NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
FULL COUNCIL MEETING
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90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Mr. Kraut I will call to order the Public Health and Health Planning Council of December 4th, 2025. I'm Jeff Kraut. I have the privilege to call to order the Public Health and Health Planning Council meeting, and I want to welcome everyone here today, council members, members of the public and DOH staff. As a reminder, I already talked about the requirements via broadcast as we did the Codes Committee and the Open Meeting Law, just to remind people Just as when the first time you speak, just identify yourself as a council member or DOH staff in your name. I just want to make sure that the members, staff, and particularly the public are aware that the Department's Certificate of Need lists serve. The unit regularly sends out important council information and notices such as our agenda, meeting dates and policy matters. I want to encourage everybody to subscribe to that listserv. There's printed instructions at the reference table how to join, or you can contact the Secretary Colleen Leonard for assistance in joining. Unfortunately, I have to mention that we have a resignation from the council. Ms. Michelle Mazzacco has made that difficult decision to step down as a member. She served on the council from May of 2024 and through this past November. On behalf of the council, Dr. Boufford and myself, we have a resolution, which I just want to highlight for you that you know, she that Michelle Mazzacco has served with the Public Health and Health Planning Council from May of 24 through November, where she served as a dedicated member of the Establish and Project Committee. And by doing so, she made a contribution to improving the functioning of the council, the New York State health care delivery system for the citizens of the state. We want to convey to Ms. Mazzacco our admiration and appreciation for the role in enhancing the health and well-being of all those who we serve, and we extend our gratitude to her for the service and send her our best wishes for her happiness and a professional achievement. We have that more as a whereas and stuff, but we'll be issuing that. If you'd like, you could send your own personal notes to Michelle to thank her. As part of the agenda for the meeting, you've received reports from the Deputy Commissioners who are not presenting today. We've done this to streamline some of the reporting and the today we're going to hear from the Office of Health Equity and Human Rights and the Office of Aging and Long-Term Care, in addition to the Commissioner. I just want to point out just going to depart kind of do a new section, if you will, just the highlights of some of those reports in case you haven't had the ability to read the report, where the public health and the nutrition and food security identified that during the federal shutdown, the WIC program and New York State maintained the services using contingency funds. The Governor for the SNAP freeze authorized additional sixty-five million dollars of food banks and fast tracked $30 million of aid that was appropriated by the legislature to keep it going. We want to commend the department, and frankly the state for keeping supporting those critical activities during the shutdown. The evidence and guidance group within public health did a DOH literature, concluded there is no causal link between prenatal acetophenone and autism. The environmental health talked about the cybersecurity for public water systems and the lead rental registry became effective to certify every three years. Public health and the prevention agenda started rolling it out to the local health departments. We'll hear more from Dr. Boufford and her committee's activities. The Wadsworth Center in improved some of the newborn screening, food safety, defense, and health systems management notified us that the hospital capacity and direct access, the

24/7 bed reporting went live. We have real-time measures of capacity. The rural health transformation grant was submitted by the department. I'm sure the Commissioner is going to talk a little about the safety net transformation investments that were made. With that, I'll going to talk about today's meeting. We're going to hear from Ms. Tina Kim about the Office of Health Equity and Human Rights, followed by Ms. Deetz providing the Aging Office of Aging and Long-Term Care and then the Commissioner. Dr. Boufford will provide an update on the activities of the Committee of Public Health. Dr. Rugge and Ms. Monroe will provide an update of the activities of the Health Planning Committee, followed by Mr. La Rue, who provide an update on the nursing home certificate and need Ad Hoc, and then I'll present the regulations for the Council. Lastly, Mr. Robinson will provide recommendations to the establishment actions from the Establishment and Project Review Committee. Before we get to Mr. Robinson's report, that we've just to remind everybody, take a look at the agenda. We've batched applications and take a look at how we've watched them to see if there's any application you want removed from a batch because you need to want to comment on it or have some discussion.

Mr. Kraut With that housekeeping behind us, I'd like to have a motion to adopt the September 18, 2025, Public Health and Health Planning Committee meeting minutes.

Mr. Kraut I have a motion, Dr. Berliner.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Torres.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Motion carries.

Mr. Kraut It's now my pleasure to introduce Ms. Tina Kim, who's going to give us a report on the activities of the Office of Health Equity and Human Rights.

Ms. Kim Thank you.

Ms. Kim Good morning, everyone. My name is Tina Kim. I am the Deputy Commissioner for the Office of Health, Equity and Human Rights at the New York State Department of Health. Thank you for the opportunity to quickly highlight some of the written updates that were provided in the Deputy Commissioner report. First, I just wanted to quickly highlight the work that the department has been undertaking with respect to health literacy. We continue to prioritize and emphasize health literacy as a key social determinant of health matter. As provided in the written report, we have a health literacy committee that had started before the COVID pandemic and was paused because it was all hands-on deck during the pandemic and was recently reconstituted to continue our priority work in the health literacy space. We recently offered trainings to staff on plain language, and I just quickly wanted to talk about the why, the why it is important, especially in this age when we feel like there's a lot of information out there. Sometimes the most effective way is to speak plainly and to be able to provide that information in a way where it's accessible for all communities. We offered a training that was part of a project funded by our colleague agency, New York State Office of People with Developmental Disabilities, or OPWDD for short. We were very grateful for this partnership to be able to provide our staff this plain

language training. Secondly, I just wanted to quickly highlight that the AIDS Institute, which is a center here within the Office of Health Equity and Human Rights has been implementing work on our statewide congenital syphilis elimination framework. It has been recognized as a key prevention policy strategy in a national policy resource that was recently released by the National Coalition for STD directors. This resource called the Innovations in Syphilis Policy Playbook highlights six innovative syphilis prevention strategies. We were very excited to be able to be highlighted in this national resource. Finally, we've been in December. This is our typical season within the AIDS Institute leading up to the World's AIDS Day and Ending the Epidemic Summit events that are going to happen next week. We provided that information for you in the written report. The 10th annual Ending the Epidemic Summit and the 27th annual World AIDS Day event is going to take place next week in Albany. We are very excited. We have a really prominent show of attendees that will be attending. This year's event theme is one journey, one community, one mission to end the epidemics. What was not provided in the written update, but recently highlighted, and we had issued a Department of Health press release on this is a docuseries that was recently issued and published online called Unfiltered. It's really to highlight the challenges that persist when it comes to fighting the HIV and AIDS epidemic, which is the disparities and the stigma that continues to be huge challenges. People of color make up just one-third of the state's population, but account for 80% of the new HIV diagnoses. This campaign, the Unfiltered docuseries is a campaign that the AIDS Institute has recently announced in the last few weeks. It's really an effort to highlight the lived experiences of Black and Brown individuals in New York and raise awareness about Prep The first episode was recently released. The new episodes will be released every two weeks on the Unfiltered website. All of these videos seek to address the disproportionate impact of HIV on communities of color and the need for culturally relevant prevention strategies. We are really proud of the work that the AIDS Institute has put out, and we will continue to remain laser focused on addressing the disparities and the stigma that continue to be major contributors in our fight towards ending the HIV and AIDS epidemic. I will pause there to see if you have any questions on the general updates from this office.

Mr. Kraut Dr. Friedrich and then Dr. Boufford.

Dr. Friedrich Marcus Friedrich, member of the council. I'm also an HIV provider, so I just want to congratulate you just put up my own. I just want to congratulate the department and the AIDS Institute. For us as HIV providers in New York, there's a lot of angst going around because they like not only because of the funding cuts, but also that there are some reports that the numbers are slowly ticking up again, which is completely against the trend because of the pre-exposure prophylaxis, or Prep We have seen you know reduced numbers for the last couple of years. I will just say that I'm very proud to live in New York and like that the AIDS Institute is doing such a great job of bringing this to the forefront. Thank you.

Ms. Kim Thank you.

Dr. Boufford Hi. Thanks very much for your report. I want to sort of reinforce what Marcus has said. I wanted to raise I don't know specifically what the plans are around the sort of celebration that you mentioned or the large event, but Professor Dr. Don Des Jarlais, who's been on the staff at NYU School of Global Public Health is retiring at the end of this calendar year. He has been a real giant in leading the AIDS Institute, AIDS research and policy making. I think it would be wonderful if there was some sort of recognition provided to him at that event or at some point by the Commissioner and others. He's very deserving. Thanks.

Mr. Kraut Dr. Soffel.

Dr. Soffel Good morning, Tina. It's always a pleasure to see you. The members of the council received a copy of a letter that was sent to you from the Community Voices for Health Systems Access. I wanted to ask you about two of the points that were raised in that letter.

Mr. Kraut I think after we do this, she's going to come and talk about the HEIA and the letters. I didn't make it clear. We broke her presentation into two parts.

Dr. Soffel Got it.

Mr. Kraut The first is some general things and then we specifically are going to have a conversation about the HEIA update. I'm sorry. I didn't make that clear.

Dr. Soffel I will hold my question. If I still have it, I will ask.

Mr. Kraut That was one of the questions she has to answer.

Mr. Kraut Any other questions on the things that Ms. Kim just described? If not, I'll leave it up to you to continue.

Ms. Kim I recognized the breathing was getting to be a problem. My voice projects. I'm happy to project. I'm happy to begin this next presentation on the Health Equity Impact Assessment Program. Again, my name is Tina Kim, Deputy Commissioner for the Office of Health Equity and Human Rights at the New York State Department of Health. I'm here with Tomi Akanbi, the Director for the Center of Health Equity Impact Assessments in the Office of Health Equity and Human Rights to provide remarks to this council related to the Health Equity Impact Assessment Program. Also, here with us virtually, but in Corning Tower are our program counsel for the Health Equity Impact Assessment Program, Jason Riegert, Deputy Director of the Bureau of Program Counsel in the Department's Division of Legal Affairs, as well as Jamie Spina, our senior attorney. As way of background, Section 2802B of the Public Health Law went into effect on June 22nd, 2023, which requires Article 28 health care facilities seeking the Public Health and Health Planning Councils or Commissioner of Health's approval for certain project applications to submit a Health Equity Impact Assessment as part of the Certificate of Need application. Here we are, December 2025 with a little over two years of program implementation under our belt. As we had gathered as we had committed to from the get-go, the department has been diligent in gathering program data and stakeholder feedback. In the grand scheme of things, two years may not be much, but as anticipated, a considerable amount of program data has been collected to inform the department's work moving forward. The Office of Health Equity and Human Rights continues to uphold its commitment to transparency and proactive stakeholder engagement. The department, including the Commissioner directly have received several letters from stakeholders regarding the Health Equity Impact Assessment Program. Since the law went into effect, the Center for Health Equity and Human Rights has regularly met with stakeholders by way of listening sessions, webinars, and technical assistance meetings with both facilities and independent entities. As Tomi will soon elaborate, the department has concrete program data that speak to the demonstrated success and effectiveness of the Health Equity Impact Assessment requirement. The Health Equity Impact Assessments have documented and elevated the expertise, perspectives, and experiences of community members, and in some cases,

improved the facility project itself. New York's Health Equity Impact Assessment program has caught the attention of many across the country. In the last year and a half, the Center for Health Equity Impact Assessment has conducted several oral and poster presentations at prominent academic and public health conferences and forums, including the American Public Health Association or APHA conference. I will now pass it over to Tomi, our Director, who will share key data points related to suggested areas of improvement from stakeholders and how the department intends to proceed. Thank you.

