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TRANSCRIPT

Mr. Holt Good morning. I'm Tom Holt. I'm the Chair of the Committee on Codes, Regulations and Legislation. I have the privilege to call the order of the committee this morning. I'd like to welcome the members, participants and observers. I'd like to remind the council members, staff and the audience that this meeting is subject to the Open Meeting Law. It is broadcast over the internet. The webcast is accessed at the Department of Health's website, NYHealth.Gov. An On Demand webcast will be available no later than seven days after the meeting for a minimum of thirty days, and a copy will be retained in the department for four months. We've got some suggestions or ground rules to follow to make this meeting successful. Because there is synchronized captioning it's important that the people do not talk over one another. Captioning cannot be done correctly with two people speaking at the same time. The first time you speak please state your name and briefly identify yourself as a council member or DOH staff. This will be of assistance to the broadcasting company who's recording this meeting. Please note that the microphones are hot mics, meaning they pick up every sound. I ask that you avoid rustling papers next to the microphone, and also be sensitive about personal conversations or sidebars as the microphones can pick up that chatter. As a reminder for the audience there's a forum that needs to be filled out prior to entering the meeting which records your attendance at these meetings. It is required by the Commission on Ethics and Lobbying and Government and in accordance with the Executive Law 166. The form is also posted on the Department of Health's website under Certificate of Need. In the future you can fill this form out prior to these council meetings. Thank you for your cooperation in helping us fulfill our duties as prescribed by the law. I now call the meeting to order of Committee on Codes, Regulations and Legislation. There are six regulations on the agenda for today. We do have quorum.

Mr. Holt First up, we have trauma centers.

Mr. Holt Can I have a motion for a recommendation of the emergency adoption of this regulation to the full council?

Mr. Holt Dr. Yang.

Mr. Holt A second?

Mr. Holt Dr. Watkins.

Mr. Holt Mr. Steven Dziura and Ms. --- from the department are available and will provide us with information on this proposal.

Mr. Holt Albany, it's you.

Mr. Dziura Good morning. Just making sure you can hear us.

Mr. Dziura Beautiful.

Mr. Dziura Good morning. My name is Steven Dziura, the Deputy Director of the Bureau of Emergency Medical Services and Trauma Systems. We bring forth again, for one more adoption, the emergency regulations, changing the trauma center standards from the former 2013 orange book version to the new green book, American College of Surgeons Trauma Standards. The public comment period on the full regulation package closed on November 27th. Those are also being brought forward as well in the next agenda item for full adoption. The purpose of this emergency regulation adoption for the final time is to cover any gap period between now and the final adoption.

Mr. Holt Thank you very much.

Mr. Holt Do we have any questions from the members of the committee or the council?

Mr. Holt Mr. Kraut.

Mr. Kraut Obviously, you have to do this because we have to meet the contemporary code of ACS, right? One of the things that you point out under the cost is there's going to be an additional cost on trauma sent to hospitals. I'm assuming many of them has already been aware and are meeting the more current version rather than the 12. The only concern I would have been particularly with safety net hospitals that are designated trauma center. There may be attendant costs to meeting the requirement that they may not be aware of. Just to be careful that the unintended consequence of them failing to comply with the standards because of economic concerns of their inability to fund it. It doesn't require a response, but it's just something I hope as we implement this that we keep an eye on particularly the safety net hospitals that have trauma center designation and making sure they can support whatever increased resources are needed to comply with this. Just a statement. I don't think it requires an answer unless you'd like to.

Mr. Dziura What I can provide if you'd like---.

Mr. Kraut Yeah.

Mr. Dziura Is the current system that we utilize is so... A trauma center in its first round when they want to become a trauma center first becomes a provisional trauma center for the period of one year until American College of Surgeons comes in to do their full verification. We use the recommendation of the American College of Surgeons. We are a little bit restricted because that is the American College of Surgeons. However, if ACS, American College of Surgeons identifies deficiencies on a site visit, we do have the ability to continue a provisional designation for a period of another year while they work through correction of those deficiencies until ACS comes back out. To bring this back to your point, should there be some struggles we do have a period of time to work with the facility to help correct these, as opposed to just shutting down the traumas.

