NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
HEALTH PLANNING COMMITTEE
December 3, 2025, 12:00PM – 4:00PM
90 CHURCH STREET, 4TH FLOOR,
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Dr. Heslin We're calling the meeting to order. We're going to get the ministerial stuff taken care of and out of the way while we wait for a couple other people.

Dr. Rugge Be aware as always that this meeting is being recorded. The mics are hot. Everything you say is going to be memorialized and published. We need to be, as always, disciplined, discreet, helpful, and organized. In preparation, minutes is revised by Denise Soffel were very helpful. Your edits were very helpful, and they've been incorporated into the minutes and now are just being printed and will be distributed momentarily.

Dr. Heslin We appreciate everybody that submitted comments and read through the minutes. Those that got the homework assignment. We very much appreciated. Those that, you know, enjoyed Thanksgiving and didn't get the homework assignment.

Dr. Rugge I don't think it was that way at all. I think everybody was very busy working to prepare for this meeting. Instead of looking back, they were looking forward to what we can say now. Just as a comment in that direction, I think it is notable how much we've come together and are sharing our thoughts not antagonistically but cooperatively. This meeting is intended to really bring things together so we can have a coherent report to the council tomorrow with specific recommendations for placing percutaneous coronary interventions and ambulatory surgical centers. We'll see how that goes. What else can we do? We think within a couple of minutes are of arriving. We don't have the minutes quite yet. Again, I do think that people have been really concentrating on this agenda. We have some people from the council itself being very, very attentive. Hugh Thomas means a lot to know that there's we're not confined to certain kinds of memberships. Everybody's voice will be heard and included in all we're trying to do.

Dr. Rugge Any introductory thoughts by members of the committee otherwise?

Dr. Rugge It's hard to approve the minutes before we see them.

Dr. Heslin While we're waiting for the minutes, I'm going to call an audible and just review briefly what the process was. I'm actually on number two overview of feedback and edits. What we did in our last meeting was we worked on getting to consensus, having all members participate, having an opinion, and then had the facilitated discussion, and John wrote down keywords on the board, and then we summarized that in a very loose meeting summary. The purpose of that very loose meeting summary was for people to be able to read it and then make comments on it, cut it up, and then get back to us on where they thought there needed to be changes and or edits. And from that, what was developed was the draft recommendations for discussion document that is in front of everybody here. Dr. Rugge, Ann, myself, and Abby took a shot at taking everything that was in the minutes that was general consensus, the group thought this could be done, that could be done, et cetera, and then put it into a format to go through each one of the ideas that were a general consensus and then subsequently put other underneath it because as part of this process we recognized that while there might be general consensus there might be other

important notes that would need to be codified with each one of those different thoughts. What we're going to do here today as part of the process to be ready for tomorrow so that Dr. Rugge and Ann can do their report outs of this process is we're going to go through each one of these different concepts and Abby here is going to live on screen put in the other comments that we're all going to think about and potentially agree to or not and there can be other and then that's going to be built into the final document that is going to be the series of recommendations from the Planning Committee of the Public Health Council for the Department to take under consideration when it's developing the draft regulations which will eventually come back through the Codes Committee. This is the final step of education, data, all the stuff that the committee's been through, and then what was done last time, hashing out thoughts, taking the meeting summary, and using that for people to focus on and submit their draft revisions to that summary, which some people did, which we appreciated. You should have that draft in front of you now with all the pieces. This shorter document was meant to focus everybody on the distillation of what was in the last meeting summary for us to then go through and put you know the comments under and then present this tomorrow. The goal of today is to test that we, the chairs who did a lot of this and write, and wherever there's an error, that's our problem because we made the errors. They don't get to make errors. We did. To test that we got this written down in a way that seems acceptable, and that we capture the diversity of comments under each one of these seemingly acceptable things. That's our goal. Once we get that done, then this portion of the process will be completed. The next portion of the process will be tomorrow for the full council to be able to go through and decide if they want to move this forward to the department for consideration.

Dr. Heslin Just as a side note, I just want to say thank you, because three things came out of this process for the department, which are incredibly valuable. The first is the power of the Planning Committee in taking a seemingly narrow topic and thinking it through in a 360 view across the health continuum, which is really not always done. We've edged at it in public council meetings before, but this really dove more into that way of thinking. We very much appreciate that. The second is this is a new and different topic, if you will, in terms of delivery of care. Well, there are fourteen or fifteen Public Health Council members that have become pretty well educated on cardiac catheterization, diagnostic, PCI, and when CONs come to you in the future, we're going to have an educated group on a topic to ask thoughtful questions rather than looking at four inches of paper and going... What does this really mean? We very much appreciate the fact that you've been deeply educated. We think that that's a really important thing. The final thing is, through this process, we're able to get the public to be able to opine in a very diverse way from site fees all the way through to who gets cared for where. That helps craft regulations rather than waiting and having to deal with it through the state public process. We're doing it prior to in a public way, very transparently, and that really helps. We're deeply grateful for the opportunity as the department to have this done here.

Dr. Heslin I'm going to turn it over to my colleagues on my left to save the rest of the agenda that I so ruthlessly... You know, changed.

Dr. Rugge Dr. Friedrich.

Dr. Friedrich Marcus Friedrich, member of the committee. Thank you, Dr. Heslin.

Dr. Friedrich My mic is on. Thank you.

Dr. Rugge Yes, we can hear you.

Dr. Friedrich I can speak louder if you want me to.

Dr. Friedrich Thank you for laying out. If I recall our last meeting, Gene, you mentioned that there is a parallel process with the experts, the Cardiac Advisory Committee. Have they met in the meantime? Can you just comment on as I understood the process is that our committee here and the PHHPC make a set of recommendations, but then there is a second or parallel pathway where the Cardiac Advisory Committee also looks over and makes recommendation and then the department will bring it together. I'm just curious. Have they met in the meantime? Obviously, they are the experts in data. They are the experts in quality. They are the experts in the clinical aspect of this. I'm just curious where we are there.

Dr. Heslin They've met, and they have submitted a letter of comments which I have to go back and test against because they were done behind their closed doors, and the department has not had the opportunity to review them and or go back and question them. It was done in a very different way, and we would like the opportunity to go through and see and test against where their thoughts are. That happened very recently as in yesterday.

Dr. Rugge My perception is that there are two major sources of research support information, one being the Cardiac Advisory Committee is a focus, strong focus and deep expertise and coronary procedures and care. That of PHHPC and the Planning Committee bring that broad perspective of how does this fit into the whole healthcare system, what does it imply, and how should we go forward? We've identified three phases as Gene has indicated. One is trying to become as educated as we can about what this process is, what it means, what the impact should be, and then hearing from the public, hearing from providers across the state, so that we can add that to our own research knowledge. We are in Phase Three, actually the end of Phase Three or nearly at the end of having pulled together recommendations for consideration initially by the council but also sending for analysis and review and support by DOH. I can only add that I took care not to try to come to any opinions initially because I didn't have any. I was in London over the Thanksgiving holidays and was busy jotting down my thoughts about what the recommendations should be and where we go at the same time without a typewriter. At the same time Ann was doing the same project and came to realize we were thinking the same way, the same things and the same priorities. I think that is largely true, but we want to make sure that anybody in this committee that has another opinion, or a hesitation should express that. I don't think we need a formal vote, but we need to record those and put them in any final report that rather than this being totally unanimous this is the direction we're seeing, and these are some of the side steps are there are the reservations that have been expressed by a group that has this appearance.

Dr. Soffel Hi. Denise Soffel, committee member. The expectation is that tomorrow at the full council meeting, you two will present the work of this committee and then the full council will be expected to vote.

Dr. Rugge No, I don't think so.

Dr. Soffel Okay, cause I just w feel like... Especially since they haven't seen any of the materials ahead of time that that would be asking a lot of our colleagues to absorb and think about and come to a smart decision about how to proceed.

Dr. Rugge This is instead our bringing the work we have done, the recommendations we have in mind for presentation to DOH, so they are understanding what we're doing, what the process is. If there are strong objections, we'll have to pay attention to decide what to do about that. This is not coming to a vote. It's not a formal proceeding where they're seeing it all in writing and they have plenty of time to scratch their heads.

Dr. Rugge Peter Robinson.

Mr. Robinson Well, I want to commend Dr. Heslin and the department and our co-chairs. I agree completely with the opening comments that were made about the added value that came from our work on this particular topic. I think the process was actually as good a one as we've had. The recommendations also look like they came very thoughtfully out of all the input that we've gotten. I really do like that. What to me is just missing, and I wouldn't change the recommendations at all, but there is no problem statement. There's no here's the issue we're trying to address, followed by the recommendations. I just think we need that. I think it really just adds more strength to the recommendations because we're trying to solve a problem. To it, an example. When we formed the Ad Hoc Committee on Ambulatory Surgery, our real concern was access, particularly Medicaid access people who were uninsured. That was really what drove our recommendations was how best to address that concern. I think we need a similar kind of set of a problem statement or a set of issues that we want to do.

Dr. Rugge Totally agree. That's not a recommendation, but it should be part of our introduction. And as I see it, this is not so much about a problem we're trying to solve, but rather an opportunity we're looking to take with so much care, leaving the inpatient setting to inventory settings with broad distribution, especially at a time when many hospitals may be shrinking or collapsing and in rural areas especially. This is very timely, very important, and may also provide sort of a road path for as we and others consider other kinds of migration of services.

Dr. Rugge Other comments?

Ms. Monroe Do the minutes.

Dr. Rugge We have to do the minutes. I'm sure everybody here is a very fast reader or has seen all the revisions that Denise has made.

Dr. Rugge Would anybody feel free to move to adopt?

Dr. Rugge He's not artificial at all, no.

All (Laughing)

Ms. Monroe They were Abby generated.

Dr. Heslin Abby abstracted it. I ran through and corrected it, and then others on the committee went back and are copy editors, I think, in their previous lives, because they did a fantastic job of fixing all the grammatical and thoughts. It was a combination of the department and the committee that generated this, no AI.

Dr. Rugge I think that speaks to your point, Peter. This has been an illustration to me of how PHHPC and his committees can be helpful collaborators. We're not telling people you

have to do it this way or that way, but we're trying to add our perspectives and our information and are to my mind being very well received.

Dr. Soffel I would just add that it was Department of Health staff, not Department of Heath staff.

Ms. Monroe We consulted with the Department of Health.

Dr. Soffel We did. Oh.... Good. I stand corrected.

All (Laughing)

Dr. Heslin Where is that?

Dr. Rugge That's why we depend on you for all those helpful additions.

Dr. Rugge Harvey Lawrence.

Mr. Lawrence My apologies. Harvey Lawrence, the member of the council. My apologies for my tardiness. I don't know if this has been covered or not. The intention is to work have hospital affiliated or own ASCs is the intention to at some point...

Ms. Monroe You and I were both tardy, should I say. There should be in front of your place a list of these recommendations and we'll go through them one by one.

Mr. Lawrence Oh, okay, I'm sorry.

Ms. Monroe We'll address that.

Mr. Robinson I move to approve the minutes.

Dr. Rugge We have a motion.

Dr. Rugge Do we have a second?

Dr. Rugge Is there any further discussion/any changes suggested?

Dr. Rugge All in favor?

Dr. Rugge Wow. Unanimous. Just like the rest of what's coming.

Dr. Rugge I think we've covered what we're trying to do next, and that is everybody needs to participate, offer their opinions when they have an opinion or any change from what is being offered. Those will be recorded and incorporated in the report that will be generated based on the discussion today. We'll try to do our best, Ann and I to include those in any presentation tomorrow to the council. I think we've covered this pretty well. As I say, we now have a list of recommendations, and Ann will be going to take us one by one.

Ms. Monroe Hello, everybody. I'm really sorry that I was late. What you have in front of you is a document that Gene and I, John Rugge and Abby wrote. It is not intended to be the final, and it is not intended to force you to a unanimous support of a particular item. We think this is general consensus based on our discussion and based on what we've

presented. I know it's hard to get people not to read ahead, and so I'd like to suggest we just take two minutes, and you can read the whole thing like Harvey just did, and so that you're not wondering when we're on number two, whether number five will appear. We'll just take two minutes.

Dr. Heslin While everybody's doing the reading, the process is that we will be putting these up on the screen so everybody can see what the different issues are. Abby's going to take contemporaneous notes for us so that that's visualized.

Dr. Eisenstein The order is does not imply importance, right?

Ms. Monroe No, the order is more chronological than it is important. It's just seemed easier to do it that way, but it's not at all a sign of what's important and what isn't.

Dr. Rugge All these items have priority.

Ms. Monroe Well, I think that Peter Robinson's point about leading this with the problem statement. If you remember at one of our meetings a woman asked, "Is there a problem we're trying to solve?" I guess this will require us to state that problem. We will head make a heading with the with the problem statement.

Mr. Thomas The minutes have a have a draft of a problem statement in them.

Ms. Monroe We'll look at that.

Mr. Thomas That may be a good place to start. It may not be broad enough, but there is a draft in there.

Ms. Monroe Again, as I said, this is general consensus, and if it's not, we'll change it. There is a statement and then underneath it is a place if you have either a dissenting opinion or a clarifying opinion. We want to make sure that that's noted. Excuse me.

Ms. Monroe The first one is that we're stating that there should be a process for expanding diagnostic and interventional cardiac catheterization into ambulatory surgery centers.

Dr. Friedrich Marcus Friedrich, member of the committee. I was under the impression that we talked only about diagnostic cath because they were the safest of both and that any intervention later on would be referred to a hospital setting. To be done in the hospital, the interventional cath. I'm a little bit surprised that we are mentioning both instead of just homing in on the lowest risk procedures. I'm curious about the rationale behind that.