Ms. Akanbi Good morning, everyone. Since the start of the Health Equity Impact Assessment Program, the department has spent considerable time reviewing Health Equity Impact Assessments and evaluating various aspects of the program. As of September 30th, 2025, the department has reviewed and approved a total of ninety-two Health Equity Impact Assessments. Sixty of the Health Equity Impact Assessments were completed for hospitals, twenty for residential health care facilities, eleven for diagnostic and treatment centers, and one for a midwifery birth center. 22% of the ninety-two health equity impact assessments received to date were for Certificate of Need projects in rural counties. When the department appeared before the Public Health and Health Planning Council for the passage of the final Health Equity Impact Assessment regulations, we were all eager to see the number and types of entities that would operate as independent entities. To date, the department is aware of nineteen distinct independent entity organizations that conduct Health Equity Impact Assessments. These independent entity organizations are primarily consultant groups, researchers and professors with experience and expertise in health equity, anti-racism, and community and stakeholder engagement. Since the Health Equity Impact Assessment statute went into effect, the department was intentional in broadly stating the parameters of who can serve as a Health Equity Impact Assessment independent entity, while providing sufficient guardrails to ensure that independent entities possess a baseline level of expertise and have no conflict of interest as required by law. Healthcare facilities are required to submit a conflict-of-interest form alongside other Health Equity Impact Assessment documentation, and this conflict-of-interest form must be completed in full and signed by the independent entity as well as the facility submitting the Certificate of Need application. To date, the department has been able to accept and review Health Equity Impact Assessments completed by all independent entities so far based on the department's parameters, including from hospital associations. All ninety-two Health Equity Impact Assessments have demonstrated the objective independent perspective as the legislation intended. The department has received feedback concerning the added cost of the Health Equity Impact Assessment to the overall Certificate of Need costs. The department does not intend for the Health Equity Impact Assessment requirement to dissuade necessary Certificate of Need projects, especially innovation or upgrades, which is evident in how the department has designed the Health Equity Impact Assessment Program. To ensure alignment with statutory intent, the department closely monitored the first two years of implementation focusing on the average and median cost of Health Equity Impact Assessments and exploring opportunities for cost reduction. I'll now share some data points of interest. Independent entities charged an average of $26,700 for an assessment. The total cost of all Health Equity Impact Assessments represented 0.06% of the total cost of the ninety-two Certificate of Need projects. An analysis of all ninety-two Health Equity Impact Assessments received by the department to date shows a median cost of $20,000. The department does not have the authority to regulate Health Equity Impact Assessment prices, nor do we have the fiscal resources to subsidize Article 28 facilities cost of conducting these assessments. Given limited resources and its regulatory authority, the department cannot serve as the independent entity producing Health Equity Impact Assessments for Certificate of Need applications across the state. Since Summer 2024,

the department has regularly convened stakeholders to provide a forum for ongoing updates, discussion, and feedback. Through these engagements, several key themes have emerged. These include stakeholder concerns regarding the cost and necessity of Health Equity Impact Assessments for expansion and relocation Certificate of Need projects, as well as challenges with the meaningful engagement process. Furthermore, stakeholders have advocated for the development and enforcement of accountability measures for healthcare facilities, the exemption of select state-funded facility projects that have to go through the Certificate of Need process, from the Health Equity Impact Assessment requirement, and increased public transparency regarding Certificate of Need applications broadly. The department is actively evaluating program data and considering stakeholder feedback, including program suggestions to determine appropriate actions regarding identified areas of concern. This includes a review of the threshold criteria for both expansion and relocation projects, with a close examination of Health Equity Impact Assessment data and careful consideration of comments from stakeholder groups. To demonstrate concretely how the department is actively evaluating program data relative to suggested changes, I'll share that based on the ninety-two Health Equity Impact Assessments received to date, if the department implements a relocation threshold of 250 feet, or about one point or 0.14 miles, there would have been three less Health Equity Impact Assessments over these last two years. When looking at relocations within a hospital's campus, some moves are as far as 0.7 miles, and out of the ninety-two Health Equity Impact Assessments reviewed, five were relocations on a hospital campus with two relocations over half a mile. The department is also exploring the possibility of Health Equity Impact Assessment exemptions for certain Certificate of Need projects. In the coming months, the department will work closely with legal counsel to ensure any proposed changes align with applicable laws and the department's authority. We are committed to working closely with all stakeholders to develop the most appropriate path forward while upholding the intent of the legislation. The specific parameters and application of any such changes will be determined through future discussion and defined at a later date. As previously noted, some stakeholders have requested that the department oversee and enforce mitigation plans developed by Article 28 healthcare facilities as part of their Health Equity Impact Assessments. As background, facilities are required to attest to the findings of their completed Health Equity Impact Assessments and create mitigation plans to address any identified negative impacts. The completed Health Equity Impact Assessment documents and redacted Certificate of Need application must be posted publicly on the facility's website within one week of acknowledgement by the department and remain accessible until a decision on the application is rendered by the Public Health and Health Planning Council or the Health Commissioner. Due to the same fiscal constraints, the department is not in a position to oversee mitigation and monitoring plans and ensure facilities are carrying out such mitigation and monitoring plans one to two years out. Understanding the value of enhanced oversight, the department will consider possible accountability measures that align with the staffing and resource capacity of the Center for Health Equity Impact Assessments. The department maintains its stance to use conditions and contingencies as appropriate, outlined in Certificate of Need application approvals if major flags are noted in the Health Equity Impact Assessment. I'm now going to take a moment to talk about meaningful engagement. Meaningful engagement is an important part of the Health Equity Impact Assessment process as specifically directed and outlined in statute. Independent entities are required to provide advanced notice to community stakeholders about proposed certificate of need projects and collect their verbal or written feedback. While we have received suggestions to consider minimizing or eliminating meaningful engagement altogether, although for what some may deem a smaller, less impactful CONs, the department recognizes the effectiveness of Health Equity Impact Assessments and increasing community participation and healthcare facility

planning and uncovering unintended impacts regardless of project size. A review of the ninety-two total assessments revealed common repeated issues in the realm of meaningful engagement, including insufficient outreach to diverse stakeholders, limited use of various communication modalities, and insufficient project details provided to stakeholders. Center staff have dedicated considerable time to meetings, calls, and listening sessions with independent entities to review issues in the assessments and provide clarifying information. In light of this, and in the interest of upholding the intent of the law, the department plans to strengthen its guidance on meaningful engagement requirements for the Health Equity Impact Assessments, improving upon weaknesses observed over the last two years. As we have demonstrated, the Center for Health Equity Impact Assessments is committed to working alongside and with facilities and independent entities on meaningful engagement. While a significant expansion of the independent entity market is not anticipated, the department has and will continue to provide independent entities with technical assistance and best practices to support the meaningful engagement process. This includes webinars, technical resources, and a contact list for local health departments. For example, to reduce feedback fatigue, the department has permitted independent entities to group related Certificate of Need projects for discussion with respondents in a single engagement rather than multiple individual engagements. Looking to the future, the department intends to provide advanced training to independent entities on the topic of community outreach and implement administrative changes to Health Equity Impact Assessment program documentation to reinforce expectations for meaningful engagement. I'll now conclude my remarks with updates on upcoming activities planned for the Health Equity Impact Assessment program. The inaugural progress report for the center will be released in early 2026, detailing the program's implementation over its first two years. Based on recent feedback from local health department officials, the center will issue stronger guidance separate from regulations to improve engagement with local health departments by independent entities. While it is voluntary to contact local health departments during the community engagement portion of the Health Equity Impact Assessment, the department intends to encourage greater transparency and improve communication from independent entities to ensure local health department officials are well informed about proposed Certificate of Need projects in their counties. The department has recognized the challenges of accessing Health Equity Impact Assessments through the public facing New York State Electronic Certificate of Need website. The center is working with staff from the Health Data New York team to build a publicly accessible site that will house all completed Health Equity Impact Assessments. In closing, we will continue our discussions with staff within the department and stakeholder groups to finalize specific details and most appropriate paths forward regarding the identified areas of concern. This collaborative process will inform the development of proposed regulations, which will then be presented to the Public Health and Health Planning Council. Thank you.

Mr. Kraut You covered a lot of real estate there. A couple of things. Since you have your report, your remarks written, if you could please share them with us. We won't rely on a transcription. We'll have the actual remarks. I'll open it up for some questions or comments. Just before I do so, I think what would be helpful at the end of this discussion is a document, maybe like two or three columns, like here are the ideas, these are the recommendations that you're going to make to change the HEIA. These are changes you want to make, but legislation would require legislative. Things we can do by regulation and things that need to be changed by legislation. Because as you'll hear, we discussed last time that this is something I think we just want to get a better understanding of. Because the central objective of increasing public awareness and engagement in these processes is a very positive and that's the objective. That's one of the byproducts of the legislation,

but the output of the HEIA is for the council in its deliberations to review a CON. The product is a product that we need. We want to make sure it's responsive to the issues are being raised as well.

Mr. Kraut With that said, I'll leave it open to questions and comments.

Dr. Soffel Denise Soffel, member of the council. I did have a question about follow-up mechanisms to assure that implementation of mitigation strategies was happening. I want to be on record as being very disappointed with the response which is that you don't have the resources to do so. Because without oversight, the requirement is fairly meaningless, and we have no way of knowing whether and to what extent the institutions are responding to the need for mitigation strategies. I think to keep that on your concern list because I think it's really important. The other comment I wanted to make was meaningful engagement. I will be very interested in seeing what you are thinking in terms of strengthening those requirements, because we've gotten some HEIAs that have to have contacted five stakeholders and consider that meaningful engagement. We have raised questions here in at the council about how that could possibly be deemed meaningful engagement in any community across the state of New York. I would be very interested in understanding how you're thinking about strengthening those requirements.