Mr. Kraut Great. Thank you.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Other questions from the council or committee?

Mr. Holt Hearing none then I'll call the question.

Mr. Holt All in favor?

Mr. Holt Oh, I'm sorry. I'm sorry.

Mr. Holt There's nobody from the public who signed up to speak in advance.

Mr. Kraut Okay.

Mr. Holt Thank you.

Mr. Holt Hearing no other questions or comments, I'll call the question.

All in favor?

All Aye.

Mr. Holt Opposed?

Mr. Holt Abstentions?

Mr. Holt That motion carries.

Mr. Holt We have for adoption the adult day health care.

Mr. Holt Can I have a motion for a recommendation of adoption of this regulation to the full Public Health and Health Planning Council?

Mr. Holt Dr. Yang.

Mr. Holt Dr. Watkins.

Mr. Holt Ms. Heidi Hayes and Steven Paton and Stephanie Paton and Ashley --- from the department are available and will provide us with information on this proposal.

Ms. Hayes Good morning. My name is Heidi Hayes. I'm the Director for the Center for Residential Surveillance with the Office of Aging and Long-Term Care.

Ms. Hayes Just making sure you can hear me.

Mr. Holt Yes.

Ms. Hayes Thank you.

Ms. Hayes We bring forward for adoption the proposed adult day health care regulations, which were originally posted for public comment in 2022 and posted again in late 2023. The regulations are needed to align with the federal home and community-based settings final rule, which requires that registrants achieve full community integration and that the settings optimize delivery of person-centered care and services, individual initiative and choices. Public comments received suggested that the department's proposed regulations exceed the requirements intended within the final rule. However, the department's proposed regulations directly reflect language from the final rule, and as such bring the department's regulations into direct alignment with the final rule. Other comments related to programmatic implementation, specifically as it relates to geographic variations and

services and support that impact community-based services from which a registrant may select, and various other requirements contained within the plain language of the final rule. Several commenters appear to misinterpret the proposed requirements as modifying programmatic oversight requirements and other comments reflected requesting modifications outside the scope of the proposal. No changes were made as a result of the comments received. Notably, the centers for Medicare Medicaid Services performed onsite compliance audits in the Summer of 2023 at some adult day health care programs. The department is in the process of finalizing corrective action subsequent to those findings. Again, these proposed modified regulations for the Adult Health Care Program regulations into alignment with the federal home and community-based settings final rule. I appreciate your time. I'll take any questions.

Mr. Holt Thank you, Ms. Hayes.

Mr. Holt Questions from the committee or from the council?

Mr. Holt Again, we had nobody from the public who had signed up to speak in advance.

Mr. Holt I'll go ahead and call the question.

Mr. Holt All in favor?

Mr. Holt Opposed?

Mr. Holt Abstentions?

Mr. Holt Motion carries.

Mr. Holt Next, we have hospital and nursing home personal protective equipment requirements.

Mr. Holt Can I have a motion for a recommendation of adoption of this regulation of the full Public Health Planning Council?

Mr. Holt Dr. Yang.

Mr. Holt Dr. Watkins.

Mr. Holt Jaclyn Sheltry and Jonathan Karmel from the department are available and will provide us with information on this proposal.

Ms. Sheltry Hi. Good morning. I'm Jaclyn Sheltry from the Department of Health. I am presenting these amendments for adoption for amendments to Sections 405.11 and 415.19 to apply PPE stockpile requirements to nursing homes and hospitals. First, by way of brief history, the department presented identical regulations to the Codes Committee and full council on September 7th, 2023, and this committee, as well as the full council recommended adoption and the full council approved. Due to State Administrative Procedure Act filing rules, however, the department was required to republish the regulations as proposed regulations. The department republish the identical regulations in the state register for a new sixty-day public comment period, which closed on January 16th. No new comments were received that were not previously considered by the Department of Health during this public comment period. I further want to note that given