Ms. Monroe It's that that's what I heard. It may be that we again phased those two things, but I don't think our goal was only to do diagnostic. It may be first to do diagnostic, but not only.

Dr. Rugge If I may. We did look at national information and more than half the states are performing PCI in ambulatory settings. There is consistency regarding quality and the lack of complications that could otherwise be avoidable. Certainly, emergency transportation in the event of a complication will be important, but the data that that exists now indicates it is safe to do PCIs and what we're seeing is that I have two major impacts, lower cost but also

broader distribution both to geographical areas and also to communities with high levels of need.

Ms. Monroe I'd suggest you hold that point until we get to phases, and you might want to add it in.

Dr. Friedrich Maybe we can then add to the other that we should include the lowest risk some wording about the lowest risk of diagnostic in PCI because patient with multi vessel diseases should probably not be done in an ambulatory surgical center.

Ms. Monroe I think that's a good point. I wrote it with phases. I think that if we clarify that we want to start with the lowest risk, if that's what people agree to. I appreciate your point, but let's see what the consensus is of the group.

Dr. Rugge One of the major threads here is patient eligibility. Everything you're saying is correct, but also the specifics in terms of what kind of clinical characteristics there need to be is something that I think we're all relying on the Cardiac Advisory Committee to assist with.

Ms. Monroe How do others feel about that?

Ms. Farrell Yes, it was my recollection as well that we were really focusing on the diagnostics, getting the diagnostics out of the hospital-based setting because indeed it was lowest risk. I remember the data point, right? Of the fifty thousand, fifty thousand being done in the hospital setting only five thousand were deemed to be appropriate, were diagnostic, I believe.

Dr. Heslin No, that was PCI.

Ms. Farrell Oh for PCI?

Dr. Heslin There are ninety thousand diagnostics. There are fifty thousand PCIs of which were considered appropriate for the PCI. The diagnostics are not tracked, so they don't actually have data on them to be able to track against. It was PCI data that was presented, and it's been PCI data that has only been presented by Cardiac Advisory Committee and others because they didn't have data on the diagnostics.

Ms. Farrell I just remember those numbers and thinking, oh my goodness, if the patient selection criteria is that restrictive, right? Because there was a whole analysis done on those ninety thousand, fifty thousand, five thousand. Of course, my concern is always going to be over utilization.

Dr. Heslin Let's be clear. It was fifty thousand PCI and five thousand, ten percent.

Ms. Farrell Yes.

Dr. Heslin Dr. Jacobs acknowledged that while that was there, diagnostic could be higher than that because they don't follow diagnostics at all. It's never been the intention of the department just to do diagnostics. It may be the intention to start someplace and go someplace, but we're not going to write a reg just for diagnostics. We're going to write a reg that's going to encompass all of cardiac catheterization, whether it's faced or not, or however it's decided. It as Marcus once said in the last meeting, we run the risk of falling

behind the rest of the country, as the rest of the committee said at that same meeting, but we need data to prove that we're doing the right thing.

Ms. Farrell What if the clinical the clinical risk characteristics of the patients and being very clear and very specific about that? I remember I brought this up. There's examples around the United States of over stenting, right? There's over utilization of stents. There are legal cases related to that all across the country, and apparently there's interpretation by doctors and there's something called the seventy thirty rule, and... You know, yadda yadda yadda. What I'm focusing on is the clinical characteristics of patients. We should be very specific about that.

Dr. Heslin We would probably look to the Cardiac Advisory Committee to for that, for their expertise, because they're the ones that have the expertise in this. We really look to them.

Dr. Eisenstein I want to disagree with something you said, Dr. Rugge, that made it into the notes. I've been very consistent from the beginning that I don't believe there is existing evidence-based data to show that doing this is safe. I'm not saying it's not safe. I'm saying I thought there was consensus, not unanimous, but consensus that we needed safety data. To put in the notes for a presentation that according to existing data PCI is safe, I don't which is what you said, which is why it's in the notes. This is not about the note taking. I don't think that accurately reflects the conversation. To me the whole point was we want to be part of building the evidence on how to do this safely.

Dr. Rugge As I understand it, what the data shows is a around the nation, with those states that are allowing or enabling PCIs, both in inpatient settings and ambulatory settings, the percentage or the number of complications is one percent in both settings. That would help to indicate while we still need more studies, there is evidence that it is appropriate to move forward.

Ms. Monroe Sorry, John. Finish, please.

Ms. Monroe Are you done?

Dr. Rugge Yeah.

Ms. Monroe I had a chance last night to talk to Sabina Lim, who's on our committee, but who wasn't able to come today, so I shared this with her. I'm wondering if her comment might not be appropriate here, which is number four. The priority is to gather important data to evaluate program effectiveness and safety. If that should not be moved up to be much more of a... Do you see it, Larry?

Ms. Monroe No, the first number four.

Ms. Farrell Letter C Number 4.

Ms. Monroe Anyway, I wonder if that, given what we've heard about lower risk, you know, beginning with lower risk activities, monitoring data all along the way to assure patient safety and effectiveness, if maybe we shouldn't move that one up as kind of a more important piece. I'm wondering if that would address that.

Dr. Eisenstein We had numerous speakers, and I thought consensus acknowledged that we don't have data to say that we can make evidence-based recommendations on this. That's my only point. You can't just make the statement it's safe to do this.

Dr. Heslin What I would suggest is... Is that the data that has been presented so far has demonstrated that it appears to be safe. That being said, there's a paucity of data that has been available since this is a relatively new procedure, and so the state needs to proceed with the appropriate cautions to make sure that we have the appropriate data necessary to ensure safety for New Yorkers.

Dr. Eisenstein That's exactly what I was saying.

Dr. Heslin It's not that it's safe or it's not safe. What we've gotten so far appears to be safe.

Dr. Eisenstein I just wanted that acknowledged in the notes.

Dr. Heslin No, no, no, I get it. It's at the paucity of data that we're all acknowledging and the need for more data to make sure that we are protecting New Yorkers in the appropriate way.

Mr. Lawrence I think I just got lost.

Ms. Monroe You got lost?

Mr. Lawrence I'm a little lost because we're talking about safety. I'm thinking that we're talking about the procedures that are happening already in the hospital setting. What we're looking to do is to move those procedures into an ambulatory surgery centers. What is it? Am I missing something here?

Dr. Rugge What a basic another consideration is that fifteen years ago these procedures were allowed to move from hospitals with full-scale cardiac surgery offerings to hospitals not having that capacity. Therefore, needing to be transferred to the hospitals with it in case of a complication. There's not as big a leap as if we were going only from inpatient with all that surgical capacity to an ambulatory setting that is removed and remote.

Mr. Lawrence That it's going to be based on a recommendation, affiliated or n essentially controlled by a hospital.

Ms. Monroe That's number one on the sheet.

Dr. Rugge We're looking for hospitals.

Ms. Monroe Do you have the sheet? I want to make sure that you do.

Dr. Rugge The idea is to be assured that hospitals have full scale responsibility for excellent care, exec high quality, and continuous reporting so that we know what is transpiring. Only later would there be consideration to have other kinds of ASCs qualify.

Ms. Monroe Hugh.

Mr. Thomas Just back to a question we were discussing, which is PCI or diagnostics, and Marcus raised it. My understanding is that we are going to apply very conservative patient evaluation criteria, whether it's a diagnostic cath or a PCI, in order for the case to be done in a surgery center that is part of a system that has a heart program, open heart and cath labs. Is that okay? The goal being to start to build data in the most conservative way take the otherwise healthy folks. They meet all the screens no matter what kind of cath, get the cath done and start from there. I'm not trying to reopen a question that was asked and answered. I just want to clarify that the criteria used for patient selection will be conservative. I mean conservative in a good way. You know, biased conservative.

Dr. Heslin In New York, we've had a history of being very conservative in the way we do these procedures. We started off with only in the thoracic, and over decades we've moved to doing PCIs in hospitals that don't have thoracic surgery backup. It wasn't a day or a week or a month. It was decades that it took to be able to move forward because we were aware. We have this Cardiac Advisory Committee that is a group of experts, not only from New York but from around the country, that think about what types of rules and then those expansions might occur. It was never done by, oh, it's this many years or this many days. It was when there was a feeling that the next step could be done safely that it got moved forward. That's been their job. Their job was, to Lindsay's point that when there was an acknowledgement, a decade, maybe a decade and a half ago, that too many caths were being done, period, there was a whole set of rules that were looked at and put in place. The hospital administrators that are in the room might remember because all of a sudden there had to be justifications as opposed to you just wanted to do it. That changed the number of caths that were done. It was a dramatic decrease in the number of catheterizations that were done within the state because there were rule sets put in place and criteria put in place by that committee and by the department. It is a multi-pronged approach that is happening here.

Ms. Monroe In trying to take what I've heard, let me put this out there and see what you think. New York should begin a process of expanding cardiac catheterization into ambulatory surgery centers, beginning with the lowest risk procedures and guided by evaluation of safety and effectiveness. It doesn't say one or the other. It said we're going to move into this gradually, guided by the data and the evaluation.

Dr. Rugge And not just catheterizations, also interventions.

Ms. Monroe What?

Dr. Rugge This will include the beginning of providing interventions in the ambulatory setting, not just diagnostic catheterization.

Ms. Monroe I didn't say just diagnostic.

Ms. Monroe I said the process of expanding cardiac catheterization, which is both diagnostic and interventive.

Dr. Rugge No, no. It is only diagnostic.

Ms. Monroe Pardon me?

Dr. Rugge Catheterization is diagnostic, as I read it.

Ms. Monroe It's an inclusive term, right?

Dr. Rugge It doesn't include interventions.

Dr. Soffel I think that what Ann wants to do is add to Bullet A, which says New York should begin a process of expanding diagnostic and interventional cardiac catheterization and then add beginning with the lowest risk procedures, blah blah blah. That's where that goes up to the top.

Ms. Monroe It's New York should begin a process of expanding diagnostic and interventional cardiac catheterization into ASCs, beginning with the lowest risk procedures and guided by the evaluation of safety and effectiveness.

Dr. Rugge Perfect.

Ms. Monroe Are people comfortable with that?

Mr. Lawrence Yes, I am. We're not stating the obvious because we're starting out with hospitals.

Ms. Monroe Well, that's letter A.

Mr. Lawrence Why not just say that up front as opposed to dropping it down.

Dr. Rugge We're saying it's limited to hospital owned or affiliated. We're not saying limited to being in the inpatient hospital setting.

Ms. Monroe Could we do this, Harvey? If after we go through where we talk about hospital ownership, if you still feel their needs because I didn't see this as a summary statement. I saw it more as... You know, here's the problem. We're going to do this. Here's what it's going to look like, A, B, C, and D. If it doesn't address that when we're done, will you speak up?

Mr. Lawrence That's a general statement.

Ms. Monroe It's a general statement.

Dr. Eisenstein Before we get too deep, quick point of clarification, Gene, maybe. I know New York state law is all encompassing and a lot of times doesn't always make sense geographically for everybody. What you said before made me think we haven't discussed the term in medicine which we hear all the time, which is the risk-benefit ratio. In other words, every procedure that's done has some level of risk, and every procedure that's done we do because there's a certain level of benefit. When the benefit greatly outweighs the risk, that's generally the standard. Is this have to be all encompassing? Because based on something you said before it hit me, there are parts of the state where the risk the benefits might outweigh the risks, and it's possible in other locations that it's not. Does this have to be statewide?

Dr. Heslin That's a really great point and that's something that PHHPC controls because when the CON comes forward, if you don't think it needs to be there, you can say no. You have the ability, at the end of the day, once this is all crafted to say no to a CON or say yes. You'll be educated now about it because you spent the last eight months learning

about this stuff. The ultimate control of where something goes is the CON approval. That's the process. We would prefer not to have it limited in regulation. We prefer to have PHHPC do its job, which is to make those determinations.

Ms. Monroe We speak about geography at a later point, D2. When we get there, perhaps it's too specific now, it says should be located there. You're saying it only should be located where it's safe and effective.

Dr. Eisenstein It should always be safe and effective. What I'm saying is it should only be located where the benefits outweigh the risks, which is a different analysis.

Ms. Monroe Let me make that note. I think that's part of what the whole evaluation is of all of this.

Mr. Robinson This is still at the general level. The term ambulatory surgery center broadly read, and these entities exist. The way that generally I'm reading what we're doing here is we're allowing the incorporation of these procedures into ambulatories, the appropriate ambulatory surgery centers as we define them. We also heard, I think, from our experts that these programs need to be in facilities with very specific equipment and very specific staff that are expert in this area. Somehow, I think we just need to have that more evident in our recommendations. I know we talked about it. I think we all agreed on it, but I just wanted to have that brought out a little bit more because the generic ambulatory the public will perceive us allowing PCI in ambulatory surgery centers. You have a room for a PCI, and you have a room that you're going to do eye procedures or whatever it is. That's not our intention.

Ms. Monroe Doesn't the Department of Health certify an ambulatory surgery center to do certain things? When it does then it's got the right staff and equipment to do it.

Mr. Robinson There are standards.

Mr. Robinson We've heard for impatient.

Mr. Robinson I'm just asking the question. I'm not trying to upset the applicant.

Dr. Heslin There are standards. The standards that we would expect we would probably be looking at would be the ones that are generally acceptable, national standards for what a cardiac catheterization room has to look like, what the staffing model has to be, what the support model has to be, what the emergency backup has to be, what the training needs to be of the people that are working at the site, all those are things that would be part of that just like it would have to be at a hospital. The important point here, and I want to be very precise about this. We currently have four different types of things that happen in cardiac catheterization. We also have hospitals that have thoracic surgery, hospitals that don't have thoracic surgery, inpatient hospitals that have thoracic surgery, outpatient ambulatory, so be careful with the word ambulatory, because ambulatory is a word that's used when a person is discharged from the hospital in the same day. They're ambulatory patients that are cared for in a hospital site having a procedure, PCI or diagnostic, that has surgical backup. There's the group that are in the hospitals that don't have surgical backup with all those same type of things. Be careful when you use the word ambulatory, because that could mean a person that's in a hospital setting having a PCI or a diagnostic. Most PCIs tend to stay overnight, but it could be in there. You just have to be very precise. We're talking ambulatory

Ms. Monroe I don't think we can be that precise.