Mr. Kraut I don't know if you want to respond. Let me just add something on meaningful engagement, just to do that. I think making people aware of what you see as a gold standard of meaningful engagement would be responsive to what Dr. Soffel said. And then the flip side of meaningful engagement also my guess it is project specific. I'm not clear where you came out on this, but if you moved a program from one floor of a building to another and required an HEIA, I think you were suggesting we wouldn't do that in the future. If you pointed out a two-tenths of a mile, a half a mile, I would say if you moved within a mile, because when we've asked people about meaningful engagement and we move something a half a mile down the road from a hospital, they said, "What are you calling us about? This is like stupid." You're even suggesting that this is a problem. That's where I think meaningful engagement has needs context. Because there are certain projects, hospital closures, major things. There's a different standard you should be expecting. I would just say that.

Ms. Kim Thank you both for your remarks.

Ms. Kim Just specifically to your remarks about the meaningful engagement side. Fully recognize that and the Certificate of Need application that project specifically where you cited the lowest number of stakeholders engaged being five, in fact are in the range of meaningful engagement stakeholders engaged five is the lowest, and the highest being nine hundred and thirteen, right? We're seeing a lot of variability in terms of the type of Certificate of Need project, how complex it is, what the project is exactly going to is it and how the community is engaged. That is a very work of the Center for Health Equity Impact Assessments. They are using various mechanisms day to day to be able to distribute best practices. It may not be in like a package like here's the placard or poster that you put to make sure that you hit all of these points, but we do listening sessions, trainings. We do have webinars to be able to readily share those best practices in real time so that they're not getting it at the end of a two-year, three-year time frame. I do want to note that the lowest number of stakeholders engaged on a CON yes was in fact five, the highest being nine hundred and thirteen. We also want to highlight that there was variability in terms of the Certificate of Need review type with full applications having an average number of 103, administrative 64, and limited review 41. I think just two additional things to note on

meaningful engagement. One is we have we have developed very good working relationships with some of the independent entities out of the nineteen. They have continued to cite that some facilities just don't have robust community stakeholder networks. Others have noted that their repeated engagements with the same network has led to feedback fatigue. We are trying to be creative and solution oriented in all the ways that we can try to address these issues. We understand that there is a need to be able to move the needle quite a bit across the entire state when it comes to stakeholder engagement. We also know that there is... It's not so predictive as to what will garner a lot of stakeholder attention versus not. The intention of the Health Equity Impact Assessments is to make sure that we can have some level of baseline engagement so that we can account for all of the experiences. To the point about meaningful engagement and relocation, we will continue to prioritize the concern that has been repeatedly raised, which is accessibility, that even with a relocation a couple of hundred feet or what seemingly looks like a not so long distance, that there remain concerns about the project with respect to its ability to implement all of the various pieces like accessibility and major concerns on impeding access even when that project is underway. I think that's just one of the things that come out of the meaningful engagement. The struggle is that what could seemingly look like a this shouldn't look so complicated. What we have found in our experience to date is that there have been unintended findings that have come out of the Health Equity Impact Assessments that have led to improvements to the Certificate of Need application. We are going to continue to look to the evidence and gather more program data to be able to inform these decisions.

Dr. Kalkut Hi. Gary Kalkut, member of the of the council. Thank you very much. I loved hearing about the overview that you presented, but also the details on HEI numbers and the number of people who are participating in meaningful engagement. You touched on a lot of the things that I wanted to ask you again.

Mr. Kraut Gary, a little closer.

Dr. Kalkut Sure.

Dr. Kalkut A number of the things I wanted to ask. Meaningful engagement. There's we have been we have struggled with the requirement that you have asked us to implement about collecting names of people who are participating in meaningful engagement. You don't ask for those names, but you have the right to get them from us. The just asking for names dissuades a lot of people from participating. One more data point. More than 50 percent of our meaningful engagement does not want to participate. Usually, it's higher than that, seventy/eighty percent. That prolongs the process and makes people not want to participate in something. That is absolutely central to HEIAs. What will you do about that? Why do you need the names?

Ms. Kim Thank you for raising this.

Ms. Kim I know that in the February meeting when I was not here this was a significant discussion. I appreciate you raising those comments and the question. We absolutely understand and do not intend for the confidential the privacy and confidentiality provisions that we have put into place to dissuade stakeholder engagement and meaningful engagement. There's a number of reasons. There's a quality control issue in the instance that we do need to go back. Evidence has shown in the last two years, and as Tomi has stated at the last meeting, we have yet to request for the information specific to individuals that are named. We understand the chilling effects that you brought up at the last meeting,

which is especially in these times when people are quite frankly afraid to step out to even get groceries. That asking for identifying information can be absolutely challenging. This is an area that we continue to actively think through, and we welcome any such suggestions. We will say that this concept concern was raised by a number of independent entities and consumer advocates in the interest of wanting to protect consumers. We felt that was like the line that we could draw. We absolutely know that there are pros and cons of the decision, and we certainly do not want to dissuade

Mr. Kraut Be clear, that's not required by legislation.

Ms. Kim It is not.

Mr. Kraut It is a regulation. That is a change that you would come out and be making. I mean, I'm telling you, when we look at stakeholder groups and we look at undocumented individuals, in this day and age, when we engage with them... They will not give us their names. I think this is something if you're saying that would be helpful in new guidance that you issue to be clear about it, instead of saying we'll think about it. It really has a problem. I'll just say on engagement. You said you'll allow us to group projects together, which I think is beneficial. When we did the Health Needs Assessment, we surveyed 13,000 people. In it I said, let's go and ask about projects we're going to do. Now, the challenge is it's not the independent assessor doing it, but it's a process that we're talking to our communities, we're engaging, we're getting feedback, and we're going to be able to feed that back to the independent assessor on each of those projects what the communities have said, how they'll use it, but it would be a nice way to know that when we use massive engagement with communities, particularly on health surveys, we could add certain questions in about projects we intend to do in the next year. That is another way to think about how to... I wouldn't give it at the exclusion of other things, but also to have that information be acceptable. You could submit to an independent assessor.

Dr. Kalkut If I understood what you said, you've never requested the names. Out of ninety-two, none have been requested. In every meaningful engagement, we have to ask for names, and it affects every one of those meaningful engagement episodes. Particularly if in two and a half years you have never asked for it, the suggestion would be to stop it so that it's much easier to get meaningful engagement from people who have come out and been solicited about their feelings of the project. It just doesn't hold water.

Mr. Kraut I know there's more questions. I'm going to do a timeout if you just stay there. The Commissioner has a bit of a time problem, so we'll suspend this discussion. Stay there. We'll turn to the Commissioner for his remarks and then we'll come back to the discussion.

Mr. Kraut Commissioner.

Dr. McDonald Thank you.

Dr. McDonald I love describing me as a time problem. I feel like that's my life lately. It's good to see you guys again today. Thank you so much. I do want to just say, like last time when we got together, I talked a little bit about the contrast between the federal government's health policy and ours, and just like you to keep that in the back of your mind really quick. I want to highlight some work the department's been doing lately. Some of the work I want to highlight, I just want to start with the word work. You know, when I think of the word work, I think of activity, it leads to productivity, leads to a positive outcome that

leads to a return on investment. It's just one way to look at the word work. Some of the work I want to highlight is Dr. Holtgrave and his team's work and our overdose work. Dr. Holtgrave, you might remember, joined us a little over a year ago, and he did a nice health economic evaluation of our opioid overdose prevention programs, how we distribute naloxone. It's the first state that's actually looked at not just distribution of naloxone, but administration of naloxone. What he showed over a two-year period with the team was over six thousand five hundred lives were saved. When you look at the years of life saved, it was just stunning how much. When you look at the return on investment, and just one little point I want to make here is like, you know, health and human services has a value for statistical life, and it varies. We showed for every dollar spent for the program, the return investment was over three thousand two hundred dollars. Really positive return on investment, just stunning. Again, the first state to do such an evaluation, and so we published that in the journal of Public Health and Management just a couple months ago. It's hard to predict what the federal government's going to do in this space, but it's not for want of trying. Our team did a really Herculean job getting a really substantial application done in a very short period of time. It is not a grant. It's a cooperative agreement. We'll get a notice, then there'll be a negotiation, and we'll see where all this lands here. You might remember last year's budget, the Safety Net Transformation Fund was authorized for us to help financially distressed safety net hospitals achieve great things. There were six additional awards that were just announced. I'm going to just tell you the six really quick. Arnot Ogden Medical Center is partnering with Cayuga Health, Krauss is partnering with Northwell, Erie County Medical Center partnering with University of Buffalo, Mamonity is partnering with Health and Hospitals, St. John's Riverside partnering with Montefiore, and Westchester Medical Center partnering with Charity Health System, Health Alliance of the Hudson Valley. Really nice projects to really help, really what I think part of the future of healthcare is just forming strong partnerships to help people navigate through what are going to be some difficult times. During the federal shutdown, food insecurity became a top issue. The Department of Health administers the Women, Infants and Children WIC program. We also administer the Hunger Prevention Nutrition Assistance Program. Agon Markets administers Nourish New York. I'm friends with everybody. We got together. A lot of good things happened during the shutdown. The Governor found sixty-five million dollars for us. We got it out in really, really rapid time. Halloween, not sure what you were doing. My staff got contracts to prove. That was really impressive to me. Ten food banks got money. It was needed. When we went to visit food banks, what we heard was record number of people from all walks of life now coming into food banks. Food banks do a lot of wonderful work in New York State. Not that you need to hear me tell you where to donate your money for end-of-year giving, but a dollar in a food bank buys three meals. Just saying. I have to talk about COVID. It almost seems like it wouldn't be me coming together if I didn't mention COVID. I'm going to talk about COVID, flu, and RSV really quickly. They're different, right? When you look at 2024 data for COVID. COVID isn't seasonal yet. We saw 2,775 deaths attributed to COVID. It's vital statistics data in 2024. 2,775 compared to the 766 for flu. Part of why I highlight that is there's a misconception in the public that flu is more serious than COVID when that's just the opposite of what we're seeing with deaths and hospitalizations. Part of that's because COVID occurs all year long, flu is in a season. The COVID numbers regarding vaccine concern me. I've been talking a little bit in the media about this. We've been doing a great deal of webinars with hospitals, nursing homes, healthcare providers, community-based partners. When we look at our COVID vaccine numbers, we're 29% less immunized than we were at the same time last year, and last year was low. I'm concerned about our preparation as a people. I think one of the things I've been trying to say loud and clear is you really need to make sure you're up to date on your COVID vaccine. The 65 and older group, 23% less than where we were at the same time last year. When I look at my flu vaccine numbers, we're about the same as

