody across the state. Again, Upstate, Downstate, across the state is very different. We want to ensure that we are including everybody in the process. We believe we have heard voices from across the spectrum, but there's always more. If people would

like to partner with us, bring their suggestions forward, we're eager to hear additional thoughts. Public engagement is something that we are very eager to do. We've done some roadshows and town halls already and we continue to look for additional opportunities for us to go into different communities. We had some here in New York City. In early July, we'll be doing some roadshows and town halls in Albany and Upstate New York further North, and then we hope to go further West and come back down to New York City as well. Again, trying to speak and engage with all different communities so we get different viewpoints and people can learn about the Master Plan for Aging and partner with us.

Dr. Torres I have the pleasure of serving on the community at Home Base. Thank you for that. You actually beat me up to that point because the cultural relevance is so important. Even in an almost recent experience I had in Albany this past Monday. Not making assumptions as to a person's identification to a cultural piece, but also a more recent event as of yesterday, the importance of also addressing mental health in the incorporation of all policies and initiatives at the community level.

Jo Boufford Ms. Monroe.

Ms. Monroe Thank you,

Ms. Monroe There's been a saying in the larger funding communities that money for children is an investment. Money for older people is an expense. The difference is that you don't get any return on an expense. I think that a big part of that is the cultural idea of ageism. I'm wondering how that's being addressed. I'm on one of the groups, and that's not part of our... But I'm wondering how you're looking at the culture of ageism and what impact it has on the ability of the plan to really accomplish what it wants to do.

Adam Herbst Thanks for that.

Adam Herbst That's a large response that requires a very long conversation and dialogue, which I don't think we have the time to do. We have committees that are addressing that. Ageism is something that we are trying to look at from different lenses. Critically, many of the ideas that we're going to hopefully put into a report to the Governor, a final report will look at strategies that have some type of return on investment. I mentioned at the beginning of my report today that the diversity of aging New Yorkers will bring opportunities. People will stay in the workforce longer. People will partner with different types of opportunities in transportation and housing that will allow people to continue to age in New York and provide quite a bit of, I believe, return on investment with strategies that we're hopefully going to implement and that will hopefully bring some of this idea of ageism into the purview and hopefully allow us to develop ways for people to see the value of staying in New York, aging in New York, and continue to contribute to our state in untold new ways as we see the demographic shifts continue. It is something that we are considering. We're doing that from a lens of equity as well. It's something that we are certainly committed to ensuring we address as part of this report.

Jo Boufford I'd just to add involved in one of the subcommittees exploring available prevention benefits and other benefits and the access of older people. It's been really interesting to hear the conversation about so many programs exist, but they don't address the needs of older persons. They don't explicitly look at serving older people. There may be a lot of... I won't say they're quick fixes. The larger ageism issue is a huge cultural issue. It's really, really important. But there are also some just real. We haven't included

them in our thinking. Yes, we could do SNAP. Yes, we could do this. Yes, we could do that. These are some interesting things.

Adam Herbst The Governor is committed to this not only at the Master Plan for Aging level, but also work with all the state agencies just within the Department of Health. I mentioned the vision and mission that we have within this office in the DOH, and it's something that we are considering as part of our daily work. The Governor I know, is committed to this. She's mentioned this in her State of the State both this year and last. We are ultimately committed to looking at ageism, developing ways to ensure that that's no longer the case in the future.

Jo Boufford Yes, Mr. Lawrence.

Mr. Lawrence Oftentimes in communities you have grandparents being parents. Is that a consideration in the plan?

Adam Herbst Sure.

Adam Herbst One of the subcommittees that we have is workforce, both formal and informal. I mentioned return on investment. There is so much time, energy and money spent on caregiving. An element of caregiving is when we have different generations caring for our loved ones and our neighbors. Something that we want to consider is how we can ensure caregivers, both the formal workforce and caregiving workforce and informal, are given the resources and tools that can allow for a return on investment and ensuring that the generations can care for each other in New York. Yes, it is something that we consider and it's something that we are hopefully going to create new resources and opportunities for New Yorkers.

Jo Boufford There's a very strong emphasis on the life course approach in really trying to look at, you know, how to look at this across an intergenerational, very, really important issue.

Jo Boufford Any other questions?

Jo Boufford Comments?

Jo Boufford Yes, Dr. Soffel.