the expiration of the regulations on September 26th, 2023, the department issued two Dear Administrator Letter and Dear CEO letters to hospitals and nursing homes regarding these stockpile requirements. Again, I am highlighting that there are no changes to the regulations since the committee voted for adoption in September 2023. Briefly, however, I will cover the substance of these regulations again. The regulations continue to require a sixty-day PPE stockpile for hospitals and nursing homes, or ninety days in the case of hospitals, in the Commissioner's discretion. The regulations also continue to require the same types of PPE for both hospitals and nursing homes, including gloves, gowns, surgical masks and N95 respirator masks. I'm also noting that the methodology principally utilizes the 2020 John Hopkins study, and that remains unchanged. However, the regulations provide that the Commissioner has authority to amend the regulations should an alternate methodology that is appropriate for New York and will adequately ensure the safety of nursing home and hospital staff and residents or patients is developed. Thank you. Please let me know if you have any questions.

Mr. Holt Thank you, Ms. Sheltry.

Mr. Holt Any questions from the members of the committee or the council?

Mr. Holt Ms. Monroe.

Ms. Monroe Ann Monroe, member of the council. How will this be monitored? Will it be part of the regular nursing home reviews that your folks make? Will they be looking at this when they go into a nursing home for compliance and quality issues?

Ms. Sheltry There are reporting requirements for both nursing homes and hospitals. We collect the data from facilities as to their number of stockpiles based on the methodology.

Ms. Monroe But there won't be eyes on the stockpile?

Ms. Sheltry I can't comment on whether or not that our surveillance teams typically look at that. I do know it's captured in our reporting, but I can find out for you.

Ms. Monroe I would suggest that it be kept that it'd be part of the surveillance tool that these folks use when they go into a facility. That would be my recommendation.

Mr. Kraut Sometimes the stockpile is not kept in the facility.

Ms. Monroe I can't hear you.

Mr. Kraut Sometimes the stockpile is not kept in the facility. It's kept in a centralized logistics center depending on how they are organized. For certain facilities it's a significant amount of space that takes into that account. I'm just saying that for some they should have it on site, some they shouldn't.

Ms. Monroe I would recommend it, at least for nursing homes.

Mr. Kraut Yeah.

Ms. Monroe And, you know, have it as something that they need to be aware of.

Ms. Sheltry And I will just note in response, just comment. There were comments we received an initial publication of the regulations asking that the regulations explicitly allow offsite storage, because some facilities found that they were having to use patient or resident space. There is a change from prior publications of the regulation to explicitly allow offsite storage.

Mr. Kraut Within New York State.

Ms. Sheltry Within New York State, yes.

Mr. Kraut We could monitor.

Mr. Holt Thank you.

Mr. Holt Other questions from the committee or the council?

Mr. Holt Hearing none, I'll call the question.

Mr. Holt All in favor?

All Aye.

Mr. Holt Opposed?

Mr. Holt Abstentions?

Mr. Holt That motion carries.

Mr. Holt Our next three regulations are on for information only.

Mr. Holt The first being general hospital emergency services behavioral health. This regulation is being presented to this committee for information and will be presented to this committee and the full Public Health and Health Planning Council for adoption at a later date. Dr. Stephanie Shulman and Mr. Jonathan Karmel from the department are available and will provide us with information on this proposal.

Ms. Shulman Good morning everyone. I'm Stephanie Shulman. I'm the Director of the department's Division of Hospitals and Diagnostic and Treatment Centers. 10NYCRR Section 405.19 is the regulation establishing the operational standards for the emergency services of general hospitals. These regulations require the emergency departments of general hospitals to screen patients for behavioral health presentations and to take additional actions when patients have complex needs, as defined by the Office of Mental Health. The current requirements in 10NYCRR Section 405.19C7 for General Hospital Emergency Services require that the hospital, in conjunction with the discharge planning program of the hospital to develop policies and procedures that specify the actions to be taken and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services, but not in need of inpatient care. A general hospital emergency department must refer emergency department patients for appropriate follow up care after discharge from the hospital, including individuals with documented substance abuse disorders who appear to have or to be at risk for substance abuse disorders. However, the current regulations do not specify reference to discharges of patients with other behavioral health presentations and