last year. We declared flu to be prevalent two days ago across New York State. It's not often I see a graph that looks like a hockey stick. This happened. You know, when I looked at this data last Friday, it was just like that. In other words, we went right into flu season in New York State. Flu came a little bit earlier this year, about two weeks earlier than last year, reminding you that if you've seen one flu season, you have seen one flu season. You're hearing a little bit about H3. So, if you're wondering about the H's and the N's, there's eighteen different H's and eleven different Ns. H stands for hemagglutinin, 11 stands for neuraminidase. We talked more about them. You'll feel nerdier than you need to. H3 seasons tend to give you more severe seasons. Recently, talked to some folks from England seeing that they had a more severe season. They're seeing a more severe season. Right now, the current vaccine efficacy, although it didn't build in the K subtype, seems to be providing the same amount of efficacy you expect out of a flu vaccine. The flu vaccine is still a solid recommendation, still something people should do. If you're wondering if the H3 subtype is in New York, it is. If the K subtype is here, it is too, right? We won't know its impact for quite some time because we don't do whole genomic sequencing of every flu specimen. Keep in mind, most people have a flu test done in a doctor's office. It's a rapid test. We do get samples sent to us at Wadsworth and we do genomic sequencing. COVID and flu, they have my full attention. RSV is interesting this year. We're seeing less RSV than we normally do, which is interesting to me. Normally by December, RSV has shown itself, but we're seeing lower numbers. That might be attributable to the immunizations that are out there. Keep in mind, infants get offered a vaccine in the newborn period, people are pregnant get a vaccine, and 65 and older get a vaccine. That might be a positive vaccine story, and I think that's good. Speaking of vaccines, the advisory committee on immunization practices meeting today. I'm concerned about where they're going with hepatitis B vaccine. Every national expert, including us has spoken about this issue. We don't see a reason to change what to me has been a very successful public health practice. I am old. I know I don't look old. Thank you. I've been doing this for thirty-five plus years. I was around when we had the legacy system that didn't work. One of the things I'm just going to throw out there is when you have a public health success, when something's working, to replace it without a better solution just doesn't make sense. It's one of the things I said about what's going on at the Federal Government with the Affordable Care Act. I mean, just basically the made gross changes to it without having a replacement, which I think is just irresponsible. We'll see what they do today. Just so you know, my team has been working on this very thoroughly. We've table topped many different scenarios of what could happen. We might release something later on today if we need to healthcare providers and the media. We'll see based on what they do. There are some my team are watching this meeting right now in great detail. But just to make sure people understand why this matters to us, because I think it's really important to understand why this hepatitis B matter. Hepatitis B, unlike hepatitis C is not curable. I think it's just really important to know that when an infant acquires hepatitis B, 90% of those infants become chronic hepatitis B carriers, and a quarter of those children will die during their childhood. That is tragic. I mean, that should just never happen in a first world country. Most countries in the world administer the vaccine at birth. We're heading in a very different time with our federal health policy. I just think it's really clear to say that New York State is not confused about this, and we know where we want to be on this issue. A couple of things we did between last time and this time was living donor support program. The team did a phenomenal job on this, really getting this program implemented. Very complicated program to put together. Living Donor Support Program is you can get up to $14,000 of reimbursed expenses if you donate part of your liver or a kidney as a living donor. It's even retroactive. The program is up and running. Regulations have been approved, not by you, but by the Transplant Council. We've had Applications. People have been paid. It is working. The team did a phenomenal job putting this fairly

complicated program together. Very proud of the team for doing that. Another law that we just implemented on time is Lead Registry Rental Law. I'm very excited about this. It went into effect November 3rd. Again, a nation-leading program. One of the things about New York that we're doing is in twenty-five high-risk counties, New York State, it's not waiting for the child to show lead toxicity or by a blood test, because there's no safe lead level. It's now the rental registry program. In other words, we're testing the property, so we don't expose the child. Every state in the country should do this. New York has implemented this. This has been a huge implementation over the last two years. Very proud of the Department to do this. Now, last but not least, World AIDS Day was December 1st. We honored it. We will continue to honor it. I think it's unfortunate the federal government chose not to honor it. There's been a lot of great things that have happened in our country. Quite frankly, when I was in medical school, retroviruses were something people barely knew about. Whether a drug would ever be treat developed to cure this or treat it was just quite frankly thought to be impossible. Science has exploded in that time. It's exploded because of investment, because of advocacy, and because of quite frankly, people just doing the right thing. Where HIV is now a controllable condition and really one that's very well managed. We do believe we can actually end the epidemic in this space. We're doing our tenth End the Epidemic seminar coming up next week on December 10th. I'm going to be speaking on it. Expect over a thousand important stakeholders to attend that. I'm looking forward to it. I just think people in the community should know that the Department of Health was some of the first people to stand by you when this first started, and we're not going anywhere in spite of what the federal government is doing. With that, I have a couple minutes for questions.

Mr. Kraut Thank you very much.

Mr. Kraut That covered a lot of contemporary issues that we're all struggling with.

Mr. Kraut Any questions for the Commissioner?

Dr. Soffel Good morning, Commissioner. I have two questions. One about vaccines. Can the Department of Health or can the State of New York mandate insurance coverage for something like the Hep B vaccine should the federal recommendations change to assure that New Yorkers continue to have access? That's question one. Question two, on the Living Donor Program. How is the awareness of that program being communicated to people who might be contemplating becoming a living donor? Because it seems to me it would be a wonderful incentive to encourage people to step up and become a living donor if they knew that there was some compensation for it.

Dr. McDonald For Living Donor Support Program, we’re definitely being letting advocates know. We've gotten some earned media on that too. We've done some social media too. Really, when you think about the Living Donor Support Program, it's important for the general public to know, but really important for the people who actually need an organ to know. Because if you need an organ and you know the living donor, so that's where we're targeting resources. Transplant Council is enough for that. When you're saying about mandate insurance coverage, the answer is it depends. We'll see. I've had conversations with the Department of Financial Services who regulates the private insurers, and of course my own team. We have role modeled various scenarios. We are not going to be caught by surprise by no matter what happens. We'll see what happens today, but I'm optimistic that this will be something that will happen that we'll actually maintain insurance coverage. By the way, the insurers would like to cover this because the cost effectiveness argument is obvious. There's a health economics argument article that just came out of the

team at Emory. They just showed a stunning cost effectiveness from hepatitis B immunization and really just how again, colossal an economic decision this would be to change the policy. I'm optimistic we're going to land in a decent place in New York State.

Mr. Kraut Medicaid and Medicare cover. It's the commercial.

Dr. McDonald Well for babies it's the Medicaid I worry about, right? Cause its babies, right? Newborns. The commercials want to cover this, I think we're going to be okay with this. I've had the conversations I need to. I think we'll do okay.

Mr. Kraut Any other questions for the Commissioner before he goes?

Ms. Monroe Thank you for that.

Ms. Monroe This may not be in your lane, and if so, excuse me, SNAP. I just read where the federal government feels that it can deny SNAP funds to states that don't give them the information they want. Where do we stand on that? How likely is it that we'll be able to get federal money for SNAP? Is it even within your Bailey wick? I'm sorry if it's agriculture.

Dr. McDonald I do not regulate SNAP. Barbara Gwynn, the Commissioner of the Office of Temporary Disability Assistance, does, but we're good friends. I'm also wanting sure the Attorney General is a good friend of mine too. We will see where this all lands. I haven't seen litigation, but the day is young. Let us just see where we go. What I'm seeing is I hear a lot of this stuff that's being said but let us see where all this lands. Obviously, it's something that Commissioner Gwynn's very closely connected to. We talk often about this, because although SNAP isn't mine, I don't ever say it's not my job. I was in the Navy. I got that. We have to see how we work together on this. This is part of why during the shutdown we came out and did what we did to make sure we supplemented where we could supplement. I couldn't address SNAP at that time. We were able to help hunger prevention nutritional assistance program. We're following the issue very closely with the Office of Temporary Disability Assistance, cause obviously we care deeply. Food is something that should not be weaponized. I think it should bother everybody who lives as a human being that food and poverty is being weaponized. This should concern everybody. Regardless of your political affiliation, it's quite frankly morally objectionable.

Dr. Boufford I just have a quick question on a different topic. I know public health workforce has been one of the priorities for the department and the recent... I don't know what to call it. Decertification or removal of public health degrees, nursing degrees, et cetera, from eligibility for federal sort of student loans. I wondered if you could just talk about that, what the implication is anything going on in New York State which would be sure if you're saying a bit.

Dr. McDonald Part of HR1 decided how much money you could borrow for student loan. The upper limit is $257,000 if you designate as a professional. They've designated a small group of people's professionals, physicians are one, theologians are others, which I don't understand that at all. I'll just got to go right there. They did not designate nurses, PAs, public health professionals, and others as professionals. We haven't seen the wording of their proposed regulation yet, but we will comment on the regulation. A lot of people will comment on the regulation. It's again just weird. I don't know how else to say this, my friends. This is just weirdness. You know, when you think about who can pay back a student loan, I think that's what you should be thinking about and how much money it costs to acquire a degree. If someone's going to sit there with a straight face and say

nurses aren't professionals, good luck. I mean, that is just absurd. One of the things about this pandemic is as a country we should be embracing public health. This administration is running away from public health, which makes no sense to me. Because when you think about the pandemic, public health put forward recommendations, decisions were made by presidents, governors, and sometimes mayors. You know, public health did great work during this pandemic and still does.

Dr. McDonald With that, I am running late, guys.

Dr. McDonald We can get together later. Thanks, my friends. This has been great. Thank you. Bye bye.

Mr. Kraut Thank you, Commissioner.

Mr. Kraut I know some of you may have had other questions, but we'll you can email him. He will respond.

Mr. Kraut Let's turn back to Ms. Kim and Ms. Akanbi.

Dr. Soto Nina Soto, council member. I want clarification if I interpreted both of your reports correctly. My hearing was that one of the challenges you're experiencing or will experience is shortage of personnel and resources. Our Chair recommended that if you did a table, what is the law, what are you doing, what would you like the legislation to be? I would add an added column if challenges and if it's something like personnel and resources. Did I interpret what you said correctly?

Ms. Kim Yes, and I we really appreciate the suggestion. We will certainly integrate that as part of our analysis.

Mr. Kraut It's a general problem we have where we pass legislation and they the Commissioner shall do the following, but they don't appropriate information or resources so the Commissioner can carry out the mandate. If you talk to Dr. Boufford over the years in public I mean, this is a constant challenge we all have. It's a good point. Dr. Berliner and then Dr. Eisenstein and then Dr. Kalkut.

Dr. Berliner Most of your work has been concentrated on factors external.

Mr. Kraut Howard, just a little closer. Thank you.

Dr. Berliner Most of your work has been focused on factors external to the hospital or the facility that that's being examined. Do you have any plans to do work internal to the hospital in terms of health equity and people's access to care and things going on? I mean the thing that's made me think about this mostly is the New York Times report on the transgender patient in surgery and the actions of the hospital. I'm just wondering if that's something in the plans going forward.

Ms. Kim I thank you.