Dr. Heslin No, we have to be that precise that we're saying.

Ms. Monroe The department has to be that precise.

Dr. Heslin I beg to differ. We have to have ambulatory surgical centers. It has to be very clear it's an ambulatory surgical center, not an ambulatory hospital center.

Ms. Monroe But this says ambulatory surgery centers.

Dr. Heslin We've not been using that word that way.

Ms. Monroe Oh, I believe we've used it. Well, we differ on that. The words we're to use are ambulatory surgery center, right?

Dr. Heslin Yes, we just need to be very precise.

Dr. Rugge I think we also will depend on the Cardiac Advisory Committee to define the qualifications for the physician. It's not just being a cardiologist. It's having the specific expertise to do this diagnostic work and the therapeutic work as well. With the inpatient standards, I suspect would be the same for the new ambulatory centers. I think we're maintaining the same standards, but we're changing the location of service. Likewise, there has to be certain technical qualifications needing upsizing this specialty equipment to do.

Ms. Monroe I think we we're con we need to be conscious of that. The only time it talks about sites other than an ASC is at the last item, which says part of future phases should include looking at all of those sites as well. I think if we stick with the term ASC and the concept of an ASC through all the rest of the recommendations... We'll be okay.

Dr. Rugge There may be an ambulatory surgical center that does only cardiac catheterizations and PCIs. There could be an ambulatory surgery center limited to cardiac caths, and PCIs as needed and as appropriate.

Ms. Monroe I think we've got to start on the first one. The second one is that we think it should roll out in phases. We've used the term demo and pilot, but I think what we're really talking about is rolling it out in phases. Is there general consensus that that's the way it should work?

Ms. Monroe Hugh, do you have a disagreement or a clarification?

Mr. Thomas I guess the comment Ann is that a phase implies there's going to be a second phase. A pilot implies it may end. I don't mean to wordsmith this and lawyer this and that's a criticism of myself.

Ms. Monroe Even though you're a wordsmith and a lawyer.

Mr. Thomas I think we should be absent some startling findings in Phase One. This would evolve into Phase Two. That's really the discussion.

Ms. Monroe I say with future phases built upon the learnings of the earlier phases, so if we learn it doesn't work.

Mr. Thomas I'm just saying as distinguished from a pilot. There's been lots of pilots. They don't go anywhere. Not in this document, Ann. I'm just saying in the conversation we've had over many meetings, we've been talking sort of interchangeably of pilot programs and phases. I'm agreeing with your language. I'm just suggesting we should all be cognizant of that. Because we have been talking about pilots here and there. It's been a lot of conversations. I'm with you. I'm just suggesting everybody needs to understand that.

Ms. Monroe Are we okay with B then? The way it's written.

Ms. Farrell Yes.

Ms. Monroe In Phase One, this first item I think needs some work. It should be limited to hospital affiliated facilities where the hospital has an ownership interest. I think that needs to be clarified. It shouldn't be a dimitimus ownership interest, two percent or controlling interest? Controlling, is that a better word in both governance and financial?

Mr. Robinson Because you're limiting it to not for profits, it really needs to be hospital owned. It has to be a hundred percent hospital owned because if you get into other partners, those other partners will bring a for-profit dimension to this. It's axiomatic almost that it has to be a hundred percent hospital owned if in Phase One.

Ms. Monroe Do people see that?

Mr. Lawrence I have a question. What are we seeing in the rest of the country in terms of ASCs? This type of ASC, is it predominantly hospital owned or is it... What is the models that we're seeing across the country?

Dr. Heslin They're generally mixed models. There are about probably sixty or seventy around the country right now in twenty-five or twenty-six different states. They are mainly for profit because most of the states don't have the same regulatory base that we do. Most of them are freestanding non-hospital based. That goes along with the demographic of there's a lot of these put in places where there aren't hospitals or availability to have a place. A lot of them are far away from their backup support. We have a different paradigm that we're looking at here in terms of even in our hospital ambulatory, non-surgical hospitals, we have rules on how far away you can be.

Mr. Lawrence Are we at any point looking to this as sort of an incubation at some point where I don't know, ten years from now there will be an ASC that is not affiliated with a hospital?

Ms. Monroe I think that would be in the future phases that would come from whatever learnings we got and build on that. We're not saying no to that, but we're not saying you must do that either.

Mr. Lawrence Are we embedding any incentives for that to happen or any breaks on it for it?

Ms. Monroe Not in this document.

Mr. Robinson I apologize. I didn't mean to jump ahead of you.

Mr. Perry Stanford Perry, member of the committee. My concern is the language around hospital affiliated versus hospital based. What difference are we looking at here? I thought we were talking hospital-based ambulatory centers versus hospital affiliated, which could mean I'm affiliated with the hospital, but twenty-five miles away from the hospital where the work is actually being performed, which would be a concern in terms of ensuring the highest degree of safety as we move forward in the initial phase.

Ms. Monroe I think this is where we're not clear collectively. There's hospital affiliated, which is exactly what you said. I have a letter that says I'm affiliated with the hospital. There's hospital based, which to me says it's right there on the campus. There's hospital owned, where it might not be on the campus, but the hospital owns it a hundred percent or two percent, and we're saying it needs to be close to a hundred, if not a hundred percent. I'm not sure which we mean.

Mr. Perry I think we need to clarify that in terms of safety and effectiveness for the initial phase prior to moving forward with additional phases or we could be opening a door that could lead to a variety of these centers all over the place that may not have immediate proximity to the hospital if that's needed.

Mr. Robinson Just a couple of things. One on the hospital owned. I think there's two reasons to have this that way. One is because there's an extension of the quality programs that already exist that will automatically be integrated into these settings because of that ownership relationship. Secondly, I think that the not-for-profit piece is extraordinarily important. I think that we have to be very thoughtful when we start to create more and more services and activities in New York that sit in the for-profit sector where the incentives are not exactly the same and where a bottom line becomes an important consideration. That's where you hope you could get into issues of overutilization and other kinds of things as well. I think that while we're talking about Phase One right now, and I understand that, but I think that even as we consider another phase and we want to geographically disperse it and have it may be less physically connected to a hospital, I think it's another step to say that we want to allow private ownership. One percent or fifty one percent, I think it's a slippery slope. I think we need to be very careful about that.

Dr. Rugge Just in terms of finding the language that works, I think hospital based implies it's going to be inside the hospital campus. I think this whole movement we're talking about is to relocate some of these services where they're closer to patients in need that may have trouble and all the rest. Other terms can be hospital owned, but then is it one percent, a hundred percent, whatever? Another term is a hospital affiliated, which means the hospital has responsibility for the operational service. My thought would be to say that we regard these new PCI services to be hospital owned and affiliated. We're not saying what percentage of hospital ownership there could be some ownership thirty percent.

Mr. Robinson I think it's very important that we not create splits in ownership because you can't do that without converting it to a for profit. It just doesn't happen.

Dr. Rugge Unless it's an FQHC.

Dr. Rugge I'm kidding, sort of.

Mr. Robinson I'm actually okay if at some point FQHC's go into the ambulatory surgery business.

Dr. Rugge I agree with you. I agree totally.

Mr. Robinson I just want to be very careful not to open a door.

Dr. Rugge Do you think we should say fully hospital owned and affiliated?

Mr. Robinson Even though it's redundant, not for profit.

Ms. Monroe I'd like to go back to Mr. Perry's point just to make sure that we either include it or we're not. He's speaking of having it physically on the campus. Is that what we think is important? Personally, I didn't hear that much of that. I didn't take that from the discussion, that it had to be physically there. That the point of this was to do it on the other side of town or whatever it might be. I want to deal with the issue of hospital-based so that we either include it or we don't.

Mr. Perry I thought the point was outpatient ambulatory services.

Ms. Farrell Like the St. Vincent's example.

Dr. Heslin It already exists cause that's known as a hospital outpatient procedure. Ambulatory procedures are done now all over the state.

Ms. Farrell No beds.

Dr. Heslin They don't stay overnight. They're discharged.

Dr. Heslin For this procedure exactly.

Dr. Friedrich I want to speak out for not making that a requirement to have that on hospital campus because there is good data in the cardiac program where we allow you know PCI hospitals without cardiac surgery, but they have to be... Gene, correct me. Like in a thirty mile or thirty-minute radius of a surgical center. I feel that is at least for me enough to be in a vicinity of somebody if something goes wrong that they can be transported to a hospital. I feel this is like not helping the cause if we require these ambulatory surgical centers to be on the campus of the hospital system.

Dr. Rugge As I understand, there will be no need for any new regulations, no need to have this committee discussion, because hospital-based services are already okay. Hospitals can do that.

Dr. Heslin I'm just answering his question. I believe the rule is that it's sixty minutes transport time. It's not a radius. It's not a distance. It's a transport time. We have hospitals that are well more than thirty miles away that fly people.

Mr. Thomas Hugh Thomas, member of the council. I was just going to say we had quite an extensive conversation about the Northwell. I'm not going to go back to pilot. It's really sort of a hybrid, because it's really not a true ambulatory surgery center. It's a hospital that was shut down. Anyway, we can get into a debate about that. They had in responding to Mr. Perry and Dr. Friedrich's comments, they were very specific transfer timelines. They

had a standby cardiac prepared ambulance. I mean, going to the staffing, which we're going to get into. They moved all their cath lab staff down there. They really did exactly I think they got at what you were saying. The practically speaking, from a hospital perspective, to require this on the campus, there's two problems with that. The first is John's right that if it's on the hospital campus, it's a hospital ambulatory procedure. Secondly, they don't have any space. One of the good things about AM surgery centers from a patient's perspective is they're a lot easier to deal with than going into a hospital campus. I think we have to accommodate both your comment through the way Northwell did or whatever other way the department comes up with, in terms of transfer times, et cetera. Right now, Gene, is it an hour? I mean, if you've got a free if you've got a hospital at cath lab and a non-cardiac surgery hospital transport air or ambulance an hour. Northwell's is short just so you know. Well, depending on traffic in Manhattan I suppose.

Dr. Eisenstein Again, in the tradition of doing this conservatively as was described before and safely, if we're trying to establish the safety data, we should do it in a fashion that's safe, as close to a hospital as possible. I was going to bring up you stole a lot of my thunder with that comment, which I'm glad you did. The Northwell example shows the thought put into doing it away from the hospital in a way that mitigates as much as possible safety to the patient. The closer to the hospital we do this, and even on the grounds or across the parking lot or something, to me is safer. If we're doing it in phases, it doesn't mean that's where it has to ultimately end. We should expand out, but that's a safe place to start is my point. Certainly, if we're not going to do it that way, have to put in the guardrails as Mr. Thomas described, so that if it is twenty/thirty miles away. Again, there's going to be places where it might have to be, while there's other geography that it's not necessary to do that. The risk benefit, I keep going back to that. My point is...I know ultimately the concept as Dr. Rugge and Ann you've said, you know, the whole point is doing this away from the hospital. Yes, but we're doing this in phases, as you've pointed out. We could start that first phase safely and have the data to take the next phase.

Ms. Monroe I have a question for Gene. We listed here the Society for... Oh, I don't have my glasses on. Cardiovascular Angiography and Interventions. The things we're describing sound to me like standards that you have to meet. I'm wondering if it's their association. You know, if we can say you must meet these standards as defined by that organization. It saves us from having. You don't agree?

Dr. Eisenstein I think we'd have to have an organization that doesn't have a horse in the race to follow their standard

Ms. Monroe Well, I don't know what it would be, but I'm...

Dr. Eisenstein On any side.

Ms. Monroe Maybe it's... What's the hospital accreditation?

Dr. Heslin Maybe our Cardiac Advisory Committee, which is our subject matter experts from all over the country, which is agnostic to Sky and all these other organizations. The standard for these centers is generally an hour is what their recommendation is. The concern the department has with it being directly on the campus is we don't actually think a lot of these will get built. Because if they're going to build it on the campus, they're going to build it as a hospital. They're not going to build it as an AM Surg Center. They just once you take that constrained space, they don't... You know, it's just not a reality that exists.

Mr. Lawrence In terms of the clinical side of this and the quality, I leave that to the physicians and folks with a lot more expertise. When I hear that there are other ambulatory centers across the country that are doing this without hospitals in the immediate vicinity. Are there outcomes that that much worse and quality or there's no data on it?

Dr. Heslin The scant amount of data that was presented to us was they actually have better outcomes. The better outcomes are based upon the fact probably they have good patient selection. They actually have better outcomes. The one finding that is true for hospital outpatient centers as well as ambulatory surgery centers is they reach people more frequently than the sites that have surgery on them. That's been a signal that's been present in the outpatient world, whether it's on the ambulatory side or not, but in all factors they actually do better in quality. It's a scant amount of data. You take it with a grain of salt.

Mr. Lawrence I think what we're also saying here is for this initial phase that we're going to have a selection process be so conservative that we're going to be looking at potentially the same population that those centers are looking at.

Dr. Heslin That's what nationally they've seen is that they've had conservative approaches and that they've had a good, strict patient selection. Again, it's a very small amount of data. Can you hang a hat on minuscule data? It's directionally appropriate. There's not enough to be able to have us hang New York State's hat on that.