Dr. Soffel This is going back to not about this presentation, which is really very interesting, but going back to your written report.

Adam Herbst Yes.

Dr. Soffel I saw you had some comments about hospice. I have read sort of nationally that there's a tension between the for-profit hospice providers and the not for profit. I was curious whether here in New York we have a significant for-profit hospice presence and whether you are seeing any differences in terms of performance or outcomes.

Adam Herbst Thanks for that question.

Adam Herbst In New York, we have currently forty-one hospice agencies in the state per capita. New York has fewer for and not for profit hospice agencies than the 49 other states

and D.C. I want to stress the fact that New York needs to develop hospice services. How we do so is something that this body should consider together with us and the Governor's Office, something that we consider. The number of for-profit hospice agencies per 100,000 state residents in New York is 0.02. The average is, I believe, 0.84. Again, New York has a 0.69 difference in the number of for-profit hospices versus what we're seeing nationally. From a quality perspective, we have some for profits in New York that are doing well. We, at the DOH are focused on ensuring that we look at all hospice providers, both for profit and not for profit from a quality perspective, both from a growth perspective and the availability of services in New York. Something that we as a body should discuss together with the DOH, which is how we would like to see hospice services develop in New York. It's something that I think we can really develop together as part of where we'd like to see both hospice services and other services grow at and for profit and not for profit basis.

Jo Boufford Any other questions?

Jo Boufford Thanks very much.

Jo Boufford We'll look forward to hearing from you in the future.

Jo Boufford We have two remaining reports, Ms. Morne who has been with us earlier. I hope she's still with us to see if she has any other additional comment she wants to make at this time in terms of the work of her office.

Tina Kim Dr. Boufford, this is Tina Kim, the Deputy Director for the Office of Health Equity Human Rights. I am stepping in for Deputy Commissioner Morne, who is currently giving a keynote. I'm happy to just highlight a few updates from the written report for the Office of Health Equity and Human Rights. First on M pox, so the AIDS Institute here in the Office of Health Equity and Human Rights continues to work with colleagues across the DOH in coordinating the state's response to any potential spikes in confirmed M pox cases through the summer months. Our key activities are focused on promoting public education and awareness, as well as the benefits of vaccination by partnering with community-based organizations and local health departments. Notably, the Department of Health held a statewide webinar in May offering a high-level summary of M pox information and of the state's response efforts. We launched a social media campaign back at the beginning of May to promote and M pox vaccine uptake. Lastly, on June 16th, the Commissioner and the Commissioner of the New York City Department of Health and Mental Hygiene held a joint live M pox briefing for providers across the state. I just want to briefly mention since it's Pride Month, Happy Pride to everyone. On the same thread of M pox efforts, the AIDS Institute is hard at work supporting specifically the LGBTQIA community every year. This is a chance to reflect on the many accomplishments of the LGBTQIA Plus community. There are numerous communications and opportunities this month for the AIDS Institute to continue to educate communities on the risks of M pox and offer vaccinations. The AIDS Institute is working with twelve funded regional CBOs, as well as two state CBOs to provide education, outreach and vaccine promotion at gay pride events across the state. The work will continue throughout the Summer at events and venues where large groups of potentially impacted populations gather. In some instances, our CBOs are providing vaccines at the events, while others are working with the local health departments to provide the vaccine. Switching to another office here in the Office of Health Equity and Human Rights. We are excited to welcome our new director as the Director of the Office of Diversity, Equity and Inclusion here in the Office of Health Equity and Human Rights. He will be leading the charge to stand up the new office and the priorities that we have both internally in the Department of Health as well as externally with our community and state