Ms. Kim Appreciate that very thoughtful suggestion and question. Yes, that is certainly something that we've have been thinking about in terms of training opportunities, technical assistance. We have been very heartened by the investments and the prioritization of health systems and providers to hire chief equity officers and to hire staff specifically to

make sure that inclusion and welcoming within the hospitals within the healthcare setting is absolutely taking place. We have been seeing that noted as the Health Equity Impact Assessments come in. Like you mentioned, there's always opportunities to improve. We are heartened by what we've seen, but we also know that across the entire spectrum and across the entire state, we can move the needle and through this we hope for that opportunity to arise. I appreciate that. We'll certainly think about that more concretely and what we can roll out outside of regulation and all of the things. Thank you.

Mr. Kraut Mr. La Rue.

Mr. La Rue Good morning. Thank you for your remarks. I've got three points if the chair will allow me. The first one is I remember when this first came before the committee, there was a lengthy discussion about outcome metrics and how were we going to measure the success of this this initiative. I don't think I heard you discussing in your remark's outcome measures. Have we determined somehow we're determining success?

Ms. Akanbi That's a great question. It's one that we've been thinking about since day one actually. Outcome measures takes time, right? And some of these Certificate of Need projects that we approved last year even still haven't even come to fruition yet. That is something that we continue to think about and we're also just waiting, you know, in order for us to be able to actually have enough projects to start implementing an evaluation piece.

Mr. La Rue I think it would be really important, at some point that we had some measurements that we could understand whether the investments and the resources are delivering what we're hoping they will.

Ms. Kim Absolutely.

Ms. Kim As our remarks had indicated, we do plan to issue the progress report. We did a number of webinars demonstrating kind of these are the findings that came out of the Health Equity Impact Assessments to date. We are also actively exploring opportunities and resources to be able to readily share the health equity data that comes in and to be able to point to some of those outcomes. Yes, as Tomi mentioned, because of the vacancy of the program, right, like significant correlations, it's a little bit challenging, but it is certainly top of mind when it comes to the evaluation piece. Thank you for raising that.

Mr. La Rue My second question is about the leading age memo. I don't know I'm sure you read it, but I found it interesting in the long-term care area that they're saying the majority of these were for added services like inpatient hemodialysis at the nursing homes, etcetera. I'm trying to understand why in those circumstances we would do an assessment because adding services is certainly not going to be detrimental to any particular group, right?

Mr. Kraut Before you answer, just I want to just because I don't want to repeat the questions. We have tagged a couple of CONs that we reviewed in that vein that to us made no sense. When Montefiore added child and adolescent psych behavioral beds when we know there's a deficit of the beds in the state and they were required to do an HEIA, they said this was an example of it's just a commonsense approach to issues. The same thing at Bronx Lebanon, a safety net provider added thirty-six beds. Columbia Memorial Hospital added services in a rural area. I think there's a generic question, in addition to the note about dialysis centers, when they're adding services. The fact of the

matter is where we know there are shortages. What's the commonsense approach? How would you address that going forward?

Ms. Kim Thank you both.

Ms. Kim This is an area that we completely understand we have met with Leading Age directly, not just recently but over the years as the implementation of the Health Equity Impact Assessment has taken place and closely evaluating the impacts as it relates to the long-term care side. This is absolutely top of mind for us. Expansions, you know revisiting that threshold is something that we are going to do. Again, based on what we are within the authority to do under with the statute, with the regulation and what we can do outside of regulation, we are going to evaluate those specifics as we had mentioned in our remarks, and we will return to you. The expansions piece we absolutely hear that from the stakeholders. We understand. Thank you.

Mr. La Rue Thank you.

Mr. La Rue My last is really a comment and it's not necessarily directed at your remarks, but it goes to the point that our Chair made about legislation being passed without any funding. In your remarks, you mentioned that it's.06 percent. If you don't have any money, oh six percent is a lot. When you add it on to all the other regulations that have been passed that have not been funded, you end up with a reimbursement crisis like we have in nursing homes. I just mentioned oh six percent is a lot when you don't have any money. Thank you.

Ms. Kim If I could just quickly say I just wanted to express our you know the department's gratitude in terms of the facilities and independent entities you know sharing the data with us, data's power and the more and some have noted about kind of the additional associated costs that may not be captured in the data. We are very open to suggestions on how to make sure that our data is rich to be able to inform those decisions.

Mr. Kraut It's helpful that you told us it was twenty-six thousand dollars. Now we will not pay more than twenty-six thousand.

Dr. Eisenstein Thank you.

Dr. Eisenstein Dr. Larry Eisenstein, Councilmember. I'm aware of CO processes that cost more than $26,000. It's not a one-size-fits-all. I was going to make a comment that Mr. La Rue talked about outcome measures, and the comment I'm going to make may prove to be incorrect when you present us with outcome data. I'm willing to be open to that. My concern going back to the term meaningful engagement is the subjective nature of it. I think the single most important thing is to follow Mr. Kraut's advice, which is that we follow the best practices, because the number of stakeholders, we heard five to nine hundred and thirty-one is purely quantitative. There's no qualitative fact in that as to who these stakeholders are and what their motive is. It could be nine hundred and thirty-one people who don't have a health equity concern at all, but don't like the parking at the new facility and are annoyed that their work position is changing. That's a reality. We've seen that happen at certain events. Whereas it could be five who are the leaders representing the people most in need in the community, and what they have to say is way more important than the nine hundred and thirty-one. So, to me, much more important than the number is that as much as possible, a standardized practice is followed, and that the information that's perceived is as objective and real to help people as possible. I don't think we should

be caught up on how many people did we speak to, how many people showed up in an event, because it doesn't mean just because there were people there, that their motive was truly regarding health equity or the conditions in a community. You made a point that you know moving 200 yards away may actually make a difference. It might, but that also doesn't mean that the stakeholders see it as a difference. Holding facilities accountable for stakeholders not thinking that that's a big enough deal to get involved isn't fair to the facilities either. My point being, to go back to what Mr. La Rue said, we really need data that not only quantifies this but puts quality to it. How many of the stakeholder interactions mattered? How many of them truly represent people who need this regulation to help them? My concern being that this is to a certain degree subjective, every single CON comes from different geography, different demographics, different purpose, that the only way to standardize it as best as possible is to follow best practices. And to me, that's what we should be evaluating is a facility following best practices. Did you follow best practices? That's where we should leave it, just my opinion. If you present data that shows that every one of these interactions is worthwhile, I'll admit that you were right. Just my thought.

Mr. Kraut I'm going to go around and end in Dr. Boufford. As I come around, that's your one shot.

Dr. Kalkut I'll be quick. You've already mentioned that the distance and my understanding was that any move change in an address, change in location requires an HEIA.

Unknown Speaker Sorry, microphone isn't working for the remote participants.

Dr. Kalkut My apologies. That the other things that come out when you do an HEIA is valuable to you, but the premise that if there's any change in location that you will then do once again extends, increases the cost, and I don't think there's enough there when it's the same bus stop, the same location for people who are using the services.

Mr. Kraut Manhattan's a little different than the Adirondacks just in distance traveled in time. I thank you for educating me, Dr. Rugge.

Mr. Kraut I'm going to give it to Dr. Boufford, then I'm going to end the conversation with just some closing comments.

Dr. Boufford This is something completely different. Going forward, one of the steps that will occur probably in the first quarter of next year during next Fall will be a review of the submissions of the hospitals and local health departments for the prevention agenda on the state health their improvement plans, their action plans. It is very specific with their priority choices and their domain choices, the issue of equity must appear. I'm wondering if you are... You mentioned the be the bandwidth issue. I wonder if you are able to participate in that process, which is you know generally led by appropriately by health department staff. That that's one thing. The other issue is that I know you have had an interagency group that's worked on the equity issue. Again, relative to the new design of the prevention agenda, which deals with domains having to do with access to care and educational equity and others, have you all thought about that yet? I just want to kind of put a heads up on it. I think it's happening, and I you know we it's something that that could be needs to be planned for and I think would be incredibly valuable and important for you all to be deeply involved in the review process and bringing in these other resources.

Ms. Kim Thank you for your comments and questions.

Ms. Kim We are absolutely happy to. We closely partner with Office of Public Health, the prevention agenda. The release of that recent cycle is a huge deal and there's certainly linkage with respect to our work. That is something that we are committed to being actively engaged in. That includes the work of the interagency group. Quite frankly, many state agencies are quite fascinated by what is happening with this work in and of itself. The fact that the law went into effect, we're collecting the data and we're starting to see some of these data points. It's something that we are actively engaging that group in. There's certainly opportunity. We are also bringing in the interagency group with respect to the prevention agenda work because a lot of people, even outside of health, even if health is not their sector or their topic area, they're very much looking to this work and curious about how it's going to roll out. Thank you.

Mr. Kraut Just a couple of closing one comment that not only came from the council before, but frankly from your Department of Health colleagues, is you heard the Commissioner issue state transformation grants. We also feel very strongly, or at least the opinion has been, that where the there's been a competitive grant, it's been reviewed by the Department of Health, and the decision was made, it's in the State's interest to move forward with these activities or applications or grants that they be exempt from the regulation as well, because you want these to go forward. You have the capital grants. I think transformation grants. That would be another issue to come here. I want to thank you for coming and spending the time and the thought that went into your comments. Just to for the record, there was references made, and I just want to acknowledge the council all the council members received a letter from the Community Voices for Health System Accountability dated November 14th, 2025, and Leading Age of New York on November 25th, twenty 2025, that also had some questions and concerns that both council members and staff had raised. I just want to thank you. If you can kind of let what was said and heard and what you said wash over. Maybe come back with a kind of a one page or these are the changes we're going to be looking to make in that are regulation, these are things we'd like to make that require legislation. I think you've heard the topics we touched upon. I think that would be very, very helpful.

Mr. La Rue If they could come back with existing staffing and what would the staffing needs to be.

Mr. Kraut I have a suspect that's a bit of an internal conversation as well. God bless. We but the fact of the matter is, what do you need to do to do monitoring? It's a fair question. Thank you so much. Really appreciate the time that we gave to it. Obviously, the council is very appreciative. This was an important issue to come back to.

Mr. Kraut I'd like to turn to Ms. Valerie Deetz to give us a report on the Office of Aging and Long-Term Care.