Mr. Lawrence No, but I'm not suggesting we do that. What I am suggesting or what it seems to imply is that we're starting off with a selection criteria that would mirror whatever their selection criteria in terms of patients. Unlike they are, we are operating in a in a much more robust health environment in terms of regulation and proximity to hospitals. That would seem to suggest that we would have a better shot at an outcome, positive quality outcomes, even if the facility is not immediately in an immediate proximity to hospital.

Dr. Heslin At the last meeting and it was a flip statement, but what I said was what we're really trying to evaluate if we did everything the same in terms of patient selection, equipment, staffing, we're really evaluating the site, right? Because we're evaluating the difference between in its closest form a hospital that doesn't do surgery for ambulatory procedures, which a lot of them are done in those sites, versus an ambulatory surgery center that doesn't do procedures. What's the difference between those two? That's what Northwell helped to outline. Ambulatory surgery centers don't have ICUs, right? Hospitals without surgery do have ICUs. Both have X-ray, both have anesthesia, both have emergency procedures, but there's the fundamental difference between the two. One closes at X hours of the night and isn't there 24/7. The other one operates 24/7, right? What we're really evaluating if we have very similar criteria and choices is a site. How do you make that site safe? At the core, that's the actual issue. How do you make that site safe to do these type of procedures?

Ms. Monroe I think what we're trying to do is to get us there not gradually, but sequentially. That's it. That's it. Not incrementally, sequentially. I want to go back. It's important how specific we are as to where these need to be. Do we have agreement? Can I get nods? I don't think we have to raise our hands, but that it needs to be hospital owned and controlled.

Mr. Lawrence Again, hospital owned and controlled initially. What about controlled and not necessarily owned or partially owned because there was some conversation.

Ms. Monroe I think those are future phases. Harvey, that's something they could look at as the as we get the data, how you spread how you distance yourself from a hospital in Phase Two or Phase Three. Do we want to start out with a less than a hundred percent ownership by a hospital?

Mr. Lawrence I heard no, Ann. I'm looking at this that we're creating a model. The questions that I have regarding that model is the impact not only on the specific task, but also how does it impact the system not only immediately but in the future. When I ask the question whether at some point we want to see in our system, delivery system, ASCs that are not necessarily affiliated with a hospital. Is that the model that we're looking to move to? What would be the cost the savings implications and everything else involved with that. If that's the ultimate model that we want to get to, then in the infrastructure that we're putting together, we want to put those put some basic foundational structures in place that would allow that to happen. If you preclude those things from happening, then you essentially suffocate the opportunity. That's what I'm struggling with when you say hospital owned, because what happens when you say its hospital owned, you basically are shutting the door for some period of time for any evolution to take place. This will be like real evolution. I don't see a revolution happening in this.

Ms. Farrell Does that limit the geography hospital owned? Again, if we want accessibility across the state. I don't know the answer to it.

Ms. Monroe John, I think I had a comment.

Dr. Rugge I think that that we can't anticipate exactly how this is going to evolve, although we do know that across all of healthcare, so much care is evolving from being strictly located in the hospital setting to going to other settings. Here we're saying Phase One, Step One is removing having all the same standards of care but removing location from the hospital campus to a hospital-owned and facilitated, affiliated setting elsewhere. I think the one and only criterion we need, other than saying we're having the same regulatory standards, the same expectations, is what's the distance. That distance can be by helicopter, by a speedy ambulance or whatever, but there has to be a demonstration of meaningful, timely access in the event of a serious complication. I see it.

Ms. Monroe I would just rephrase what you said. We are not building a model. We're developing a model, which I think are two different things. We don't know what it might look like at the end. These are some baby steps to get the data and the information that we need to tell us that we might be able to move it further.

Mr. Lawrence I would accept the hospital incubating this model. Again, in terms of the future, if more and more services are moving into ambulatory care settings, leaving the hospitals for those more difficult and challenging inpatient. That seems to work in terms of efficiency and cost savings for a whole bunch of things. We have to line this incubation in such a way that that is allowed to occur at some later date.

Dr. Rugge That it just raised that possibility, that's for sure.

Dr. Soffel Harvey, I hear your point. I'm wondering if you look at the recommendations and we look at D, which is few additional considerations, we add a new Bullet 5 right under where it says future sites should include hospitals, blah, blah, blah, blah. Add a bullet that says future sites may include entities that are not hospital owned. It's there as an acknowledgement that in the future this is something that we might want to be considering.

Mr. Lawrence Yeah, that that would work. It's intentionality sort of thing.

Dr. Soffel No, I understand that. I understand that. And so, it seems to me that I if it's articulated that even though we say initially it is hospital owned only, that does not preclude the possibility that in the future that can be expanded to other ownership models as well.

Dr. Rugge Just to say that maybe be better formatted in an introductory statement about what this is all about rather than here under a specific recommendation.

Dr. Soffel Well, except that, Sean, we do say future sites should include hospitals with thoracic surgery, without surgery, outpatient procedures, blah, blah, blah. We talk about that set of future options. It seems perfectly consistent to then say in addition, future sites could include different ownership models as well. I'm talking about a D4, right, and add a new D5.

Mr. Robinson It may be philosophically a good thing to think about, but these kinds of facilities require capitalization. Therefore, the entities that would actually undertake to form these, establish these, would need to have access to capital. That starts to create a different dynamic because when you get capital invested in something, the people who make those capital investments want to return on that investment. We start to go down a very slippery slope here. That's why I'm a little bit cautious about even your recommendation. Please excuse me for pushing back. I just don't want to open the door unnecessarily. I think New York State has been fortunate in that we've kept at least certain things out of the bailiwick of the corporate practice of medicine, but not everything. I mean, we've got nursing homes. We've got ambulatory surgery centers now that are in the for-profit arena. I don't want us to take this particular technology in service, which is kind of being moved out of the hospital in order to create more capacity and to create better access but also create another opportunity to have another sector of health care moving into the proprietary realm.

Dr. Eisenstein Well, for the first time ever, I think I'm just going to disagree with you, Mr. Lawrence. The reason is because I think it's addressed in points A and B, what your concern is. Point A says New York should begin a process of expanding diagnostic and interventional cardiac catheterization into ambulatory surgery centers. Ambulatory surgery centers come in multiple different forms. This doesn't preclude any of it. The next one says we this should roll out in phases with future phases being built upon the learnings of earlier phases. The part that we're discussing is only about phase one and the learnings of Phase One. I don't think there's anything in the main points that precludes us from going anywhere with this. To me, I respectfully disagree that this precludes us from going anywhere in the future.

Mr. Lawrence I share the concerns about in about opening up the health care and especially at this level to for-profit and for-profit enterprise. I think I've said once before is that in a for-profit system, if there's a bottom line, the bottom line can go to buy someone's yacht as opposed to a not-for-profit system where in theory the dollars are recirculated into the delivery system. But at the same time, you know, the question is if this is happening in the rest of the country, and it is that the outcomes are better or not bad if it's comparable. Is this something that we should consider here in the state and look at? To look at whether it can make a difference in terms of access and provide opportunities because again the impact on this on this again we're making a decision looking at this particular process. Not

looking at the potential impact on the entire delivery system, which again, staffing, safety net hospitals. When I say staffing, you know, if one hospital has and hospitals in New York City are not equal. There are some that are very well off and have the capital to make those investments. There are others that are be you know basically struggling. Again, you have not an equally distributed number of resources. If we end up with a system in which these ambulatory care surgery centers are all opened by hospitals that are doing well in neighborhoods that may not need them, but in other neighborhoods we still have hospitals that are safety net hospitals that are basically struggling to keep their doors open. I don't see how that address the access issues, the health equity issues and so foreclosing the opportunity for some level of innovation and because I am assuming that at some point, to your point, capital is going to be required for these. I'm assuming also that this is a one of the procedures within an institutional setting that has a pretty robust margin compared to others. There's a good likelihood that capital will flow into to these types of ambulatory care centers.

Ms. Monroe Harvey, you must have been channeling you on the last column on the second last comment on the second page that says included would be the financial impact on the health system and individual hospitals, as well as identification of possible payment reform.

Mr. Lawrence Right, that's again we're building. I don't know. You say we're building a model or we're not building a model. We're setting.

Ms. Monroe We're moving down the road. I don't think we have a model.

Mr. Lawrence We're moving down the road. Again, ultimately the question is whether we want to see ambulatory care centers on a standalone basis involved.

Ms. Monroe And I would respond personally that only if the safety and effectiveness data justify that.

Mr. Lawrence That's a given. If you can't achieve that, then absolutely not, right? That's why I think incubation. The more challenging question for me is whether that's... You know, if we have an ACS on a standalone basis, how does that impact on access? How does that impact on cost in the entire system?

Dr. Soffel Well, I had a slightly different reaction to Peter's comment, which is, and I'm less sanguine than you perhaps about for-profits. I would be really happy if we had no for-profit healthcare business in the state of New York, but that's conversation for another day. I think that my concern about limiting to hospitals only is that hospitals in New York State already have an incredible amount of power and clout over the entire health care delivery system. To give them another piece exclusively under hospital auspice seems to me to work against the need to build nonhospital health care infrastructure across the state. I would really like to think that we could imagine this moving into entities that are not hospital owned at some point when safety has been proven. Because hospitals already have such a heavy hand on the scale in terms of health care delivery in the State of New York. They don't really need any more help.

Ms. Farrell The facility fees associated with hospital care are demonstrated to exceed, right? I mean it's very, very expensive when you look at procedures done in a hospital aligned facility. That's why, you know, so many hospitals were out buying up ambulatory surgery centers. Number one, you know, again, they want to control the patients, but it

costs twice as much when they're adding on facility fees as opposed to physician owned or otherwise owned ambulatory surgery facility.

Dr. Eisenstein Can I just counterpoint at risk of getting hit? Counterpoint is while hospitals... I'm going to disagree on your comment that hospitals have all the power and clout. They also have incredible regulation. That's protective of the patients. They have safety and quality reporting that has to be done. In the earliest phases, this is what we're trying to establish: safety and quality. At no point has anybody said that this shouldn't go in a direction where really anything can become of it. Well, but that's a down the road conversation. For right now, Phase One, you know, I think if we're going to approve safety, the regulation, the reporting, the quality requirements, the staffing requirements, all of that that goes with licensure, Article 28 licensure, joint commission requirements, all of that is going to be necessary, especially in the beginning to show the safety and efficacy that that that we're talking about. Just one other point, Mr. Lawrence. Just we saw, and I think you and I spoke similarly at a recent planning council planning meeting. We saw an ambulatory surgery center that went in front of us for a CON that was putting an ambulatory surgery center in a vulnerable community. Yet they were not anticipating seeing patients from that community for the most part. We grilled them and questioned them. I don't think we should just assume that taking it to there's going to be private entities that that do address health equity and there are going to be others that aren't as good actors that don't. I don't see how whether it's in a hospital or whether it's in a privately owned operation that doesn't automatically serve the access of the community. I think each situation in the future would have to be handled on an individual basis.

Dr. Friedrich I want to make a comment. I understood Mr. Lawrence differently, and that is a point that we Mrs. Soffel and I made at the last meeting if you erect barriers that are too high and saying its only hospital owned and they can only run that, you will not get the data to think about the later phases of this. It will skew the data towards the halves versus the have nots. That is like a big problem what I'm also seeing with Mr. Robinson's argument that maybe that at the end this even the Phase One will stall. Nobody will build and nobody will do this outside their hospital walls because the capital requirements are too high to erect surgical center. We have not even talked about should it be just for cardiac cath procedures or should it be for everything else. I'm heavily for having in any ambulatory surgical center it should be allowed. That's how I understood Mr. Lawrence that if you officially build the walls too high, the barriers too high for this program, even in Phase One, that you will not get the right data to have a meaningful discussion and a decision later on to expand it to other areas.

Mr. Lawrence Absolutely. That once it's built and it's open and it's running, then there's going to be a pylon for the folks that are that are able to pile on and everyone else it becomes a closed system at that point. I guess what I'm suggesting is that we have built into this up front is some opportunity or some intention to have potential to have it expanded. Again, I'm completely on the private side. I have some questions, but at the same time I think I made the point a while back that if there are opportunities for private monies to be brought into the system and still be controlled by not for profits I'm not sure. You know, that's a model that that might work.

Dr. Rugge Peter, I don't know why we're going there.

Mr. Robinson I'm feeling very flexible about extending it to other kinds of not-for-profit entities in the future. I just want to avoid private for-profit entities from starting to play a role a significant role in this. I bring back to your attention the history of dialysis in New York

State and what happened with that. We were struggling to regulate it and to control it and to ensure that these companies do the right thing.

Mr. Lawrence The reality is our system as it exists now. Private money is involved with not-for-profit institutions. They come in through the front door by grants and contributions. In a large part, they don't necessarily go to struggling safe net hospitals. Private money is already in, probably not in the operational side of things, but they contribute, they underwrite a lot of institutional a lot of the institutions in in in the health delivery system.

Dr. Rugge I'm just thinking this is sort of a sidetrack, may maybe not as an umbrella consideration. Why would we want to have more outpatient or ambulatory settings for cardiac caths? I think there are two reasons. One is improving access, dedication to underserved communities, and also geographic access in rural areas that especially now may be losing hospitals. The other is lower costs. The cost for ambulatory PCIs is $6,600 and forty 40 percent higher in the inpatient setting. Also, when we get into the financing issues, this becomes very complex because even though we have a not-for-profit system, New York has one of the most expensive, maybe the most expensive health care system of any state in the nation. It is not as if we've guaranteed financial savings by being not for profit, but those are bigger issues than we can deal with because it's a huge complex and insolvable crisis at this point. I think again if we keep our eyes on what our goals are that we are looking at more efficient use of services to make them more cost effective and we're looking at expanding access to people in need who may otherwise be excluded from care. All along the way we're going to look at outcomes and all the rest and we'll be very open in future phases to expanding In ways that we can't be sure of now.