complex needs for the emergency department. This proposed revision will rectify some of those issues. 10NYCRR 405.19 also already requires emergency departments to screen for domestic violence, sexual offence, substance use disorder and human trafficking. In addition, hospital emergency departments are required in conjunction with the discharge planning program of the hospital to specify the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services, but not in need of inpatient care. This revision to the regulation would expand the requirement that all emergency departments have to screen patients to include all behavioral health presentations, including by checking for records and electronic health information systems, and by attempting to obtain collateral information from family and friends. Emergency departments must screen at that time for suicide risk, violence risk, and to determine whether or not the patient has complex needs as defined by the Office of Mental Health Regulations. General hospitals with inpatient psychiatric units must take additional actions for patients with complex needs presenting to the emergency department, including making appropriate referrals and confirming an appointment for psychiatric aftercare with an identified provider within seven calendar days or as soon as possible with the patient's consent. The emergency department will send a discharge summary detailing the presenting mental health history, hospital course and other relevant treatment information to the outpatient, residential or long-term care treatment programs. The intended purpose of this is to create a continued linkage to care for persons with complex needs who can otherwise be lost to follow up without additional assistance in obtaining follow up care.

Ms. Shulman Does anyone have any questions?

Mr. Holt Thank you, Dr. Shulman.

Mr. Holt Questions from the council or committee?

Mr. Holt Mr. Kraut.

Mr. Kraut Yeah.

Mr. Kraut No issue with the intent of the reg. I don't think I have to go into a lot of questions about this because it's being posted for information. I'm expecting, the people responsible for implementing it will have some. This is one of the changes that actually specifies a time frame within seven days to make an appointment for a follow up, which is for somebody who presents in an ED with mental health issues that's... They're in a crisis, obviously. You want to get them into care, aftercare as soon as you rule that they're not being admitted. The concern that I have operationally is to explain, you know, can we do that through telehealth? Does it have to be a warm handoff? Does it have to be with a provider? There's going to be those operational issues. The concern I have is if you make a disposition decision in the middle of the night and you don't have electronic ability to schedule that appointment. Let's say we're up in a rural hospital. You then technically how this is described, you can't release the patient until you've made that appointment. You'll say, you know, I'm ready to send you home, but I can't send you home till I have an appointment made. You keep them. They're agitated. They walk out against medical advice. I think there is operational implications here that I would expect the College of Emergency Physicians will respond to. I just would hope that when this comes back to us either these are clarified in some sort of guidance, but I know they'll be a host of operational concerns and they'll vary from region to region just because... we don't have a well-developed network to be able to get a psych appointment within some reasonable

period of time. I'll just leave it at that, that I'm hoping the public will raise these issues and they'll get resolved. I think it's an admirable objective.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Dr. Watkins.

Mr. Kraut Yeah.

Dr. Watins I agree with Mr. Kraut. First I want to say to the department that this is a great behavioral health measure that you are putting to the emergency room, but I then I want on the other side, say the impact to emergency rooms can be catastrophic with this new regulation that's going to be voted on. If you are in an emergency room now there's already a three hour wait, especially just for our EMS staff who have to have a warm handoff to someone within the emergency room. We're going to have to require emergency rooms to either have to have social workers there or, as Mr. Kraut has indicated making sure that there is telehealth provided, so that we can have the seven-day referral for someone who can treat someone with behavioral issues. For rural communities, even if we are looking to have a referral to a behavioral health provider, we have a lack of behavioral health providers in these communities. I just want to make sure that that is part of your thinking process as we move forward with communications with our emergency rooms, who will probably have quite a bit to say about this particular regulation.

Mr. Holt Thank you, Dr. Watkins.

Mr. Holt Dr. Lim.