Ms. Deetz Good morning, everybody. I'm Val Deetz. I am the Deputy Director for the Office of Aging and Long-Term Care. A shout out to Tina and Tomi for including our office in external stakeholder meetings. We do appreciate that. We echo those concerns that were brought up by Scott. Thank you. Just a couple of quick updates from the Office of Aging and Long-Term Care. Everyone has the report. We're really proud of our Center for Hospice and Palliative Care, which just celebrated its one-year anniversary, was created in 2024, and it's led by Kara Travis. Over the last twelve months now, Kira and her team have visited each and every one of the hospice residents and hospice agencies across New York State. Met with many, many palliative care and primary care physicians, and spent a great deal of time developing educational materials and web content for both the

providers and for consumers. Getting out there and actually making end-of-life care important in everyone's life, because it really is. We have now started to receive questions and calls from across the country for our Center for Hospice and Palliative Care asking about the benefits, asking what kind of services that New York State does provide in this area. Next year in 2026, just as a FYI, we'll continue our work in hospice, but we're also going to branch into palliative care. We're going to reinvigorate that 2018 Palliative Care Work Group, picking up where the council left off at that point in time. We're very much looking forward to that. We do hope to add additional staff to that program as well. One program that we don't talk a lot about is a Center for Home and Community Based Services. We do oversee over 1,500 home care providers. We also oversee the hospice providers in this center. We administer the Money Falls of Person Program and the Alzheimer's Dementia Program as well. We're really proud of the team led by Mike in that area. We have seen more transitions out of nursing homes, 470 to be exact, from nursing homes transition, individuals transition from the nursing home to the community throughout 2025, which is probably the highest it's been in the last ten years. That's happened through different waiver programs and Money Files of Person and Open Doors. We've played a lead role in the Alzheimer's disease program providing technical assistance and training to regional coordinators, supporting dementia capable services location statewide. We're very, very excited about that. Lastly, I want to just bring a shout out to our Center for Residential Surveillance led by Heidi Hayes. Heidi's done a phenomenal job of actually providing education and training to nursing homes and adult care facility providers across the state hosting twenty-five lunch and learn educational sessions to effectively improve the overall quality of care in our health and residential care facilities. Lastly, just on the grant side since we all have just heard some information about grants, we have provided over $18 million through our vital access provider and assurance program and $45.2 million in awards were made to twelve providers through our statewide health care facility transformation for grants. With that, I want to say thank you for inviting me to speak today. I'll stop and see if there's any questions.

Mr. La Rue I don't have a question per se. A comment. I've said this before, but I just want to reiterate the great appreciation that for the Department and the State putting this program together around hospice and palliative care. I think it's an extremely important initiative and it can make a real difference in a lot of people's lives. I'm glad to see the progress and look forward to next year.

Ms. Deetz Thank you.

Mr. Kraut Dr. Berliner.

Dr. Berliner Several years ago we used to hear complaints, particularly from long term care facilities in central New York, that the inspectors were particularly harsh, critical, gave them a hard time, however you want to define it. I must say we have not heard anything in in two or three years at least about that. I'm wondering what happened. Did you change inspectors? Did you change standards?

Ms. Deetz We always have new staff that join in some turnover and staff, but we have been providing a lot of education. When we are not in the building doing surveys, we can't we are collaborators. When we're in the buildings doing surveys, we're there for regulatory purposes. We do have staff out, I believe they're out today actually out west doing cabinet meetings with one of our associations and some of the providers. Starting to hear get the feedback and share experiences that really has hopefully helped a lot. Does it exist still out there? It certainly does.

Ms. Monroe I've noticed in the CON requests that we get, seldom is there a comment by the Ombudsman. I don't think it falls under your direction, but how robust is that program? Is it really meaningful? How much weight do you put on what they have to say?

Ms. Deetz We don't oversee the Ombudsman program. It's the New York State Office for Aging. I don't want to comment on them. We have a very good working relationship with the State Office for the Aging and specifically the Ombudsman program. Any type of activity if it's a significant complaint, immediate jeopardies, or any type of closure activities, we work hand in hand with their office to ensure that resident rights are maintained throughout that process.

Ms. Monroe Is there a reason why so many CONs we see say no comment from the Ombudsman? Does that mean the department and you guys who prepare the CON have no input or it's no meaningful input to report to us?

Ms. Deetz I can't answer that, Ms. Monroe. I think we'll wait toward the CON reviews and maybe or Andy, I don't know if you had anything, but we can take that back to Claudette Royal who's our state Ombudsman and ask her if there's any specific.

Mr. Kraut But to the point Ms. Monroe said, when the Ombudsman says I have an issue. It has tremendous weight.

Ms. Monroe I would agree, but I can't count on one hand how many times we've heard that.

Mr. Kraut You don't need more than one hand.

Mr. Kraut You're right.

Mr. Kraut Thank you for the report. I'm going to bring up an issue. I should have mentioned this to you beforehand. The state strategic plan on long term care w that was issued. Did anything come of it? Is there not the master plan? Was it not issued? It's the Master Plan on Aging. I'm sorry. Is there any anything that came out of that that has relevance for the council or in general?

Ms. Deetz Many of the folks around the table are aware it was released over this Summer. A lot of work went into that Master Plan for Aging. Many of those proposals had already been underway. Some of them have been completed. And as the different agencies that act in the state council continue to work on pieces of legislation and policies, aging will be at the forefront.

Mr. Kraut Thank you.

Dr. Boufford I was side barring with Jeff, so he asked the question he asked. I wanted to ask another one. Probably before COVID, I would say like the year before COVID, the council had requested a strategic plan for long term care services regardless of venue, whether it was home care, whether it was, you know, residential, etcetera, and there had it never happened, and I think that was... it doesn't happen there either. I can have lived through that for the last couple of years. It did a lot of good things, but it wasn't... That wasn't really the focus of the master plan in that regard. I was wondering now that it sounds really exciting the fact that you're there's somebody looking at each of the venues

in which this work is provided and you were all kind of together and engaging with each other if this might be something to reconsider. Because I think there was concern of sort of explosion of one type of long-term care services, perhaps lack of dealing with enough other models from other parts of the country, Ms. Monroe had been raising, and things have happened, but I think we haven't seen it in a kind of holistic way. Maybe it could just be presented, and we could hear it next time or that comment.

Ms. Deetz Thank you for that comment, Dr. Buford, and I think maybe you and I could touch space sometime too after this.

Mr. Kraut Thank you very much. Appreciate the reports.

Mr. Kraut I am now going to turn to Dr. Boufford to give us an update on the activities of the Public Health Committee and the Ad Hoc Committee to lead the state health improvement plan.

Dr. Boufford I went back and read through the notes from last meeting, and I had reported more to you than I thought I had, so I won't repeat myself. I did want to talk about what has been done and what's been going on since the last meeting of the council. I think it's fair to characterize the work that's been going on as sort of setting up the implementation infrastructure for the prevention agenda going forward. Just to remind everyone that the reason we raise this here is the Public Health Committee on behalf of the council, which has statutory authority to really responsibility really to oversee the development and implementation of the prevention agenda. It's one of our fundamental raison deter. You will have gotten an email recently from Colleen indicating that the originally planned meeting for December 2nd of the Public Health Committee and December 8th of the Ad Hoc Committee have been rescheduled. They've been deferred. Part of this was space room availability and part of it was because of this the holiday season, the responses for the Ad Hoc Committee were not what we wanted it to be to really bother to convene the group. The plan now we happily now to avoid any other conflicts with the Public Health Committee. We now have dates for the entire year of 2026 and venues. They've been sent out to you. We want you to be sure those are in your calendar and generally they're the day before the council meeting. There's just no time available during committee day. That's been one of our problems beforehand. The other issue is that the Ad Hoc Committee we're looking at a date now of January 21st, because we wanted to have that sooner rather than later, so that we can begin to continue the conversation that was begun in our September meeting. Let me mention three areas in which the Public Health Committee is overseeing the work other overseeing the prevention agenda activities on behalf of the council. One is the actual implementation of the prevention agenda itself. I'm going to talk about each of these in a little more detail. The second was we wanted to be made aware of how the prevention agenda is engaging interagency collaboration on advancing the prevention agenda because the new definition of or the new approach to the prevention agenda includes considerable work in other agencies that will be necessary to coordinate with the prevention agenda if it's going to be successful and show results in the other areas of education, housing, economic development, et cetera. The third area that we are overseeing is the issue of community benefit and the degree to which especially the community health improvement category of Schedule H and community benefit is very basically the same guidance to hospitals and health care facilities as the guidance of the prevention agenda and how that is being aligned over time. Those are the three areas we're looking at. The other one that's come up is that we've talked about it off and on in the council but now is the time I think to go back to it. With the new prevention agenda, we need to revisit the language related to the

CON regarding prevention agenda which was put into the requirements for acute care facility to submit. I think the Sloan Kettering one that came in this month is interesting because they said we didn't really do anything in the prevention agenda on the priority we talked about but we're adding value relative to chronic disease prevention. I've seen that we've had some submissions previously that said we didn't do anything, but it was approved. Some of my colleagues have raised this. I think it's revisiting what does that mean in light of these other issues that are being reported on and is there a sort of level for that. Those are the things we're looking at. Quickly on the Ad Hoc Committee the meeting that was held on September 16th. The Ad Hoc Committee are state level professional associations, nonprofits and advocacy groups that have whose issues and concerns are aligned with the prevention agenda. We have a number of state agencies that have joined us. They are not officially a part of that group. That's this interagency issue I mentioned. We have a very good opening conversation with about thirty to forty groups that have historically been involved. We decided since we're delaying now, the delay until the January meeting, we will go out to each of those that are currently members, validate that the person they've identified as their contact person designee is in fact the right person and that we have contact information with them. We're also going to open up the opportunity for other state level entities that meet the criteria for the Ad Hoc Committee to join. We're planning an extended three-hour interactive meeting for the next convening, which will allow the state the various members of the Ad Hoc Committee to meet with staff of the health department of the other agency of aging OASAS and OMH at least, who have been core members of our prevention agenda work to really talk about how their organizations can help advance the goals of the prevention agenda over the next while. There's a very clear sort of.... Hopefully, I won't contract is too strong, but I think very clear understanding of how they feel they can contribute at the statewide level with other agencies they may interact with and also at local level, mobilizing. Many of them have local infrastructure to work with local health departments and hospital leadership on implementing the prevention agenda locally. The other issue is what but what they might need to brief their constituents. Because in the past we've prepared Power Points, we've prepared presentations, people have. It's a two-way street. It's a really important vehicle for advancing the prevention agenda. The other quick comments, the timetable for having information, the hospitals have a federal requirement to conduct their community needs assessment and service plans and submit them by the end of December of this year. As you know, there was a delay in the formal issuing of the prevention agenda guidance to local health departments. It was finally it was issued in July. We're a little off sync on the timetable, and the way they're working to deal with that is that if to the degree hospitals and local health departments are working together on these submissions, which we hope is happening. It's a voluntary process. They will submit them together at the end of the calendar year. If they have not worked together because of the sequencing question, then the local health departments will have until July 1st to issue it to issue their or submit their plans with the guidance that they will be asked to have to describe to the department how they complement or supplement or align with the plans that were submitted by their hospital partners. That's the way that's going to go. There is a review within the department. The question I asked to our equity colleagues was for them to participate in that. Each of the submissions is reviewed and assessed as to its satisfaction, satisfactory and if they have been pushed back in the past, not too many, but sometimes. We'll have that process. I think, you know, even having our Public Health Committee meeting in February will be helpful. We'll have some information about how that went for the December submissions and how it's going on the review process. Let's see. You got in your written material, the notion there is a sort of explanation, technical assistance discussion process going on with webinars for local health departments, hospitals, other community organizations that have been going on during the month of September. The