Ms. Monroe I think that's a really valid point. I'm going to put a little pin in this one because we clearly have some strong opinions, let me say. This might be a perfect one where there's another underneath because we don't, but I'm going to propose this. One of the reasons we looked up the term straw dog, because we were going to use that term, and what it is something that's followed and then destroyed. Consider this statement a straw dog that I'm putting out there. Number one, C1, Phase One should be limited to hospitals that have ownership control. Do we want a hundred percent? Do we want just control? That may be debated. We may want to put that in the other as there we don't have full agreement on this. Also to say that nothing by limiting phase one to these providers would it limit the ability of future phases to be broader in their approach. Does that do it for now? We're only on one.

Mr. Lawrence Well, it's just if we can speak to intentionality.

Ms. Monroe Speak to what?

Mr. Lawrence To the intent is to get to Phase One. That the initial row out is limited to hospitals with the expectation that other not for profit entities may with experience. I'm looking at hospitals more of the incubators for this, so that they are, and I don't know how that happens. As an ASC, how do you get in how do you in fact do this independent of a hospital? It just doesn't seem like it's ever possible the way it's being controlled.

Ms. Monroe Well, I think let's put that off for right now.

Mr. Lawrence I'm just trying to find that link to how do you get an independent ASC to be in to operate in this in this space at some point because it they will never have an opportunity.

Ms. Monroe Phase One they won't have an opportunity.

Mr. Lawrence How would they in Phase Two?

Ms. Monroe The way the department writes it. We're expressing our commitment to further phases and f based on learnings, and that it's not our intent to limit it to what happens in Phase One. Beyond that, I don't know that we have any commitment say in this.

Ms. Farrell Again, just in lieu of hospital owned, controlled, whatever, we could insist on accreditation. There are accrediting bodies for ambulatory surgery centers that do PCI. I'm looking at it right now.

Dr. Heslin There are multiple accreditation centers. I don't know that that's the core discussion here though. I think the core discussion is... Is it always going to be controlled by the hospital is what Harvey is concerned about. The concern on the other side is that if we put too many restrictions in place, hospital-owned, that's one, right? Not for profit is a significant one because of the capital cost, unless somebody goes out and gets a grant, and New York State does lots of granting programs out there. There's a whole bunch of different ways to do that. But that being said, our principal concern at this committee from day one has been safety. Phase One needs to be the safe phase, and we do need, I think that the concept of starting off with a phase makes sense. The department's position was we didn't want to write two or three or four versions of regulation, which is why we thought the phase discussion was good, because we can move from one place to the next to the next. Knowing the intentionality, as you say, Harvey, of that the committee and others will want to move to different places. Doesn't necessarily have to be solved today. What we have to solve for today is what's going to be the beginning. Because there are going to be more bytes at the apple as this gets written, right? Because we haven't even defined phase two yet.

Mr. Lawrence While you were speaking, if we were to add with subsequent phases being open to non-hospital entities.

Dr. Heslin Well, I would suggest respectfully with subsequent phases being opened based upon safety being open to appropriate vendors, because essentially it's a vendor. Hospital's a vendor, a not for profit, FQHC's a vendor, they're vendors, right? We're agnostic to what the type of vendor it is.

Ms. Monroe Yeah. We'll figure out how to put that in there, Harvey, and so that it's clear. I'm going to put there's difference of opinion on whether controlling is sufficient or one hundred percent. I mean, cause we're not going to answer every possible thing.

Mr. Lawrence Well, if we have the subsequent bases being open to other vendors or other then I have no issue with that.

Ms. Monroe I'm going to make sure that's in there somewhere.

Mr. Lawrence Somewhere 100% ownership.

Ms. Monroe Let's take a vote.

Dr. Heslin Before you vote, let me just say Mr. Robinson's a hundred percent correct, which is it's very difficult to run a not-for-profit that has different controlling portions of ownership. It's either sort of an all or none type thing just in the business world. From a business perspective, he's pretty right on that.

Ms. Monroe Let's see if others perceive it that way. The question is, is it sufficient to say the hospital would have a controlling interest or do we want to say the hospital would be the one hundred percent owner?

Mr. Lawrence In Phase One.

Ms. Monroe In Phase One only.

Ms. Monroe Who's for controlling interest?

Ms. Monroe One, two, three, four.

Ms. Monroe Who's for one hundred percent ownership the first time through?

Ms. Monroe One, two, three, four, five, six.

Ms. Monroe I'm for a hundred percent.

Ms. Monroe And did you vote?

Ms. Monroe Hundred percent is what's going to go in the sentence, and the other is going to be.

Ms. Monroe This is all under Phase One, yes.

Ms. Monroe We'll have another... You know, some committee members thought controlling interest would be sufficient.

Mr. Lawrence Maybe I should ask what flows after con 100% ownership because I thought you accepted with subsequent phases.

Ms. Monroe Well, I said I'm going to make sure that the document refers

Mr. Lawrence I would like to see that up front with subsequent phases.

Ms. Monroe In that number, in number one.

Mr. Lawrence That's why I'm having a problem.

Dr. Rugge I think a way of expressing this as well. There's a unanimous agreement that should be hospital controlled, with a majority feeling that I that stipulating a hundred percent control in Phase One is key.

Mr. Lawrence With subsequent phases open not limited to hospital service.

Dr. Rugge Just would point out that in part what we're preparing for is the unknowable. Technology changes so fast that we can't predict what what's going on. Absolutely.

Therefore, keeping up with all the changes going on in the world and in medicine and healthcare is part of what we're doing. We can't wait to predict what's going to be the ultimate outcomes.

Ms. Monroe Let's go on to number two, that it should be limited to hospitals with existing cardiac programs Phase One now. Does anyone see it differently?

Dr. Friedrich We have to define cardiac programs. Do you mean cardiac thoracic surgery programs? Just repeating what Gene Heslin said before, we have to be precise. Like a cardiac program is to me a hospital that also does PCI but doesn't have a cardiac surgery program on it.

Ms. Monroe Well that's laid out in other phases that those descriptions of things.

Dr. Friedrich You mean with an existing cardiac surgery program?

Ms. Monroe Is that what it should say?

Ms. Monroe Existing cardiac surgery programs will be fined for Phase One. The ambulatory surgery centers will be required to use the hospital's quality review and data per reporting systems. They're owned somewhere.

Dr. Friedrich Should there be something in there because the cardiac program currently does not collect data on diagnostic halves that should be included there?

Ms. Monroe We may not. Put a pin in that. We'll come back to that.

Ms. Monroe Number three, they should be limited to nonprofit ASCs. They're a hundred percent hospital owned.

Ms. Monroe Pardon me?

Ms. Monroe I know, but there seemed to be in a lot of the discussion that we had a real concern that that be articulated.

Ms. Monroe Anyone else?

Ms. Monroe Oh, we got through two of 'me.

Ms. Monroe By the way, I think this is exactly what we should be doing. I know it can appear redundant and long, but this is important that it reflects our committee's work. Number four, as I mentioned to you

Mr. Lawrence What is the rationale again for limiting it squared eliminate it to nonprofit ASC?

Ms. Monroe Well, it's a hundred percent hospital owned.

Mr. Thomas I think for at least from my perspective, Harvey, in this state, hospitals are all not for profit. We are requiring the surgery centers to be controlled by hospitals. Hospitals can't control an ASC that is not owned and controlled, and I know there's a discussion about whether owned or controlled, but owned means 100 percent, and we talked about

that if the surgery center is owned a hundred percent by a hospital, it is going to be not-for-profit.

Mr. Lawrence I'm sorry. I didn't see Phase One.

Mr. Thomas I got it. The construct that how we build this. I don't mind saying it again.

Mr. Thomas There's no reason why a not-for-profit hospital that owns a surgery center would leave it in for profit solution. Why would it do that? It doesn't make any business sense. It doesn't make tax sense. It doesn't make capital sense. It doesn't. We're getting off into granularity. You're right, Gene, but I think we're... I'm with ya.

Dr. Rugge Some way by way of a requirement of the owner is the provision of assured urgent and emergency transportation

Ms. Monroe Where are you talking about that?

Dr. Rugge Well, some place. I'm not seeing any mention here of emergency transportation and that should be built in as an understood requirement.

Ms. Monroe Because I think that's a standard. We're not articulating

Dr. Rugge It's a standard but it's a service too.

Ms. Monroe If it's like equivalent of your ASC has to have certain transportation requirements, right Gene? Am I right about that?

Dr. Heslin One of the things we do want to be careful about as we look at these things is we don't want to build requirements necessarily that are more onerous than might be for hospitals that don't have surgery attached to them right now because many hospitals don't own their own ambulance squads. You have to meet the industry where it is. I think that if you're limiting it to hospitals with surgery, not all of them have their own ambulance squads either.

Dr. Rugge I don't think this has to be a hospital owned ambulance. There has to be a contractual or ownership relationship.

Dr. Heslin That's part of a standard is that there would be an appropriate transfer agreement, and it would involve the ambulance. It would involve the proper crews.

Dr. Rugge There needs to be absolute assurance that emergency transport is needed, which is one new feature that is not required on the hospital campus.

Dr. Heslin No, no, that actually is but John, that is required right now for hospitals that don't have surgery, that they have transfer agreements with availability of ambulances. That's already a requirement in the current world.

Dr. Eisenstein I don't think we're at this table qualified to determine what the appropriate level of transportation would be. That should be a matter of the experts in the field to determine that. So, their guidance, their guidance will be vital, whether it's the CAC or whatever the standards are for doing this kind of work. We certainly shouldn't be putting

anything in that we are dictating what the transportation we want safe transportation, but I don't know what that would be in this situation.

Dr. Heslin The more general statement is you want to have the appropriate safety requirements in place for patients to maintain a safe environment throughout the course of their procedure.

Ms. Monroe Is that important for us to say?

Dr. Heslin We've talked about safety throughout everything, so that is important to say.

Dr. Rugge An emergency transportation.

Dr. Heslin Because that covers everything. It covers your staffing issue, it covers your backup issues, it covers your emergency procedures, it covers your transport procedures, it covers your discharge procedure, it covers your post-discharge phone call procedure, because all that is part of a safe procedure being performed by somebody on somebody else. That one generic term covers it all. It's not for you to figure out what the specifics are, but it is important to say that the expectation is that this is going to be a safe process.

Ms. Monroe Well, I think we can clarify that in some of the earlier statements. I want to point to people in number four, and I I'm going to recommend that it go up to be number one because it is so important. But the bottom, the last part, a wide variety of indicators including social vulnerability indices, in other social determinants of health, including age. I don't know that access is included in those things, but it should be listed as one of the evaluation methods was access. Do you agree?

Ms. Monroe I don't know. That's up to these guys, the Cardiac Advisory Committee. I don't know. I just know it was important in our discussion. It was very important in our discussion.

Dr. Rugge Instead of being a standard, I think that's a goal and we're going to be measuring the effect of having more widely dispersed availability of cardiac caths and PCI, does that really expand access?

Ms. Monroe Only if it actually happens.

Dr. Rugge We'll know what it happens after we start to do it.

Ms. Monroe Well that's why shouldn't it be one of the measures?

Dr. Rugge Being a measure is... That is something we should certainly be measuring as an outcome. It's a goal. It's not something we can dictate to say for sure we're going to expand access. We're doing all this in order to expand access.

Ms. Monroe This says is that they'll use a variety of indicators and access would be one of them.

Dr. Soffel Ann, I'm asking a different question, which is having spent my life thinking about these issues, there is not a metric for access. There are multiple ways of that you can think about access, including taking Medicaid, including financial access, including geographic access, including hours of the day that are open. There are many, many ways to think

about access and barriers to access, and access per se is not the thing that you want. I understand the point, absolutely, a hundred percent. I'm not sure that there's a way to articulate data collection for an ambulatory surgery center that would grasp that. I just don't know.

Ms. Monroe Well, I don't either. I go back to Harvey's point that if you build it in an underserved community but or in Larry's point from the CON that was here last time, you build it in an underserved community but doesn't serve anybody from that community. How that's not what you want. What is that term that we want them to verify that this ASC, wherever it is, is achieving broad access? Is it payer source?

Mr. Lawrence It could be payer source. It could be demographics. It could if you're in a locum in a low-income area and everyone that's using the facility is high income, then speaks to your access. I don't know if it's something that we have to define here, but what we're doing is articulating what we'd like to have someone investigate.

Dr. Heslin That's more of a vision statement, but may I suggest that you in the opening statement that it's this is going to be centers that are owned by hospitals that do thoracic surgery, you've already biased the data pool because those centers tend to be socioeconomically different centers. They tend to be geographically located in certain areas and not in other areas. People tend to travel to those areas. By the natural state of the way you made your initial thought, which is that they're going to be surgery centers that do centers that do surgery, you've already biased the data of an access issue in terms of some of your geographics and economic demographics. I think it's going to be very hard to collect. I think it's a good aspiration, but I'm not sure that there's a way that is can be done that hasn't been biased already.

Mr. Lawrence I guess the aspiration it gives us an opportunity to ask the question when they arrive for approval.

Dr. Heslin Oh, I agree with that. I think that that has to be asked. It should be challenged. But at the end of the day, by the selection of the way, you know, if you open it up to every hospital in the state, geographically everybody's covered. If you do it at hospitals that do cardiac catheterization now with or without surgery, you get a large group. When you start to limit it to those that only do surgery, you've got a de minimis group of hospitals compared to the overall geography of the state. You've already limited two limits down. People, if we're going to put a distance, people aren't going to transport to a competitor, they're going to transport to mother ship.

Ms. Monroe If from Phase One you learn that by hooking it to a hospital that does surgery, you do not get broad community access. Therefore, Phase Two or Phase Three may need to be to broaden it beyond hospitals that do that do cardiac surgery if you want to get community access. How else do you get there?