partners. More updates from the office will be shared at upcoming meetings. Related to our work being advanced in the Office of Gun Violence Prevention, in addition to June being Pride Month, June is also designated as the National Gun Violence Awareness Month. We continue to advance our partnerships across the community and state agencies to reduce the prevalence of gun violence in New York State. We launched a Gun Violence Awareness Month social media campaign this month orchestrated monument and asset lighting of state buildings. We've issued a letter from not only the Commissioner of Health, but also a press release from the Governor's Office. We launched a Office of Gun Violence Prevention web page. It's the first kind of official online presence of the Office of Gun Violence Prevention on the DOH website, sharing the history of the office, the priorities, important links, data resources and additional information. And as well, we had Office of Gun Violence Prevention staff attend different community events. In the same vein, I know that we had a focused amount of conversation around the Health Equity Impact Assessment. We are so excited to welcome our new director of the Health Equity Impact Assessment Unit to the Office of Health Equity and Human Rights. Previously transferred from the Division of Nutrition and has been with us in the state and will continue to provide a leadership role in standing up this new unit for the Health Equity Impact Assessment Program. Lastly, in the written report, we have a number of status updates and report outs from the Office of Minority Health and Health Disparities Prevention. Specifically, just want to highlight the work, the recent work that has been happening with the Racial Equity Working Group. The members voted in a recent meeting to focus the preliminary report that is due to the legislature on three topics. One is to focus on methods for community engagement and tools for government agencies to engage with communities of color regarding health care services. The second topic is focused on measures to promote racially equitable hiring and promotion of employees, including in health care. Third is a focus on support of initiatives at all levels of government that advance efforts to reduce or eliminate racism. The Racial Equity Working Group has identified five speakers to provide a presentation addressing these topics that have been specifically called out and named in the legislation. Bimonthly meetings of this Racial Equity Working group will continue through the end of this calendar year in order for the conversations to happen and for the readiness of not only the working group but also the department in preparing the final report that is due to the Legislature at the end of this calendar year. Responses will be utilized to further inform the work plan activities and the end of year report of this Racial Equity Working group.

Tina Kim I will stop there to open it up for any questions and will want to refer to the written report for a much-detailed outlining of not only the verbal reports that I gave right now, but also other updates from the Office of Health Equity.

Tina Kim Thank you.

Dr. Boufford Thank you very much.

Dr. Boufford Any questions for Ms. Kim?

Dr. Boufford Not seeing any hear around the table. I think we had between your written report, your just recent summary, and then our engagement with Commissioner Morne earlier, I think we're in good shape on the work of your office. Congratulations for a terrific work and bringing new people on.

Dr. Boufford Last but not least, Dr. Bauer, Dr. Ursula Bauer will get to go first next time, Ursula.

Dr. Boufford Anyway, please, your report.

Dr. Bauer Thanks so much.

Dr. Bauer Really appreciate everyone sticking with it today. I will be brief and just call out a couple of items from the written report that we submitted. On June 1st, we released a report on infant mortality. This is based on data from 2016 through 2019. I will note and I know you've heard this before, that so much of our basic work was paused during COVID, and we are really working hard to catch up. We don't like to be this far behind in terms of our data review, but we're really pleased to get this report out based on the 2016 to 2019 data. Based on those data, New York's infant mortality rate has improved, already exceeding our Healthy People 2030 goal for the nation. However, despite our efforts and certainly national and local efforts to combat and eliminate racial and ethnic disparities in infant mortality, those disparities do continue to persist here in New York and nationally. In fact, we actually saw a slight uptick in the infant mortality rate for non-Hispanic Black infants from 8.37 to 8.46 deaths per 100,000 live births. That rate, of course, is almost three times higher than the rate for non-Hispanic white infants. As the report notes, the factors driving disparities in infant health are multifactorial and complex and include employment status, income, housing, transportation, food security, access to healthy foods, all the social determinants that we know so well, as well as quality of medical care received. Historic and persistent racism and discrimination also play a role in driving these racial disparities. On a good news front, I'd like to share that thanks to the legislature and the Governor and our tobacco control program and our advocacy partners, New York will have the highest and strongest state cigarette tax in the nation. The tax was increased by $1.00 from $4.35 to $5.35 as part of the 2023/2024 enacted budget. That goes into effect on September 1st. As you know, tobacco tax increases and keeping those increases coming are one of the most effective ways to reduce smoking and tobacco use, especially among children. We are preparing for the tax increase by working with our partners to educate community members to increase access to nicotine replacement therapy and Quitline services and also planning a series of cessation ads to run as the law goes into effect. We will continue our work to achieve a policy goal around flavored tobacco products. We had put that forward this year and will continue to work on that as an additional effort to save lives and advance health equity. I thank Dr. Boufford and the Public Health Committee. We had a terrific meeting on Monday, covered a lot of territory and are really on track, I think, to continue our planning of the prevention agenda. As Dr. Boufford mentioned, we have a meeting of the Ad Hoc Committee coming up on July 13th, and that will give us a nice sense of input and feedback from our partners as we look to the next cycle of the prevention agenda. I will note we took a little bit of a different approach to our written report for this meeting. I would welcome feedback from PHHPC. What you would like to see in our written report. As you know, this is a new process for us, so we're trying different approaches and happy to hear from you.