Dr. Lim Hi. Sabina Lim, council member. I agree with everyone. I totally understand and agree with the overall intent. I have a lot of questions, but I'll try to sort of keep it to just sort of themes of main comments for consideration. I think first of all, I agree with what Dr. Watkins said and Mr. Kraut said as this the operational impact. But more specifically, I think if there were clarification in the regulations about some specific things. Number one would be sort of what exactly do you mean by patients with behavioral health presentations? Is that a primary diagnosis or a concurrent diagnosis? That sort of operationally makes a big difference. If it's someone with a primary condition, most of them would actually go to a CPEP if there is one. That's specification would be really helpful. I think the other second piece, which speaks to the operational complexities is that there are essentially about five new screens that are added. About two of those are already in place, specifically the suicide screening requirement is a joint commission and CMS requirement. I would just ask to make sure that that particularly the suicide screening, that that aligns with the requirements of CMS and Joint Commission,. Because I think there's a slight difference there. That's possible. Again, just once you screen, you have to refer, and you have to do something. I think the reality is, is that it's the overnight issues, as Mr. Kraut said, but also just during the daytime. I do worry a lot about the ability to... The amount that I'm not sure that the cost impact will be quite the number that was outlined. I think it might be more for certain hospitals depending on the number of people that they have to serve. My last question will be and sorry for taking up so much time. In the section about the general hospitals with inpatient psych units, just to clarify that the inpatient psychiatric units definitely already do those kinds of things in terms of the discharge. It wasn't quite clear if that meant that the people in the emergency room who do not get admitted to those psych units would also need that same discharge process requirement. If that could be specified a little bit more, that would be very helpful. Again, I think if the goal can be to how can we

provide more comprehensive connections to care, which is, I think, the key thing that needs to be addressed and which this is trying to address. If we can make this within the realm of sort of operational feasibility considering the state of our system, I think that would be really helpful. Thank you.

Mr. Holt Thank you, Dr. Lim.

Mr. Holt Understanding again that this is being presented for information for today. The department can certainly respond to the questions that have been raised by Dr. Lim and others. Dr. Lim, would you rather that these be responded to when we get to the next phase of review for this or these questions to be answered this morning?

Dr. Lim Yes.

Mr. Holt Thank you.

Mr. Holt Ms. Soffel.

Ms. Soffel Denise Soffel, committee member/council member. I think that the goal is absolutely appropriate and overdue. I am aware that many hospitals struggle with handoffs, especially when there are behavioral health complications in a case. I think there's an additional wrinkle that needs to be sort of thought through, which is many people who are in managed care plans have a care coordinator or a care manager, a case manager of some sort who may or may not be involved in that person's ongoing connection to care, but who certainly would need to be involved and informed about what was happening in an emergency department encounter. Similarly, many Medicaid folks, especially those with behavioral health issues are members of health homes. The health homes have responsibility for making those handoffs smooth and easy and clean. I think that those kinds of multiple people touching an individual with complex health care needs and complex behavioral health needs, needs to be sort of thought through as you finalize these regulations.

Mr. Holt Thank you, Ms. Soffel.

Mr. Holt Any other questions?

Mr. Holt Ms. Monroe.

Ms. Monroe I just want to be clear. The responsibility is to have an appointment for this person. I mean, there's lots of other criteria, but they have to have an appointment somewhere before they can be discharged from the emergency room. Is that accurate?

Mr. Holt I believe so. We'll let the department respond.

Ms. Monroe Is that accurate?

Mr. Karmel Can you hear me?

Mr. Karmel This is Jonathan Karmel from the Department of Health. Just to address and again summarize what this regulation does. For general hospitals that don't have inpatient psych units, this might be a small hospital, might be a rural hospital. Your hospitals that

don't have inpatient psych units. They are supposed to do a screening for behavioral health presentation.

Ms. Monroe Excuse me, Sir. I understand all that. I'm asking is, is what the emergency room has to---

Mr. Karmel ---about six people who asked a number of different questions. I'm addressing all of the questions at once including yours. Absolutely. We're going to get into all of that. So, for hospitals that don't have psych units, there's a screening for a behavioral health presentation similar to types of screenings that are already done for domestic violence and for human trafficking and for sexual assault and for substance use disorder. It's true that we have not defined behavioral health presentation, but if you look someone up on the statewide health information for New York, you look them up on psyches, you look them up in the prescription monitoring program to see if there are narcotics being prescribed to this person. That those kinds of things could be helpful. If the person may have complex needs then---

Mr. Holt Hang on, we have a bit of a hiccup here.

Mr. Holt We're not able to hear you at this moment.