Dr. Heslin No, no, that's exactly right. That's a very kind of gross view of access as opposed to a micro view of access, like down to a type of patient or a demographic or an insurance.

Ms. Monroe I do believe that's what the committee wants.

Mr. Lawrence I don't think it's necessarily a bad thing to have the hospital who's going to participate in this think about access.

Dr. Soffel I would suggest that we require a health equity impact assessment as part of the CON for these applications, because at least that's a tool that we have spent a lot of time thinking about and we know has some validity to it. I'm not sure whether they would automatically require one, but I think that we could certainly say as part of the approval process an HEIA must be done.

Mr. Robinson I don't think the data that we've been presented with so far actually suggest... It may be that it does that there is an access issue. We haven't actually seen data that says there is an access problem.

Ms. Monroe What do you mean?

Mr. Robinson Across New York State.

Mr. Robinson I mean, I think that the real question is if we start to create these centers... Are we going to see more of these procedures being done? Is it going to be the fact that those procedures are going to be done for populations, subgroups, either by payer or demographics or other kinds of things that have been underserved for this particular service? I don't think we know the answer to that.

Ms. Monroe No, we don't.

Mr. Robinson There may be unanswered. I think it's good that we try to do things that measure what's going on, and then we can determine whether we're having an impact or not. I don't necessarily know that we can predictively say we will.

Dr. Heslin On a percentage of population, we have some places that do a very small amount, and then we have other places that as a percentage of population do a much larger amount. While it doesn't suggest you can't get an absolute out of that because it's not been studied, so that you can't. It's not a data point. It's anecdotal. Anecdotally we know that either some people are doing way more than they should, or some people are just simply doing way less than they should.

Dr. Heslin And that's exactly the point. We don't know which one it is.

Mr. Perry We do know, based on the meeting minutes from the last meeting, item number seven, as new standards of care are being developed, limiting access for all, we know that access is an issue going into this project. It's critically important that we have some level of health equity assessment built into the project from day one to ensure that indeed we address what we've already agreed is an issue. Versus putting it off to Phase Two or Phase Three, which means that those folks who are limited now will continue to be limited until we get to the additional phase five years from now, ten years from now, fifteen years from now. I don't know. We already know that up front, because we stated in the minutes.

Dr. Heslin Yeah, and we also know that since the last meeting, Medicare has approved a new procedure for ambulatory surgery centers and has a new payment code out for ablations. That was just published about a week ago.

Dr. Rugge Since our last meeting.

Dr. Heslin They're actually expanding what they're allowing in ambulatory surgery centers to be done. Food for thought.

Dr. Ortiz I think from a health equity standpoint, I'm the current chair of the Health Equity Council, so I think I could bring this to the council to get their view on it. I want to go back to how this got on our agenda or for this committee. It wasn't that there were communities up at arms because they didn't have access. They said that there were hospitals and physician groups who wanted to have more capacity in the cath labs because of more complicated procedures. I'm trying to say true to what the problem statement was. What I'm not hearing is how are we going to measure health equity? Two, is it really a community problem right now? I'm not sure how we get at that, but I think if we take it to the Health Equity Council, we can at least have some discussion from their view about... Oh yeah, maybe they are hearing it in their in the community, but no one has asked them.

Dr. Heslin Good point.

Dr. Ortiz We're meeting on Friday. I'm not sure if I can squeeze it on the agenda this Friday.

Dr. Eisenstein And if I can along those lines, Dr. Heslin mentioned one of the main impetus of doing this in the first place, because access has a lot of different definitions, is that cath lab space was limited in some regions because of doing more complicated procedures like ablation. Are we solving that the how long people are waiting for ablation by doing this? Are we impacting that access problem, which I mean, but it's something that can be measured is what I'm suggesting going forward, because if that's an impetus for doing this, we should know that we're solving the problem as we do it.

Dr. Heslin We'd have to have a substantial number of these labs up and running in order to make that type of decision. Cause a one off you're not going to be able to do access. If you have five of these around the state, you're not going to be able to really have a robust access discussion. You could have a safety discussion. You have to have a density of centers in order to be able to understand have your impact access. Cause a one off isn't going to do it. It's not enough data.

Mr. Robinson I think the other thing is the prior approval issue on some of these procedures and how that affects access as well.

Ms. Monroe I want to have us all take a break in just a minute, but I'd like to finish the page. Number five says that DOH will approve these things through their process, but we expect there to be a time limited CON and I've added to that a Health Equity Impact Assessment for each of these.

Ms. Monroe Is there any disagreement with that?

Ms. Monroe I don't know if I worded it right. I don't know. It should be that these have to come through the CON process, and they need to have a Health Equity Impact Assessment. I don't know if it's brand new how you do one of those, but that's not up to me to decide.

Ms. Monroe Any disagreement, any comment, any people are okay with that?

Ms. Monroe It's 2:25pm. Let's take ten minutes, and then we'll come back and power through the rest of this.

Dr. Rugge I would only suggest before we conclude, we do need a vote. We need a resolution to thank Abby for making sense of all of this and having a coherent statement of exactly what we're all saying.

Ms. Monroe Along with clinical patient selection criteria, which we know will come from the Cardiac Advisory Committee. There also needs to be Medicaid and low-income commercial patients as part of the initial rollout.

Ms. Monroe Any objection, any comments, any thoughts?

Dr. Rugge What happens if in one program or another those people are not included?

Ms. Monroe When it comes to us, we wouldn't approve it. I don't know what the department will do with that.

Dr. Heslin There are two things. First is that we would expect that a CON for any ambulatory surgery center would have its percentages of projections for low income and Medicaid and others. Second is my understanding was this committee was considering saying that this was going to be a limited CON and so they're going to have to come back to the council for full approval of that CON. I think that you have two controls in place that were built around the current ASC world already to that statement. I think it's important to say it, but you do have controls already as the Public Health Council.

Ms. Monroe I think we have to rely on those.

Ms. Monroe Any questions about number six?

Ms. Monroe Number seven, if you remember, came up when Lois Utley from what was the name of her group? I always forget it. Anyway, she's an advocate. They were really excited to be included in this discussion but really took it from the perspective of consumers and patients need to understand why they're going to a different place, what that's about, and make sure that they're educated about the procedure, etcetera. Any concerns about that?

Dr. Rugge Just important for patients to know what their options are.

Ms. Monroe Yeah, that's part of it.

Mr. Perry My only concern would be patient choice and based on the recommendation from the assessment of that particular patient, would they still have the choice to say, I prefer to have this procedure in a different setting, a hospital setting with all the trappings around it?

Ms. Monroe That's an interesting question. I think what you're saying is that if I'm now being referred to the ASC, which is not in my neighborhood where the hospital where I'm familiar with and I have to take a different subway to get there or whatever, do I have the option as a patient to say I would prefer to be treated in the hospital?

Mr. Perry Exactly.

Ms. Monroe Would they have that right today? Would they have that right with this phase?

Dr. Heslin I think that depends on the clinician, right? Because right now it's patient and clinician discussion. Because someone who has a hip replacement, you know, if their physician says I'm going to do it here and the patient doesn't want it done there, they have to choose a different clinician. I don't know that there's ever been the time where... A patient can say I want to have a procedure done here, but the physician can say they don't want to do that. That's true of all procedures. It's that's that physician-patient relationship and discussion that occurs.

Ms. Monroe It also may be if they have moved all of their cardiac cath to the ASC, you couldn't have it done at the hospital. There wouldn't be a choice.

Mr. Perry There wouldn't be a choice.

Mr. Thomas In this whole conversation, we're limiting, at least in Phase One, the availability of ambulatory surgery center cath procedures, PCI or catheterizations, to very small percentage of the of the population, which means that the sponsoring organizations will be maintaining a fully operational cath lab that could be available. If my cardiologist said you're just not a good candidate for ambulatory surgery center cath lab. I'm going to do you in the hospital. I mean, that's the conversation when that would happen. Whether it's a cath or a hip or a knee, it's going to be at least that's in my experience that comes down to the physician and their patient and their decision. Yes, if all moved out, I'd say that given the way this is structured that's pretty unlikely at least in Phase One.

Ms. Monroe What we might say is that the consumer patient education program would include a discussion of patient choice where available.

Mr. Perry That would be great.

Ms. Monroe I like you.

Ms. Monroe Got it.

Ms. Monroe The next section D could be for Phase One but could be for all the other phases too. It's not limited to phase one. I took this, Gene, from something you had written about the society's ethical considerations, and I don't know exactly what that is.

Dr. Heslin They had a series of ethical considerations, specifically the one that we had spoken about was if a person didn't have the ability to be supported at home, they had to be done as an inpatient. That was the principal one that we had spoken about. We want to make sure that a patient going through a procedure is safe. Safe starts at the discussion of that you need it done and what the options are, to where you need to have it done and the options are, because this is part of shared decision making. The final piece of safe is that when you go home, you're in an environment that you're safe. If you have a catheterization that's done through your leg, you might have a bigger complication of breath bleeding versus the wrist, which is a lower complication of bleeding, the two principal access sites. If you're home living by yourself and you're in a six story walk up, you have to walk up six stories, you have nobody else around or can be with you... That might not be deemed safe. Therefore, the type of person would be considered for an inpatient, regardless of whether it's being done at an ambulatory center.

Ms. Monroe By using that as an example support at home It gives some definition to the term ethical.

Dr. Soffel I would like to add. There was a s couple of slides in the presentation that I was really sort of impressed by. They talked about that, but they also talked about conflict of interest potentially when a physician is a partial owner of a center, that they may have it escalates concerns about cherry picking of patients and patients during and patients being denied access to care. They had a couple of bullets that kind of spoke about that set of issues that I think are important for us to keep on the table.

Dr. Heslin We won't have that because since we're doing Phase One as a hospital owned not for profit, by definition, they can't own it.

Dr. Soffel I understand but it says for additional phases. I can read.

All (Laughing)

Ms. Monroe If there are a number of them, can we just leave it as ethical considerations or do we need to articulate them?

Dr. Soffel I would think it was it's worth going back to their slides and sort of saying that these are the three that we think are really critical.

Ms. Monroe By tomorrow morning we have to do this.

Dr. Heslin Again, all of the slides and all of the minutes are part of the whole packet that we have. I think it's enough to say that, you know, we're going to be evaluating for a corporation the entirety of what they have in their ethical considerations, right? We're not picking or choosing one or two or three, but we're going to evaluate all of them.

Ms. Monroe Any questions on those?

Dr. Eisenstein We have the expertise to determine which patients qualify or don't. I think that the ethical point is to follow the standards of care by the experts.

Ms. Monroe We're going to move on from that one. Everybody okay?

Ms. Monroe We go as the phases and learnings evolve, these programs should be located in different geographic and demographic parts of the state to better understand the impact of using an ambulatory surgery center site. Do we want the word should?

Ms. Monroe Well, that's even more definitive. I was wondering if it needed to be less definitive. I don't know.

Dr. Rugge Are to be located?

Ms. Monroe If it's okay, I'm going to just leave it alone. I think it does the same thing, should and will and are, as opposed to possibly should, will, or was my only question. We'll leave it the way it is for now.

Ms. Monroe Three, consider appropriate nursing staffing and credentialing for ambulatory surgery centers. I didn't know about the word consider and I'm going to ask you, Dr. Ortiz, about that. What how should this do we want to implement appropriate nursing staffing and credentialing?

Dr. Ortiz It's required now. Currently, they have to be like ACLS. They have to have so much cardiac experience. It's pretty much laid out whether they use the amplitude care nursing scope or they use emergency cardiac. I think it's pretty, but the word consider probably isn't.

Ms. Monroe Would require be an appropriate one?

Dr. Heslin Respectfully, I would like to add to this area because this is nursing, staffing and credentialing, but I think we also need to have something in there about appropriate site and equipment and appropriate safety and emergency protocols consistent with industry standards. We would outline not just the nursing but also the physician, ancillary support staff and the soup to nuts from when you meet the person at the front door till their discharge.

Ms. Monroe I think it can just say appropriate staffing.

Dr. Heslin Appropriate staffing and credentialing. I'd also put in about the construction piece. I'd put in about the emergency procedures piece. I would be very prescriptive about those two.

Mr. Perry And that includes transportation as well.

Dr. Heslin Emergency procedures would include everything from... You know, you need a band aid to full resuscitation, transport, et cetera.

Ms. Monroe Necessary and appropriate.

Ms. Monroe Are we okay with that, Larry?

Dr. Eisenstein One more thing. I didn't bring up this point, but a few people did throughout our discussions is that there's a nursing shortage to begin with, and this could have a structural impact. I think as part of our assessment of Phase One, we need to determine if it put a stress within other nursing facilities, because this is going to be you know, highly sought after.

Dr. Heslin Facility A pays a dollar more, Facility B then pays a dollar fifty more, then Facility C pays a dollar seventy-five more, and then you go back around the loop, and they all steal from each other in a community. That's the common practice right now. That's the world that exists. We have physicians that change the side of the street in communities based upon their ability to get reimbursement. Unfortunately, that's the capitalistic side of our not-for-profit system.

Dr. Ortiz To your point, there is in the standard that nursing services within ambulatory care centers they cannot report directly to physicians. They have to report to like a charge nurse or a head nurse. Your point is well taken. If they want something with experience and management experience, they're going to just shift people. I would imagine they would move them from the campus to the ACS. We don't know.

Dr. Heslin That would be based where the standards are. One of the things that came up, and I don't know what the right timing is, but there was one discussion. I can't remember who brought it up. About the seasoned ability of the clinicians to practice outside of their mothership. I know that when diagnostics were first done in hospitals without surgery, since they weren't doing a lot of them, they had to be married to a hospital that had surgery, and then they had to actually go there and do procedures and train in those centers in addition to working in their communities, and they did this back and forth thing for a couple years while those centers were building up to maintain skill sets and quality control. There's a variety of different ways to address that. It's all part of what happened.