interagency group within the equity part of the department were briefed in November on the prevention agenda and a discussion about how different agencies may be interested in working with us. I think it's important to point out that the interagency committee established within the equity group is really more of a personal services agencies that provide personal services, health social services to individuals, not necessarily agencies that are acting on community conditions and some of the other issues that we need to bring the other agencies in on. Dr. Whalen, who's done fabulous work on making sure all of this is happening that I'm describing, I'll thank them formally at the end of this has been we're we've been talking about this issue, and the idea would be to take some of those agencies from the existing council and then to identify others that need to be brought into a kind of special more Ad Hoc Interagency Group to focus on the prevention agenda implementation down the road. There was also mentioned in the last notes that that there was a contract out for sort of a health equity technical assistance contract that has been awarded to New York State IPRO and they have I think I've already begun they were beginning in September it's a one year contract to work with them the Office of Public Health Services arranged a conference call I did meet with them and as part of an entry conversation. I think only because I'm probably the only one historically involved with the prevention agenda all the staff in the department have changed since we started this and so it was a really good discussion. We went back to the historical background how it's modified over time, how it's changed more recently. I think it was helpful briefing. I had eventually identified them mostly working on the healthcare side which is useful in this process. Public health leadership is very involved. I'm satisfied they're very sensitive to the broader population issues. We'll see as it plays out but that they have the capacity to work both within the health facilities issues that we will be taking up and also outside the facilities. There's also been work on revising the dashboard that will receive the information, have it posted, and the website has been revised. A lot's been happening. Again, thanks to Liza Whalen and Mark Waldemeyer who has taken over the Office of Public Health Services and it renamed, and Zara who's been very involved in it as liaison on the data collection. Very briefly to the Public Health Committees role back to the interagency group. I mentioned we're going to be probably putting together more of an ad hoc group, and we'll be able to hear more about that at our next meeting. Finally, the community benefit reporting. We've been discussing this for a while. I mentioned last time the Governor's budget language requested the Commissioner to send to requests from the house from hospitals their Schedule H reporting as part of community benefit to be able to assess that. We in the prevention agenda, I keep saying this over and over again, I'll say it again, we are only interested in the one category of community health improvement, which it's a challenging category to define, but that's what we're interested in. The last time this was looked at about two or three years ago, there is there was a little shy of two hundred million dollars in that category every year. This is big money for public health when there is no other money coming into that community change process. That's why there's an interest. I think we've been discussing with Dr. Whalen, Dr. Fish. Whose office really manages both the CON language revision and the guidance to hospitals in submitting the report on their or on their Schedule H, the desire to begin at least to create some specificity in the reporting of that category. I am having when I was at the New York Academy, our staff did qualitative follow-ups to look at what was in the category. I think it's fair to say there hasn't been a lot of attention drawn to it because it's pretty small. It's in the data we have from luckily a doctoral thesis that was produced out of Albany in June, we have almost eight years of data by hospital by category across the entire state of New York on community benefits submissions and the amount of money in the community health improvement is 0.8 percent of all the submissions. It hasn't changed much, if anything it's gone down in the last four to five years. That's why we're focusing on it. We will continue to do so. We're in ongoing conversations about how that language can add

value and then again the council has I think we want to would like to see you know revisiting at least the conditionalities for prevention gender involvement on the CON process. We started with acute hospitals. We had actually talked about it going beyond acute hospitals but didn't get there. This may be an opportunity to look at broader engagement on Article 28 than we have in the past. I don't know if Dr. Fish wants to comment or whatever, but I'm happy to take any questions people have.

Mr. Kraut It covered a lot of real estate. It just shows the activity level of this, and you'll hear from the other committees in a moment.

Mr. Kraut Are there any questions for Dr. Boufford? Any comments?

Mr. Kraut You heard the last point she was making about the link, particularly on CON review, where we have a section on the community health improvement and the link to the prevention agenda and to have greater clarity. I think that will come back probably to us in in some other guidance that we will be giving for CON submissions.

Mr. Kraut I'm now going to move to Dr. Rugge and Ms. Monroe who is going to give us an update on the activities of the Health Planning Committee.

Dr. Rugge Placement of both diagnostic and therapeutic cardiac services in ambulatory settings, namely cardiac catheterizations for diagnostic purposes, and also percutaneous PCI coronary interventions, and namely putting stents in where there was a partial blockage that could jeopardize the function of the heart. We then proceeded in three phases. One is to us develop a shared and deep understanding of what these procedures are, what they contribute, what they amount to. Then to obtain a broad range of input from providers and their associations, number two, from the public, and also conferring with the Cardiac Advisory Committee, which is a special specialized focus on these very issues. I have to make another personal observation in that yesterday in the course of our meeting, Ann Monroe reminded me that at the beginning of all this, I was concerned that that we may find our committee members all tired out by all this discussion, all this learning, all these updates. With everyone contributing and not to do a debate but to come to a shared understanding of how to proceed with this important new initiative and its governance including of course PHHPC. With this we moved on to a number of topics for input and deliberations, including the significance and the consequences of PCIs in ambulatory settings by review of national experience, the focus on the experience of states that have enabled this opportunity with all the variants and their regulatory oversight, ranging from Texas and two other states that don't do any overset at all. If you're going to do it, you just do it to Illinois, which has a system already in place that's functioning for a few years that can be informative to the style and the approach that New York State undertakes. Our reviews included looking at the numbers and the percentage of intervention procedures in these ambulatory settings, the complication rates between inpatient hospital-based and outpatient ambulatory-based settings, finding that there was no significant difference. You can imagine which is higher and which is lower. Also, a comparison of quality, which, if anything, seems to indicate improved quality in the ambulatory settings, perhaps a little bit tainted by the selection of patients to go in those settings. In any case, yesterday, we, I think completed our third phase of deliberating and preparing recommendations for presentation to year to this council, which you'll hear in just a couple of minutes from Ann Monroe. In preparation now, based on yesterday's meeting is a printed report, which the committee will be meeting about and affirming, approving at our committee day in January, then relaying that, communicating that report to all the members of the council, coming back to the council in February with the hope that there would be approval to then submit

this to the department for consideration and development of new policies. Not that they haven't heard something about this already, but to formalize this process and demonstrate how the engagement of this council works to address change in a very fast changing environment. My favorite news story is between our last two meetings, Medicare decided yes indeed, Medicare would reimburse PCIs, percutaneous coronary interventions in these ambulatory settings.

Dr. Rugge Ann Monroe is our partner will proceed with just listing and mentioning the recommendations.

Ms. Monroe Thanks, John.

Ms. Monroe Can you hear me?

Ms. Monroe I'm not going to go through every recommendation because you'll see that in the written report. I want to highlight a few things. We went into the meeting yesterday with a draft of recommendations, and the committee really wrestled with that. We were aiming for general consensus of the committee. Frankly, except on one item, which I'll highlight here, we did have general consensus. The way that the committee is recommending is that we go in phases, that we be very conservative. Safety is the number one priority for moving these procedures out of a hospital into a community-based setting, particularly in ASC, and that until we can prove with good data, which is also a problem, getting data, because there isn't a lot of historical data that we can rely on, that it is safe to move it past these settings. We're suggesting you move sequentially, and you not start out with opening the doors for a wide variety of organizations. The Cardiac Advisory Committee will be in charge of this project, but we have emphasized in the committee that PHHPC needs to be kept informed of what's happening because we have great investment in this. Our committee spent five meetings learning about I didn't even know what PCI was and it turns out I'd had one.

All (Laughing)

Ms. Monroe What can I say? I probably wasn't the only consumer. They told me it was a flu shot. As we move past Phase One, if we move past Phase One, that it needs to be built on the learnings, the data that we developed. Also, as John just mentioned, there will be reimbursement changes, because this will take a period of time for this Phase One, and who knows what reimbursement models might be there, what marketplace changes might be there, as well as the learnings from the first phase.

Ms. Monroe Let me just touch briefly on a couple of those. As I said, we want to lead with safety. That is the number one priority of moving these services out of a hospital into a community setting. Until that can be shown to be safety in Phase One, we are not recommending that you move on to any other phases. I mentioned that we were looking for general consensus, and only one item did we not have general consensus. John and my commitment was that if there was a strong minority feeling, that would be reported as well as the finding of a larger part of the group. You know, I've never been a big fan of what I call consensus by exhaustion, where you force people into a unanimous recommendation. This was on who should be the primary driver in this Phase One. Everyone agreed it was hospitals. The question was what percentage of ownership needed to be shown in order to move into this phase? There was a debate, a very good debate in the group between 100% ownership of the ASC versus what did we call it? What did we call it? Oh, controlling. Thank you, committee. Controlling interest in the ASC. We

did have a vote on that question, and both will be reported. 100% did have six votes, controlling had four votes. Both will be provided in our recommendation. It was so close you can't really it will be up to the department and PHHPC if you choose to take a position on that. We said any anything in Phase One has to include Medicaid and low-income commercial patients. It can't just be a patient selection criteria that kind of creams off the top and doesn't represent those committees. We said there has to be a time-limited CON that comes before us along with an HEIA. That's going to be really important. We will have an opportunity to visit these potential sites from the PHHPC perspective and look at them. As I said, we were more specific in Phase One than in future phases because we have to wait and see what comes out of that phase. It was very clear on the committee's part that we wanted future phases to look at both geographic and sponsor diversity. It wouldn't just be 100% owned hospitals. It might be partially owned hospitals. It might be programs that have outpatient that want to move in this direction. We're agnostic right now on what those future phases should look like we want a significant emphasis on Phase One. It needs to look at what staffing is really needed, what the credentialing is, what the emergency protocols are, how far away do you need to be from a hospital when there's an emergency. These are all things that will have to be looked at in Phase One. We feel we built a lot of specifics on phase one, leading the leaving the other phases to what happens in development. As I said we really expect that PHHPC will be kept informed of how Phase One is going and what learnings there are. Our committee learned a great deal about diagnostic and interventional cardiology that As I said, at least I, but I think most of us didn't really know much about that. We're proud of the learnings that we've had. If you were here yesterday, you would hear people refer to those learnings. In closing, I would just like to thank Gene Heslin and the and Abby in the department, to my co-Chair, and to PHHPC for giving us responsibility for bringing this along. I don't want to put PSA in here. Is that what they are? Public service announcement. I think we've developed a process that it's kind of like what's the next one you want us to look at? We'll see. We had promised to have these results to you by today. We're pretty close to that, right? Except the committee has to look at the final document before we submit it to you. Thank you to PHHPC for giving us this opportunity.