Mr. Karmel Sorry about that.

Mr. Holt That's okay.

Mr. Karmel Can you hear me now?

Mr. Holt We can. Thank you.

Mr. Karmel That's the hospitals that don't have inpatient psych units. The hospitals that do have inpatient psych units if there is a patient in the emergency room that has complex needs there are some additional requirements. Yes, the expectation is this is a hospital that has an inpatient psych unit, but these regulations are for the emergency room. When a patient comes to the emergency room in a hospital that has an inpatient psych unit and the patient has complex needs there are these additional requirements, specifically with regard to the requirement to make an appointment for psychiatric aftercare within seven days. The requirement to make an appointment for psychiatric aftercare again applies in hospitals with inpatient psych units and only for patients who have been determined to have complex needs. Under these proposed regulations it states, if after making diligent efforts, a hospital cannot identify an after-care provider with an available appointment within seven calendar days, the hospital shall document its efforts and schedule the appointment for as soon as possible thereafter. Thus, if the hospital documents its efforts and schedules the appointment for as soon as possible it may discharge the patient. We already have some clarification on that, but certainly there's going to have to be more guidance from the department in order to implement these regulations.

Ms. Monroe Thank you. I'm trying to figure out how to say this. I feel like I'm in a deja vu. In the mid 70's I was part of Illinois's deinstitutionalization program. We would discharge people with an appointment. We would be surprised that they were back into the facility or the emergency room before that appointment date. I'm asking is a hand-off is that the hospital has fulfilled its responsibility to this person if they have an appointment scheduled

in some other setting within seven days or as soon as can possibly be set? The hospital will have fulfilled its responsibilities if it's done that. It's that correct?

Ms. Shulman Let me try to answer a little bit. There are more responsibilities that the hospital has than just making this appointment.

Ms. Monroe I misspoke. I understand all the screening and all of that that has to be done. I'm asking when the person leaves the facility, they have an appointment in their hand. That is to assure their next step. Am I understanding that correctly? Well, I don't need to put you on the spot. I think I said what my concern is. I'll just go on.

Mr. Holt Thank you, Ms. Monroe.

Mr. Holt Again, we're in the information stages of this. Those questions are helpful in terms of the department now going back and being able to be responsive. I'm sure there'll be communications from other members of the community as well that will be helpful as we move this regulation through. Thanks.

Mr. Holt Other questions from the committee or council?

Mr. Holt Dr. Kalkut.

Dr. Kalkut I don't have a question about the proposed regulation. I think there is some precedent for this and measure of this in this where there was a measure for a psychiatric discharge and for emergency room discharge for psychiatric patients to make an appointment within seven days. I don't recall what the data was that looked at those outcomes and whether the appointments were, in fact, as Ann is saying were kept. I think it may be beneficial to look back and see what the compliance with that measure was within the suite of measures and how often that appointment was met. Thank you.

Mr. Holt Thank you, Dr. Kalkut.

Mr. Holt Dr. Torres.

Dr. Torres I'm so sorry. I may be out of concept here. I remember about thirty years ago there used to be a term. I was just racking my brain. COPS, right? Comprehensive outpatient psychiatric services when I was in outpatients, services. There was an agreement or a mandate that they had a priority status on the outpatient side where they needed to be seen five days upon discharge. I don't know how the landscape has changed, but I remember the COPS term.

Mr. Kraut I think that evolved into CPEP.

Dr. Lim That has essentially been translated into a regulatory requirement for the outpatient clinics if you're under 31. We have to accept patients who are coming out of a CPEP within five days. There are companion regulations on the OMH side that go along exactly like this.

Mr. Holt Thank you all for the comments and questions.

Mr. Holt As I said, we'll be seeing this one again. It sounds like we'll have more robust conversation. This regulation will now be presented to the full council for information.

Mr. Holt There was nobody from the public who had signed up to speak at this point on this.

Mr. Holt Thank you.

Mr. Holt Our next code for information is a statewide health information network of New York or SHIN-NY. This regulation is being presented to this committee for information only and will be presented to the committee and the full public and Health Planning Council for adoption at a later date. Mr. James Kirkwood and Mr. Jonathan Karmel from the department are available and will provide us with information on this proposal.