Ms. Monroe This next one I think talks about what possible future sites there would be. In the spirit of the discussion that we've had, I'd like to start that sentence by saying among other possible sites, comma, future sites could include hospitals with thoracic surgery, hospitals without outpatient procedures, da da da, and other ASCs.

Dr. Heslin As point of clarification, we're already in Phase One doing hospitals with the classic surface. That one might not need to be on the list.

Ms. Monroe That could continue. You could continue to have those.

Ms. Monroe Let me think about that. Is that okay if I think about it?

Ms. Monroe Harvey, I think that covers a lot of what you've talked about too, to make sure that it's broader.

Ms. Monroe Did you have a question, Abby? Did you say something?

Dr. Soffel I wanted a new bullet, so hold that thought.

Ms. Monroe Did you have something? I want to make sure that we get this one nailed down.

Dr. Soffel Peter is raising a question that I had raised earlier, but it was not about this bullet. It was about p potentially adding an additional bullet. I suggested to him that adding it there is not where it belongs. In my mind, it belongs in its own separate bullet about future sites and different ownership sites, rather than adding ownership to or taking it away from the future sites, meaning the types of places, in response to Harvey's question or concern because I had suggested that.

Dr. Soffel No, separate bullet.

Dr. Heslin If you look up on the board, what Abby has done is she has...

Ms. Monroe I can't read that at all.

Dr. Heslin it says D5 add new D5 bullet to state that future sites should include different types.

Dr. Soffel Could.

Ms. Monroe Are we satisfied with that one?

Mr. Perry Adding the not-for-profit component to ownership, is that what you're asking?

Dr. Soffel That's what Peter is suggesting.

Mr. Perry She said it'll be satisfied with what Peter suggested.

Ms. Monroe I think I need a little help. I'm not sure that I'm tracking right this moment.

Ms. Monroe Well I've tried to look down there and I can't see it.

Ms. Monroe Add new D5 bullet could include different types of ownership. What is your point?

Dr. Heslin Peter wants it to be all an only not for profit system. He doesn't want there to be any for profit.

Ms. Monroe Is everyone in agreement on that, that it must always be in the not-for-profit world?

Dr. Ortiz Didn't originally some physician groups come forward to the department too?

Ms. Monroe Yes.

Dr. Ortiz Would they always be not profit?

Ms. Monroe They're not.

Dr. Ortiz Would this proposed regulation meet their needs?

Ms. Monroe I don't want to limit the future development of these things. The fact that we would look at others different sites and we could look at different ownership models.

Ms. Monroe How about this? We show it as another.

Mr. Robinson Let me just say this. I think that broadly speaking, this is a bigger issue in this particular sector, right? I think in general for New York State, do we want to continue to expand those parts of the health care delivery system that are in the for-profit world? We are now seeing venture funds buying primary care practice. Health equity, we will lose the ability to ensure access to everyone if we allow that to continue. We struggle with those things right now that are in the for-profit sector, and we're constantly trying to enforce regulations that require for-profit operators to create the kind of access and payer mix access and other kinds of things that we're looking for. I feel very strongly about this that we don't want to open the door again to more of that. I would rather we start at the not-for-profit rather than create already an opening where this thing can go in that direction too. That's how.

Ms. Monroe That's a powerful statement, and I think we need to, for general consensus, we need to get a sense of the group. One option is to include in possible sites and possible ownership ma different ownership models and have a disclaimer in that that some people feel that it must always be nonprofit, so that's one option. The other option is that

we reverse that. We don't consider other ownership models, but in the disclaimer underneath it, we point that some people believe that that should be able to be added.

Ms. Monroe The first one is that we do not add the option of other ownership models but rather show that as a disclaimer. Who believes that to be the case? Did I confuse myself?

Dr. Soffel The distinction that you were making was either to say potential types of ownership include and not limit it to not for profit and then have a disclaimer that says some people think not for profit only.

Ms. Monroe That's the vote.

Dr. Soffel Versus the include different types of not-for-profit ownership and others say they don't they would like to see.

Ms. Monroe The point is in the write up it would allow all kinds of different models. We don't know what they would look like. You know, Starbucks may move into that marina.

Ms. Monroe The disagreement would be that only nonprofits would be allowed.

Dr. Soffel That's number one.

Ms. Monroe That's number one.

Ms. Monroe I'm asking for support or disagreement with number one.

Mr. Lawrence I am not disagreeing, I guess I'm just challenging whether we know enough to make that to accept and state that we shouldn't have not... We should only have not for profits.

Ms. Monroe Well that's what this would say. We could look at all kinds of ownership. The disagreement would be the members who feel it must be nonprofit. They must be nonprofit.

Dr. Rugge We're not really in a position to dictate that. We can make we can make that a suggestion for the future, but five years from now this committee might change its mind.

Ms. Monroe Are we clear?

Ms. Monroe I mean, it's been a long day. I'll try it once more. I think I'm in agreement with you, Harvey. The number one is that we would allow that in future phases, different ownership models could be considered. If we write that, we'll write a disclaimer that there are some members who believe it should only be nonprofit. That's one. The other is the reverse. That we only want nonprofits and that there are some members who think we should have more. We're going to go with number one. We'll allow other ownership models. The disclaimer are those who want only nonprofits. That's option one. Who agrees with that option?

Dr. Ortiz Can we have a point of clarification?

Dr. Ortiz What's the structure when hospital or health systems have an agreement or a contract with a physician group for specific services? Would they be negated from this?

Ms. Monroe I have no idea.

Dr. Ortiz Okay, but the hospital's paying the service agreement.

Dr. Ortiz I just wanted to make sure that was clear.

Ms. Monroe Are you clear now?

Dr. Ortiz Yeah.

Ms. Monroe More different ownership models with a disclaimer that it should be nonprofit only. Let's see votes.

Ms. Monroe Thank you, Marcus.

Ms. Monroe The reverse, I just want to see where people are voting, is that it should be nonprofits. There's a disclaimer that some believe there should be other models. Well, that's clearly the more the decision of the group. Both will be represented, one as the general consensus and one as a disclaimer.

Ms. Monroe There's one more, which is that as Gene advised John and I, it's going to fall under the Cardiac Advisory Committee to manage all of this, that that's their business. We want PHHPC to have a role in this after all that we have invested in it. And so, we want periodic reports to us on what data they're learning, what findings they're having, what success, what challenges, and as I said, the financial impact on the health system and individual hospitals, as well as identification of possible payment reform.

Mr. Robinson I think that's so important. I agree with that. The reason it's important is because we're still going to be doing a case-by-case CON review of any application. For us to get the input from the Cardiac Advisory Committee to further inform our knowledge can only be valuable. I think that's exactly the way it should be.

Ms. Monroe I would add it can only be valuable and absolutely necessary if we're going to know what to do with those CON's when they come forward.

Dr. Heslin I would think that that's part of a continued education program, which I think is right. The one piece I will add, if we only have one or two of these in the state, you're probably not getting robust financial impact on the health system or you might get it on the hospital that's there, but it one or two isn't going to give you robust information. Safety, quality, program evolution, all the rest of those things. I just caution expectations that you're going to have financial impact on the health system with one or two or three of these things around the state. It's just not a big enough N to be able to get you to that place.

Dr. Rugge Do we have a target?

Dr. Heslin No, I don't have a target. It has to be enough density in the model to actually impact change. One center is probably not going to be enough density in any area to impact enough change to actually show up more than a rounding error. That's the problem with statistics. You've got to have density to be able to get that.

Ms. Monroe I also think there's the idea of hope. I hope we learn from these things enough. You might not see it as robust data, but I like the term because it means you put some time and effort into this to make it as good as it could be.

Dr. Heslin No, no, I agree with that. Again, one of the things that we're doing this way is because there isn't robust data in the country. We've argued all along there's no robust data because there's a paucity of these things that exist. I'm just pointing out that if we only have a few of these, you're not getting robust data. You get anecdotal pointed data in certain areas that could be robust.

Ms. Monroe Do people want me to take that out?

Dr. Heslin No, it should stay. I'm just tampering expectation.

Mr. Lawrence I think it should stay. I think that, you know, although you won't have data that would impact on the system, you'll have data that in that immediate neighborhood or that again will give you some you could separate the noise and then pull out. We know this is happening with the staffing. We know that this is happening in terms of the cost for the procedures. Those are things that you could use to extrapolate if you had four or five of them in different neighborhoods.

Dr. Heslin Again, it depends upon density and things like that. One of the things I just want to be careful about is setting an expectation because when you put it in writing, five years from now, when nobody around this table remembers that we did this and somebody looks back and goes, Oh, look at that. We are going to do this. We would do that. History rewrites itself. I'm just being very clear about density, population, workload.

Ms. Monroe I appreciate that very much. I at the same time it's our job to come up with recommendations. If we think it's important enough to put in there, I think we should put it in there.

Dr. Heslin I'm going to point out there has to be a business case to stand up against that because one of the things that we always struggle with in anything we do is what's high value and high value impact versus low value and low value impact and where do scant resources that we have that are becoming scanter come?

Mr. Lawrence The number of ASCs that we are going to allow to enter into this?

Dr. Heslin The answer is you've already done that because you've limited it to the hospitals that only do surgery, which is a de minimis amount of the hospitals in New York State. You've already built the limitation in Phase One.

Mr. Lawrence That limitation is not geographic for those hospitals, are they?

Dr. Heslin It's somewhat geographic because you wouldn't expect a hospital that is doing thoracic surgery to put one of these centers too far away because then they can't do the transport. You have limited it probably to where mothership is going to be that does that geography that does that surgery. You're not going to have somebody out on the island where many of them do cardiac surgery put something up in the North Country. They just not going to do it because they can't geographically apply that person.

Mr. Lawrence Theoretically, how many of these centers based on the number of hospitals that are will be affected, how many of these will be would do you anticipate?

Dr. Heslin Depends on where in the state. Out on Long Island, a lot of them do thoracic surgery. There are ten or eleven of them out there of the twenty-six hospitals that are on the island, twenty-three of them do cardiac catheterization.

Mr. Lawrence You would expect all of them to.

Dr. Heslin No, I don't expect all of them, but some of them might, right?

Dr. Heslin A half a dozen of them do surgery on the island, right? A half a dozen of them in New York City do surgery. When you start getting up, you know, you got Albany Med and St. Peter's that do surgery and then nothing does surgery north of there to the Canadian border or all across Tug Hill. You got twenty-five percent of geography of New York State that doesn't do surgery. That's a reality.

Dr. Friedrich I think that that is an important like question as well. Another important question that we have not put in our recommendations if we want to allow multi-specialty versus, you know, we're just having an ambulatory surgical center for cardiac cath or allow that be done in an es existing ambulatory surgical center that already does joint replacement or something like that.

Dr. Rugge I think we've already designated what the expectations and the requirements are to be. We don't need to go about single specialty or multi-specialty.

Ms. Monroe This has been a long afternoon. You guys have hung in there. This is really appreciated. We've done a lot of good work together. The idea is that tomorrow John, and I will present. Tonight, Abby and I will write up a new list of recommendations and we'll do our absolute best to get everything in that we talked about. We're presenting it to the council tomorrow. My hope... Our hope, I should say is that they don't try to wordsmith it at council. They're coming the way they are. I don't know what they're going to do with it tomorrow, if they're going to try and vote on it or not... That's up to them. If they want to have a further discussion with us, maybe at the next council meeting. There's things in our recommendations that they're not clear about, just like it has been here. We're happy to have that discussion. We're not opening it up tomorrow for them to go... Is robust the right word in this document? What does a disagreement statement mean? Are people in comfortable with that if we do it that way? Harvey, I'm looking for a nod from you. You're supporting us going forward with this.

Dr. Heslin The one thing the department would like is that we'd like to have this sooner than later because we see the need to start to get this written.

Ms. Monroe You mean sooner than tomorrow?

Dr. Heslin No, I mean if the if the council is amenable to submitting this for consideration, this goes a long way in partnership with the Cardiac Advisory Committee to getting the draft regulation written. We're not moving forward until we have a good understanding of what our two main leadership groups are giving us.

Mr. Robinson I would just have a conversation with Jeff to brief him on what your intentions are, so he's prepared. I'm sure he'll agree with that. I think it would be good to just kind of like make sure he's on board with this approach.

Ms. Monroe Maybe we can talk, John can talk to him before tomorrow.

Mr. Robinson Have a conversation with John.

Mr. Thomas Gene, you're not looking for approval tomorrow?

Dr. Heslin I would like to have it approved. If it's substantially done, I'd like to have it approved.

Dr. Rugge Approved for consideration?

Dr. Heslin It's approved for consideration. This is all being submitted as recommendation for consideration for the department to write. What the goal is for us to get the committee's thoughts codified to a place where we can actually start utilizing them.

Mr. Robinson Ann, maybe what we can do, and John is present to the council for information the recommendations from the Planning Committee that are being submitted to the department. This way you're not even forced to go into a vote of the full council, but the Planning Committee.

Ms. Monroe Our role is to present our recommendations to the council. I don't think we should go be going around the council.

Mr. Robinson I'm trying to find a way to sort of like expedite what Dr. Heslin wants to do in terms of kind of moving this forward.

Dr. Heslin I guess my question is, once this is Abby and Ann tonight into this digested form, we've had two kind of conclusive meetings. How many more conclusive meetings is the Planning Committee going to have to discuss this? Is this being presented to the council?

Mr. Robinson We're done.

Dr. Heslin If you're done, then the council isn't going to wordsmith it, are they?

Dr. Soffel That's what I think.

Dr. Heslin I'm trying to get to. They need to review. Tomorrow will be the review then.