Dr. Bauer I'll stop there.

Dr. Bauer Thanks.

Dr. Boufford Thanks very much.

Dr. Boufford I think that's actually a really, Ursula's last point, if we could get feedback from people about how they like the written report. Maybe you can just make a few

comments now in terms of just length, presentation, etc., just quickly, because it is brand new.

Dr. Boufford Before we do that, let me see if there are specific questions for her on her report.

Dr. Boufford Dr. Soffel.

Dr. Soffel Good afternoon. I know that you mentioned this on Monday, and it's also in your written report that as part of the prevention agenda, you are meeting with stakeholders, and you specifically identified both the county health folks and the hospital folks. As a consumer representative on this council, I am very interested in what are the consumer groups that you have met with or that you plan to meet with moving forward?

Dr. Bauer Thank you for that question.

Dr. Bauer The local health departments and the hospitals are the primary sort of movers and shakers of the prevention agenda. They are certainly key stakeholders. Many of our other partners are represented on the Ad Hoc Committee. That's probably our main wide stakeholder engagement group. We do meet with, for example, the Health Equity Council, so other groups within state government and around the state. We do not have a particular way to reach consumers. that's an interesting question. We had talked, as you noted at the Monday Public Health Committee meeting of potentially convening community advisory boards for the objectives of the prevention agenda, But we hadn't discussed how we solicit that input into the prevention agenda and weigh the value of that, the importance of that. Certainly, our local health departments are very engaged in their communities as they are formulating their community needs assessments and their community plans. The state doesn't directly have a consumer approach, but our local health departments do.

Dr. Boufford Just to remind everyone, the Ad Hoc Committee is an open invitation for state level non-profits, advocacy groups, professional organizations and others. I think we were between thirty and forty organizations that have, if you will, renewed their membership and been involved in the Ad Hoc Committee. I don't know. Is there a state level consumers union? I'm not aware. I'm not sure it would come out as health care or health related necessarily, but something to look at. We've invited also business counsel who has yet to take advantage of our invitation, but hopefully. No, I know you're not. I know you're not, but I'm just talking about it's interesting to identify these sorts of groupings that might be missing.

Dr. Boufford Dr. Torres.

Dr. Torres I'll be honored to volunteer thirteen of my seniors' older adult centers for participation in this. They would be excited just to hear directly from the older adults.

Dr. Boufford That's great. You want to get them on the master plan activity too. That would be great.

Dr. Boufford Any other?

Dr. Boufford Yes, Ms. Monroe.

Ann Monroe Thank you for that report, Dr. Bauer.

Ann Monroe You've mentioned that hospitals and county offices are your key contacts. I think that's fine. I'm wondering about primary care. Do you have FQHCs agencies involved in your discussion? Because that's where a lot of this primary care needs to be provided. Hospitals may not be the closest place in communities to individual people who are trying to work through your program. Just to comment on that, do you have primary care representative in your key circle of advisors?

Dr. Bauer I mentioned that the local health department and the hospitals are the key drivers of change for the prevention agenda. Some of that is in statute in terms of their required community service plans, required community health assessments and community health plans. The prevention agenda is really focused on public health and preventing people from needing those health care services. We certainly do have FQHCs among our partners and our providing input, but we're really looking at prevention, primary prevention. One of the questions that we have on the table as we look at planning for the next cycle of the prevention agenda is, do we need to move even farther upstream? We've been very focused on the cancer screening, for example, hypertension management, diabetes management, which are critical. Do we need to move even farther upstream and look at preventing those conditions in the first place? Even farther upstream in looking at the environmental context that drive so much of health and the social determinants of health. That's a live question, I guess, in our discussions of planning for the next site.

Ann Monroe I would just comment that I think if you're looking at primary prevention and getting even more upstream, the hospitals may not be the best reflectors because of their role as acute care providers. As you move upstream, I would like to urge you to include the health care providers who work upstream, not just the hospitals.