Mr. Kirkwood Hi. I'm Jim Kirkwood, Director of the Center for Health Data Innovation at the Office of Quality and Patient Safety in the Department of Health. The SHIN-NY regulations were originally promulgated about a decade ago, and since then we've had a significant amount of advancement interoperability between electronic health records themselves and the development and national networks, in the sort of requirements coming from the Department of Health and Human Services on hospitals and other providers health plans to exchange data. What we want to do with these regulations is really modernize the network that we have to ensure it aligns with those changes. In addition, we're looking like the SHIN-NY is being used more for public health programs and also to support the Medicaid Waiver, 1115 Waiver and the social care networks, we'd like to have a system that's more able to support consistency across the state. What we're looking to do in the regulations themselves is we're establishing the SHIN-NY, establishing more of a statewide infrastructure to support a lot of that consistency. That includes a statewide consent registry, a provider directory, and also a data repository to support some of that public health and Medicaid reporting. We also have a statewide collaboration process as part of the SHIN-NY, where a stakeholder group is facilitated to make recommendations on policies right now. Whether it's about data sharing and others. We also want to enable the group to support the development of standards for how data should be made interoperable and how that should align with some of those national networks. So, for example, there's a lot of exchange that goes on right now between Epic to Epic or other national networks such as Care Quality. What we'd like to do is be able to align with that a lot better to have a more efficient system. Also, what this would do is establish a common participation agreement across the SHIN-NY sort of the rights of participants in the SHIN-NY and the obligations are clear across the state and not different from member to member. A What we're looking to do is require our qualified entities and those participating in the SHIN-NY to process a statewide consent where that would better enable things like the exchange of information when somebody is going from say a primary care to a specialist by referral. What we're requiring of the qualified entities is them to submit data to that statewide data repository. Based on recommendations from that statewide collaboration process, where they will identify standards of data that should go into the statewide repository. What comes out of it will also be governed by the collaboration process to support ensuring that it aligns with Public Health Law and also Medicaid requirements. What we also do is establish that both the qualified entities and facilities that are required to connect to the SHIN-NY. We have guidance on that. Based on that, again, the statewide collaboration process for what data should be submitted, both those facilities and the qualified entities, what it would be. It would describe those requirements for interoperability. Finally, within the qualified entities we actually remove some of the minimum set of services. We want to focus more on interoperability and how data gets exchanged, rather than dictating a workflow that would happen at a particular facility. Lastly for the, for the facilities themselves, in addition to sending data to that

statewide data repository, they would also allow some of those who have the technical capability to connect directly to the SHIN-NY rather than having to go through a qualified entity. We believe this will help us focus the department's resources on supporting some of those safety net organizations rather than supporting all facilities across the state. That's it.

Mr. Holt Thank you, Mr. Kirkwood.

Mr. Holt Do we have questions from the members of the committee or the council?

Mr. Holt Dr. Bennett.

Dr. Bennett Yes.

Dr. Bennett Thank you. Thanks, Jim, for that. Let me just preface this by saying that I've been involved in this effort for over twenty years, at first at the regional level with our Capital Region and for the last decade, on the board of the New York Health Collaborative where I'm currently the Chair. I'm excited about this regulation because it's going to support our statewide initiatives, particularly our 1115 Waiver. We need the SHIN-NY to work seamlessly across all regions. These regulation changes create common rules of the road. They move us to one process for privacy protection instead of six and make clear that the data needs to be liberated from regional organizations. If we want our big investments in the SHIN-NY to be useful for health reform and public health initiatives that span the whole state that span all these regions. We need to make these changes. We know the SHIN-NY will need to adapt because there are new federally promoted methods of exchanging health data as well as the epic electronic health records system, which is expanding and doing more and more. The current regulations when passed a while ago helped create the SHIN-NY we have. Without these adjustments the regulations will bound us to the status quo. With these regulations, we'll be able to move into the future to serve the state. Thank you.

Mr. Holt Thank you for the comments, Dr. Bennett.

Mr. Holt Mr. Kraut.