Mr. Lawrence Whatever the department comes up with will ultimately have to be approved by the council.

Dr. Heslin What happens is we're going to take all of this work that's been done, these recommendations for consideration, the recommendations that come from the Cardiac Advisory Committee, that's all going to be put together, and we're going to sit down and we're going to try to craft a regulation out of all those different thoughts. What's going to then happen is it's going to go through the regular regulatory process, which means that it goes through the internal regulatory process for the department, a couple of months, and

then it goes out to Codes Committee, it gets read at Codes Committee, it goes through the full process. We have that diagram, that big page, that eighteen months of page that goes through the whole process, and then we go through and then it has to be approved, and then it goes on from there.

Mr. Lawrence The committee has worked to come up with a proposal on behalf of the council, the full council is now presenting that to the full council for the full council's consideration. The council will then have another opportunity to have a vote on that at some with the Codes Committee.

Dr. Rugge One is planning it out and helping to configure the regulations. Another is final approval regulations. The third is implementing those regulations on a case-by-case basis.

Mr. Lawrence The council then would be asked tomorrow to accept the recommendation of the committee. I'm just wanting to clarify that.

Ms. Ngwashi Marthe Ngwashi, attorney at the Department of Health. I want to just clarify the processes that are being discussed right now about what has been discussed today. You have some recommendations that you would like to present to the full council. However, I don't know that what has been discussed today is on something that is presentable to the full council tomorrow. Now, if I missed that and there is something that's already produced as a result of the conversation today that's ready for you guys to consider that can go to the full council tomorrow, then I would like to see that, but I haven't seen that yet. That's why I wanted to just make sure I understand what you're discussing and what the steps are going to be before we start talking about regulations.

Dr. Rugge I don't think we're asking for them to approve our recommendations as a council, but instead the council authorizing the committee to release its recommendations to the Department of Health for its consideration.

Ms. Ngwashi Even so the recommendations that you have discussed today are not in a form that you can go to the council tomorrow to say this is what... Are you going to have another meeting to say this is what we talked about. Everybody on this committee has agreed to this. You wouldn't be able to just say we've had the discussion today. Nobody has seen the final draft of the document about the recommendations. However, we want the full council to authorize anything moving forward. It can't follow that way.

Dr. Rugge It seems to me we're engaged in a collaborative move. We're not issuing regulations here or final documents. We're based on all the conversation we've had, we're asking the council to allow us to submit on behalf of the council these recommendations for consideration by the department and we will be as a council reviewing them and continuing to move forward.

Ms. Ngwashi Sure.

Ms. Ngwashi When you have the document with those recommendations, I think then that time it would be appropriate to make to present that question to the full council.

Dr. Rugge You're saying the department won't be ordered to address these recommendations until we have another council meeting?

Ms. Ngwashi I don't even think you can address them because I can sit and start asking each one of these members what are the recommendations? Would you be able to tell me based on your discussion today? Who should go to the council?

Dr. Soffel I would like to raise a point that I raised early, which is if I were a council member not on this committee, I would not be comfortable with being handed something so complex in a ten-minute presentation and told I had to vote yay or nay. I don't think that's a fair position to put our fellow council members in, because I certainly would not be happy. Even if I trusted everybody on this committee implicitly, I would still like to have some time to think about it, to review it, to read the document and to have questions.

Dr. Soffel I think that a presentation that says here's the gist of where we are, and you will be receiving as soon as it's finalized a list of the committee recommendations, and we will be discussing it at the next full council meeting for full council sign-off.

Dr. Rugge Should we have a committee meeting then before that council meeting?

Ms. Monroe We don't need to what?

Dr. Soffel Have another committee meeting. I think that as long as you circulate a document and we all say yes, that in fact reflects my understanding of what we agreed to, then we don't need to have another meeting.

Mr. Lawrence We just had a formal vote on the recommendations. Does that count at all?

Ms. Ngwashi What I need to understand is you had a formal vote on what recommendations.

Mr. Lawrence The draft that we would propose.

Ms. Ngwashi A draft of what everybody really pretty much has in notes somewhere. There's nothing that is definitive for any of us to see. I have my notes. You probably have your notes. The full council so that you can let them know at what stage you're at. It's just that I don't know that you have anything finalized yet for even this committee's consideration. If you have edits to it, etc. You know, I think there was a lot of meaningful discussion today, and to take it to the next step without even people having the benefit of looking at what the discussion today entailed. I don't know that you're losing anything by preparing the document prior to asking for that of the council.

Mr. Lawrence If we were to have a final draft of that document and then have it circulated this evening.

Ms. Ngwashi Which is what?

Mr. Lawrence Vote by email would that be sufficient to at least present it to the council not for necessarily for action but essentially to be at the starting gate. Would that that process be sufficient?

Ms. Ngwashi I think I'm just trying to understand what the race is here. Is there some sort of time implication?

Dr. Heslin We would like to get this done. We've been asked to get this done sooner than later.

Ms. Ngwashi Sure, I understand that. You still have to follow a process.

Dr. Heslin We can take this outside the room.

Ms. Ngwashi What you're going to do later.

Ms. Monroe Well, I think there's two things. When I write it tonight, we can present it tomorrow as close to a final. We can have it finalized through email and telephone if necessary. We can maybe but not before the meeting tomorrow.

Dr. Heslin What's going to happen is this. We can get the draft done. Dr. Rugge and Ann can present where we're at tomorrow, which is substantively done. We can then turn around.

Dr. Heslin Are you paying attention?

Ms. Ngwashi I'm sorry.

Dr. Heslin Thank you.

Dr. Heslin We can present it tomorrow as substantively done. We can then have a committee meeting to review the draft, have the draft approved, and then at the February meeting we can then present the final document, which everybody will have ample time to be able to read, to be able to then have the document accepted by the full council if they so choose. That solves for all the problems because it completes the document, gives this committee a chance to review it and then vote on it, which is then a finalized document, gives the council the ability to review it and plenty of time to read it, and then gives them the ability to make a decision on it at the February meeting. Does that meet the needs?

Ms. Ngwashi I didn't hear what is happening tomorrow.

Dr. Heslin It was a discussion of what happened at today's meeting, a substantive review of what happened at today's meeting for informational purposes.

Dr. Rugge To be a progress report on behalf of the committee...true?

Dr. Heslin Correct.

Ms. Monroe Will we need to submit anything tomorrow or could John and I do a verbal report, which means I don't have to stay up all night and write this.

Ms. Ngwashi I think what you would do is the same thing you would do at any council meeting.

Ms. Monroe I'm sorry.

Ms. Ngwashi You would do is the same thing you would do at any council meeting.

Ms. Monroe John could talk about the process and I could walk through the various recommendations without handing out a piece of paper.

Ms. Ngwashi Whatever you would do for a full council meeting to discuss what your committee talked about is what you can do for tomorrow.

Dr. Rugge There's no legal requirement for us to deliver paperwork. We have to deliver a progress paperwork.

Ms. Monroe Marcus.

Dr. Friedrich I'm just wondering because we have like Codes Committee meeting in the beginning of full council meetings, and you know if the deciding factor is that we need a vote on something... You know, all of us will probably be attending tomorrow anyway. If we have another Health Planning Committee tomorrow, before the full council meeting that will not be, and we vote on the recommendation.

Dr. Heslin I would recommend no. The reason I recommend no is because even if we had that done in that period of time and it was a document that everybody accepted, the council would not have the time to then review it with enough time to feel comfortable going through all the nuances of the document. If we're not going to a finalization tomorrow, it doesn't make sense to put extraordinary stressors on the committee and others.

Mr. Lawrence Is it possible to have the draft that we worked on printed down, circulated, and have one final edit and then vote on that as a committee before we leave today?

Dr. Heslin No.

Mr. Lawrence No.

Dr. Heslin No, we've gotten pages of notes.

Ms. Monroe A I maybe could have done it, not AM.

Ms. Monroe I guess my question to the department is will you be able to use our draft to begin your thinking?

Dr. Rugge Only in secret.

Dr. Heslin Long before we even contemplated having our first meeting, I've been using your comments for my thinking, Ann.

Ms. Monroe That's what you'll have to put up with then.

Mr. Robinson No, but I think your point is well taken. If the department can say, you know, we've got this preliminary information, it hasn't gone through and been vetted. Because you're also taking input from the Cardiac Advisory Committee and other groups, you can start to w work in anticipation of... You can still... Getting the final confirmation from the council on its recommendations may require you to tweak a little bit, but I think it you will at least be able to sort of work in parallel rather than working in sequence.

Dr. Heslin We've got good directional understanding of what's happening at this point in time. There's good directional understanding.

Dr. Ortiz This is a question for Marthe. Are these committees able to do any work not in a formal setting?

Ms. Ngwashi No.

Dr. Ortiz Okay, that's what I thought. We can't vote online.

Mr. Lawrence I was suggesting if we had a quick draft. There's no way to get to the draft that we worked on.

Dr. Heslin It has to be a public meeting.

Unknown Speaker No, I'm talking about now.

Ms. Monroe Who is that?

Dr. Rugge That's the public right there.

Dr. Heslin To that point we can certainly have this substantially done, and I don't think that there should be any real difficulty with circulating the draft. I don't think there'd be a real difficulty with having the meeting before one of the parallel meetings next time.

Ms. Monroe You're saying perhaps we could meet even briefly if everything is done and approved and s we're all satisfied before the next the February PHHPC meeting we could meet that morning or whatever.

Dr. Heslin You know, what is going to come out of today's meeting is substantially going to be the minutes and meeting summary of this meeting. I would propose we do the same thing we did the last time, which is we're going to circulate it to everybody so they can make their comments and you're going to edit that and then that can be the document that goes out.

Ms. Monroe I would like to propose an alternative way of doing this. No offense.

Dr. Heslin No offense taken.

Ms. Monroe John needs to write an introduction to this document about the problem statement and what we've done. I will take because both Abby and I took voracious notes on the recommendation page. She and I will rework that page to include the things we talked about, show where there's disagreement, all of that. It's not minutes of a meeting. It's a document that's separate from that. I don't want to expect Abby to have captured every specific change we want to make on this list of recommendations. That's the way I will propose doing it if it meets Marthe's criteria and Gene's.

Dr. Heslin I'm good with that.

Dr. Rugge Instead of producing minutes we'll produce the recommendations and an introduction explaining the context.

Ms. Monroe We're not giving a written report tomorrow. We're planning on a February meeting for the full thing to go to the council and in between then we will have a document that we'll have to rely on you about if we have to meet in person again which really concerns me.

Ms. Ngwashi I think I'm not understanding what it is you're not wanting to do.

Dr. Rugge We're writing the product of this discussion rather than miss describing.

Ms. Ngwashi Do you usually give minutes at each full council meeting?

Dr. Rugge We just for us for our own benefit for our own selves. That's what we think. That it's perfectly okay to do it this way, but we just are asking you for legal advice.

Ms. Ngwashi I thought we already established what is going to happen. Tomorrow you're going to give a report about what you're committing.

Ms. Monroe A verbal report.

Ms. Ngwashi Correct, and that's what you always do.

Ms. Monroe That's correct.

Ms. Ngwashi You are going to finally get a document that consists of what we discussed today and also feedback from other areas. That document you all need to be able review.

Ms. Monroe We have to do it in person.

Dr. Rugge Yes we do have to do it.

Ms. Ngwashi Yes, these are the recommendations that we want to present to the full council.

Dr. Rugge Could we send the document, the preliminary document to the council members before we have a committee meeting?

Unknown Speaker Why don't we just do it for fifteen, thirty minutes before the next full council meeting?

Ms. Monroe In February?

Dr. Rugge The council members need to see the report before they take action.

Unknown Speaker If it's a public meeting, don't we have to have invite the public?

Dr. Soffel Could it be circulated as a draft?

Dr. Rugge Yes and then indicate that we have endorsed that draft.

Dr. Ortiz When did we endorse it? We didn't endorse it.

Dr. Heslin Coes Committee meets all the time just before a full council meeting they go through the report and then they give a report after the meeting.

Dr. Rugge Rather than meeting in January.

Dr. Ortiz We already have Health Planning.

Mr. Robinson Let's do it on the couple weeks, three weeks.

Ms. Monroe That would be the next one too.

Mr. Robinson Because then you got another two weeks before the full council. If the committee does anything to modify it, you have a chance to sort of perfect it before going to full council.

Ms. Monroe John and I need to discuss that because for us all to come in a day early for...

Dr. Rugge No, two weeks early.

Ms. Monroe What?

Dr. Rugge Two weeks early.

Ms. Monroe That's what I mean. You come in the day early to have a meeting, seems like a big cost.

Ms. Monroe Yeah, but not everybody.

Ms. Monroe John doesn't come.

Dr. Ortiz We have a Public Health Committee meeting on the eighteenth.

Ms. Monroe Of February?

Ms. Monroe When's the----

Ms. Monroe Well maybe we don't need to discuss this now. We can work with Colleen and you and get it worked out.

Dr. Ortiz Committee day in January.

Dr. Rugge We'll do a draft, send it to the committee members, and then if there's a need for further committee discussion and amendments, we have to m then meet in person on committee day. If everybody says this is this reflects what we've already decided.

Dr. Ortiz Is there Codes tomorrow.

Dr. Rugge I think if everybody says yes, this is very consistent with our meeting.

Ms. Monroe We have to meet.

Ms. Monroe How about in Buffalo?

Mr. Lawrence Is this a public meeting that is designated that that we have to have given notice to the public?

Unknown Speaker If you draft approved by the committee, circulated to the council.

Dr. Rugge See you in Albany.

All (Laughing)

Dr. Rugge Would anybody care to make a motion to adjourn?

Dr. Rugge We don't need a second.

Dr. Rugge Unless somebody stays here to meet further, we're adjourned.