Mr. Robinson Ann, just a comment on that. I fully agree that community health centers and other providers, but hospitals really are more health systems now. For example, we have the largest in our area group of primary care providers as part of our health system. I think that's probably reflective of the way health systems have evolved across the state. I completely agree with you, but not to the exclusion of hospitals, because I think they are major providers of primary care as well.

Dr. Boufford They have a statutory responsibility which we're eager to develop in this. I would say as a member of the Ad Hoc Committee. Also, the New York Association of Family Physicians has been a pretty active member historically. We've had different professional groups at different points in time, but their voice is definitely important and definitely there. I think Ursula's point is we're also in this next round really trying to see how most effectively you bring in the work of other sectors, other agencies across the state that are not in the health care business, if you will, you know, more than we were able to do last time.

Dr. Bauer I'll just add that hospitals have a key impact on the community outside of their health care delivery. They're employers. They procure things. They work with businesses. They manage supply chains. All of those activities can really help enrich a community and improve the health of a community completely independent of the health care delivery role.

Dr. Boufford Absolutely. The anchor institution concept.

Dr. Boufford Dr. Watkins.

Dr. Watkins I'm going to just divert the conversation just a little bit. In our Ad Hoc Committee, we talked a little bit about mortality, maternal mortality, and then Dr. Bauer on just concentrate a little bit on infant mortality. I'm really concerned about what I'm hearing and especially the gap and the disparity. I was wondering if there's a way that we can start to get some reports here at the council on some of the suggestions that are going up either to the Governor's Office or to the Commissioner as to how we could reduce this gap that we continue to see here in New York.

Dr. Boufford I mean, Dr. Siegenthaler presented a really nice Power Point, which might be of interest. I'm sure it's posted at this point. Again, and in keeping track of this on the Public Health Committee initially, and we can certainly present it to the council to keep our eye on the maternal mortality issue. Obviously, as Ursula has raised the infant mortality disparity, we certainly should look at them together, that important opportunity.

Dr. Bauer Absolutely. I mean, these are things that we are working on. These are essential issues. They reflect our society. There are areas where we need to make dramatic improvements. Welcome what we can do more. What we can do better. There is a lot of room for improvement here. We're working very hard, but we're eager to do even more and do better.

Dr. Boufford Any other questions for Dr. Bauer?

Dr. Boufford Thank you very much for hanging in there till the end. Just to remind, we'll move---

Dr. Boufford I didn't see him.

Dr. Boufford Anyway, as we move towards adjournment, just to remind everyone, as I mentioned a couple of times, we will have the Ad Hoc Committee to lead the state health agenda. We encourage as many council members as possible to come. It'll be on July 13th in Albany and Buffalo. It'll be, I think, a 10:30 to 1:30 kind of arrangement. The next meetings of the council will be on August 24th and September 7th. Both of them will be in Albany.

Dr. Boufford Ms. Soto's reaching for her microphone.

Ms. Soto I just have a clarification. Is the August 24 a committee meeting and then September is the full council?

Dr. Boufford Well, my language says both are council, so that is incorrect.

Ms. Soto The 24 is committee.

Dr. Boufford The August 24th is committee day. September 7th is the next meeting of the council.

Dr. Boufford Thank you. Thanks for asking that question and clarifying it.

Dr. Boufford Any other last chance before adjournment?

Dr. Boufford Any other questions, concerns?

Dr. Boufford We'll work to see if we can address some of these issues in a sort of broader presentation space now that we're beginning to master the written report. I think I did cut off a question.

Dr. Boufford Were there any comments on the written report?

Ann Monroe I thought the written report was very thorough. I think if we want to go ahead with that and just have the presenters present the highest points. I don't think we saw that with the master plan, but that was probably the first time that we've seen that and from now on we should get the highlights.

Dr. Boufford Good point.

Dr. Boufford Any other comments on the written report?

Dr. Boufford I think generally people are welcoming it and we just, as you say, use it for its purposes, which is to get the highlights put into the oral presentation.

Dr. Boufford I will now request a motion to adjourn the Public Health and Health Planning Committee.

Dr. Boufford Dr. Watkins, Dr. Yang are jumping on it.

Dr. Boufford Thank you very much.

Dr. Boufford All in favor?

Dr. Boufford We'll stand adjourned.

Dr. Boufford Thank you very much.

Mr. Robinson You made Jeff proud.

Dr. Boufford Channeling Jeff.