Mr. Kraut Yeah.

Mr. Kraut As Dr. Bennet disclosed. I'll do the same. I've been involved equally long with him. I was the Founder of the Long Island Patient Exchange back then we had a grant, I think. This is phenomenal. I mean, we would never have built the system we have today knowing what we know today. Certainly, after COVID, we recognized the challenges of the importance of interoperability and the exchange of information not only for patient care, but for good data to drive good policy. I think that's great. Jim, I really appreciate the focus on aligning the investments we're making with what the QEs are doing and changing their role. In that context, I'd like to ask you what do you see the ongoing role of regional QEs? Specifically, how do you think they'll bring value to other organizations in underserved communities? I mean, where do you see the future of this going?

Mr. Kirkwood Specifically, with the waiver, right? The waiver is intended to support the Medicaid program. What they're doing and we've seen this previously, for example, in Rochester, where they're supporting a community social care exchange. This is years ago was what has happened. We expect the qualified entities to be able to support more of that activity locally. While they would meet the statewide standards and have consistency

across the state, we expect them to be more focused on supporting those initiatives that are specific to those communities and supporting a lot of those underserved communities' safety nets and others and supporting public health reporting that we really needed for example, during COVID.

Mr. Kraut Thank you.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt Any other questions?

Ms. Soffel I think this sort of piggybacks on Mr. Kraut's question. One of the things that we learned during the experience was that the entities that are providing services around social determinants of health have a very, very hard time communicating data back and forth to the health entities around individual patients and consumers. I am interested in what you guys are thinking about how to improve that data flow as social determinants of health are becoming more central to our public health initiatives and the work that we are expecting of health care providers better linkages, better connectivity. I know it's a huge lift, and I'm sort of interested in in what your department's thinking is on that.

Mr. Kirkwood Sure.

Mr. Kirkwood As part of the preparation for the waiver we're working very closely with the national standards makers on social determinants of health. We don't think they go far enough right now. They recognize that too. There's something called the Gravity Project, where it's about interoperability of social in terms of health data. What we're doing is we're working with them in how we're looking forward to supporting the waiver. Some of these IT platforms that are out there. There's lots of them out there that folks are already using around the state. What we're trying to do is really help define what those standards for what one of those I.T. platforms should do for setting, say, screening data or referral information, or sort of what the outcome of the particular case management activity. What we're looking to do is align with those standards and sort of help build them out. For example, as part of the project we are working with the Gravity project to help define different sort of code sets that need to go into one of the results sorts of standards that's out there. Support really that interoperability so that electronic health record that has to adhere to those standards can really understand them the meaning when it goes across the sort of the wall, so to speak.

Mr. Holt Thank you, Jim.

Mr. Holt Other questions from the committee or council?

Mr. Holt Again, this is for information only. This will now be presented to the full council. In a little while, for their information as well.

Mr. Holt Lastly, we have general hospital medical staff recertification. This regulation is being presented to this committee for information only. It will be presented to this committee and the full Public Health and Health Planning Council for adoption at a later date. Mr. Robert Serenka and Jonathan Karmel of the department are available will provide us with information on this proposal.

Mr. Serenka Good morning. My name is Bob Serenka. I'm the Deputy Director of the Center for Health Care Policy and Resource Development. Pursuant to the Public Health Law, Section 2803, this council has the authorization to adopt and amend rules regarding the operation of Article 28 general hospitals. This regulation proposes to lengthen the requirement those hospitals to review the credentials of medical staff from every two years to every three years. This is consistent with recommendation by the Joint Commission. Comments are due next week. We've received five comments. All of them have been positive.

Mr. Serenka Are there any questions?

Mr. Holt Thank you very much.

Mr. Holt Questions for members of the committee or from the council?

Mr. Holt Again, nobody from the public good signed up in advance to this.

Mr. Holt Again, this will be presented to the full council for information in an upcoming meeting.

Mr. Holt That concludes this morning's meeting of Codes, Regulations and Legislation.

Mr. Kraut That lasts one is a big welcome change.

Mr. Robinson You'll get a standing ovation.

Mr. Kraut Thank you very much.