Mr. Kraut I thank you and Dr. Rugge.

Ms. Monroe Any questions?

Mr. Kraut Just before we opened up to question, I think you and Dr. Rugge have to be thanked and congratulated because you did it's an amazing process. The feedback we get not only from other council members but from the public was extraordinary. I think you you're right. It's what's next. It was a very meaningful responsibility with the department. We're looking forward to it.

Mr. Kraut Let's open it up to questions. Any questions or comments? You're going to have another opportunity when the recommendations come back to us in a written format where we'll have a broader conversation.

Ms. Monroe The committee really requests that when those recommendations come to the council that you not pull out your pencil and try to redo the thinking of the committee.

Mr. Kraut Why don't we do this? I know in advance of sending out the agenda and the thing, once the committee meets and finalizes it, even if we're a little out of cycle, let's get it out to the council so people can read it and if they have questions or comments to direct them back to Dr. Rugge and Ms. Monroe and the department, so they, you know, as you

create your presentation, you can be responding. It would be nice if we have that opportunity, and then when we come together in the room, it might facilitate a more concise discussion.

Dr. Boufford I've been wanting to ask this question since you all took this up. How does this work? This kind of thing is exciting what you're talking about. I'm glad it's been satisfactory. How does this relate to the activities of the State Cardiac Advisory Council? I've never quite understood that from the beginning of that process.

Dr. Rugge Oh, there, here we go. Yeah, basically as we understand it, there will be two primary sources of support and information to the department as they compose regulations, which then will come back to us for approval and then will be implemented through the CON process. One is from PHHPC, the other is from the Cardiac Advisory Council, which is a group of experts with both state and national experience with a strong focus on cardiac interventions and the expertise that goes with that.

Ms. Monroe They are submitting recommendations as well to the department. It's our hope that they're very comparable and not antagonistic to each other. They will run this program and will make decisions around patient selection and things like that, the clinical side, but we want to make sure that some of these other issues are dealt with by them.

Mr. Kraut All I would say is this is another process issue that we have not had experience with by sometimes it's the Cardiac Advisory Committee alone without our input. By having our input here, you have a stake in it. We are the final decision maker, with the final review that goes in recommendations to the department whether or not to approve or disapprove. We'll see there'll be a new process going forward if there's any changes of these in the future, most likely it would have to come back to us as well as the Cardiac Advisory Commission. That'll be something we'll take up on.

Dr. Rugge In keeping with that we have already as a committee, on behalf of the council, conferred with the Cardiac Advisory Committee. It is clearly a cooperative approach, not one that is separated or diverse. That's how we bring, we hope, the best possible approach to the very fast changing environment that we're facing, in this case in cardiac care.

Mr. Kraut We look forward to your next report and the final reports. Thank you.

Mr. Kraut I'm going to turn to d Mr. La Rue on a report on the Nursing Home CON Ad Hoc Committee.

Mr. La Rue Thank you.

Mr. La Rue During our first two meetings of the Ad Hoc Committee with the Public Health and Health Planning Council, the committee focused on the qualifications and review of proposed operators or operating entity to ensure that the key individuals have adequate and relevant experience to serve in the capacity of an operator. If such individuals have no experience operating a residential health care facility was also discussed at great length. The current requirements are in New York State Public Health Law 2801-A3 and 3B, and New York State Public Health Law 2803B and New York State Public Health Law 2896-C10 and New York Codes and Regulations 600.1 and 600.2. These current qualifications are defined as adequate is defined as a minimum of five years' experience. Relevant is defined as a licensed nursing home administrator, director of nursing, owner, operator, or

other leadership position held at a healthcare facility. If sufficient experience is not demonstrated, the applicant is required to revise the operating structure to include an individual with acceptable experience. A condition may be included on the approval that requires the individual with clinical experience to remain in the operating structure for a period of no less than five years. Our third committee meeting is coming up, and following that meeting, where we expect that we will conclude the input and begin developing recommendations, we expect that the fourth meeting, those recommendations will be made and brought back to the full council and the department.

Mr. Kraut Any questions or comments?

Dr. Boufford In my continuing effort to inject the notion of prevention into the work. I don't know if this was on the agenda for the committee, but since it's opened up, I wanted to raise it. Again, we had talked before about the degree to which CON applications for residential long-term care facilities could that the prevention agenda goals might be extended to some response to that. Let me be clear about what I'm talking about. One of the things that's very clear in the prevention agenda is this it's explicit in the leadership issues that it's this life course approach. It's all ages. We've had really strong engagement from because of the Master Plan on Aging, but also AARP and other advocates for aging all along the way to be sure that the needs of older people, and I know everybody in a residential nursing home is not an older person, but the needs of older people in in the prevention agenda work. It strikes me that if the group when you finish you're the first issue, if you're having as much fun as Ann and John seem to be having, that you might consider the degree to which there might be something added to the CON submissions of long-term care facilities relating to the prevention agenda. There's a lot of work on healthy aging of opening up the walls of nursing homes to communities, of allowing residents who are able to engage more easily with their community so they're not isolated, et cetera, et cetera. There's a space there that I think I'd love to If you all could tackle it maybe before you abandon the show.

Mr. La Rue We'd be happy to do so. If you have specific recommendations or thoughts. If you could forward them to us, it'd be very helpful. Thank you.

Mr. Kraut Any other questions?

Mr. Kraut Dr. Soffel.

Dr. Soffel Hi. I just wanted to make a comment. During one of our meetings, we had a rather chilling presentation from staff from the Attorney General's Office about what has happened in several nursing homes across New York State that have gone from a not-for-profit operation to a for-profit one. They laid out for us kind of the systematic ways that for-profit entities suck money out of the facility to pay profits to their owners and how they do that and the staffing changes that happen so to allow that to happen and the impact on quality. It was a very eye-opening presentation. I know that we can't change allowing for-profit entities to operate in New York State, but I think for all of us, because this was part of what generated this Ad Hoc Committee was questions about these conversions. I think all of our sort of implicit fears about those conversions are, according to the Attorney General staff quite well founded. It's something just for all of us to keep in mind.

Mr. Kraut I would encourage anybody who has not seen it's on the web archive. You should see it. It is dramatic. I suspect it's a Phase Two conversation maybe for the Ad Hoc Committee at some point in time.

Dr. Kalkut Scott, thank you for this.

Dr. Kalkut Just a quick one. In the Phase One, what other large topics are you taking on?

Mr. Kraut That's it.

Dr. Kalkut Just the credential.

Mr. La Rue Actually, the entire gamut of what Dr. Soffel just mentioned has been discussed at great length. We certainly expect that we'll be making some recommendations based on all the information that we receive that are within the swim lane of our authority to do so.

Dr. Kalkut Okay, that's great to hear. Thank you.

Mr. Kraut Again, I want to thank you. This is another venue that's been tremendously helpful and beneficial and really good. I just want to remind people we're going to get the final reports of both the Planning Committee and the Ad Hoc Committee, most likely by February 19th. That's going to be a full council day in Albany. Just if you haven't budgeted it in your calendar, please make an effort to be here because those are going to be important discussions and important notes. That's going to be on February 19th is the full council meeting. I'll repeat that at the end.

Mr. Kraut I'm going to give the report on regulations and legislation committee. The following proposed regulation was presented to the committee for information only and will be presented to the committee and the full Public Health Council for adoption at another date. This is 24-05 amendment of Subpart 7-2 of Title 10. That was for the children's camps. We heard this morning many of you were here about the regulation and that'll complete the agenda of the Codes, Regulations and Legislation Committee. If there's any questions, we'll staff is available. I think all of you were here this morning to hear it. Thank you.

Mr. Kraut I'm now going to turn it to Mr. Robinson who's going to give the report on the actions of Establishment and Project Review.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson I actually would like to begin by acknowledging the work of Department of Health staff around the CON process itself and particularly calling out Shelly Glock and Andrew Lebwohl. I'm learning your name. We are well served as a committee by the work of those two individuals and their teams and just want to acknowledge the terrific work they do to get us ready to do what we do here. Mr. Kraut noted that we are going to batch these applications, and so this is sort of a last opportunity suggestion. If you have anything you want to pull out for individual discussion, happy to do that. Otherwise, I'm just going to roll.

Mr. Robinson Roll I shall. These are applications for acute care services under construction.

Mr. Robinson Application 251219C, Memorial Hospital for Cancer and Allied Diseases in New York County. This is constructing a new twenty-seven floor building and certifying 156 net new medical surgical beds, forty intensive care beds, twelve ORs, fifty-four packing

rooms, a radiology suite, and an interventional radiology suite. The new building will be connected to the current Memorial Hospital through an existing tunnel and a new two-story bridge. This is just a one of the largest projects, I think from a capital cost standpoint that we've seen here, but certainly well needed and long overdue.

Mr. Robinson Application 252033C, Guthrie Cortland Medical Center in Tompkins County, certifying a new hospital extension clinic in lease space for a single specialty ambulatory surgery, specializing in gastroenterology at 720 Willow Avenue on the 3rd floor in Ithaca.

Mr. Robinson Continuing on with applications for ambulatory surgery centers.

Mr. Robinson 252042C, Queen's Surgical Center in Kings County, certifying a new multi-specialty ambulatory surgery center, extension clinic in 1807 66th Street in Brooklyn, and allowing for the performance of certain renovations. The extension clinic will consist of seven operating rooms, one procedure room, and provide pediatric dental ophthalmologic and urologic surgical services. This is, by the way a limited life application for five years from the date of issuance.

Mr. Robinson I'm going to make a move for those applications as a batch, so the department and the committee recommend approval. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second by Dr. Berliner.

Mr. Kraut May I have a vote?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson This next application will be taken separately because of a conflict and recusal by Dr. Kalkut who's left the room.

Mr. Robinson Application 251235C, NYU Langone Hospital in Suffolk County. This is to construct a five-story building on the hospital campus to house 144 med surge and ICU beds with no change to the number of certified beds. Department and committee may recommend approval with conditions and contingencies. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second. Dr. Berliner.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Kraut You have Dr. Kalkut come back.

Mr. Robinson Application 252076C, Liberty Endoscopy Center in New York County, noting an interest by Dr. Lim. Sorry. Certify a second specialty vascular surgery to become a dual single specialty freestanding ambulatory center with no construction.

Mr. Robinson Moving on to other ambulatory surgery establishment and constructions.

Mr. Robinson 25123E, Advanced Surgery Center LLC, doing business as EMU in Rockland County. This is to transfer 100 percent membership interest from the sole withdrawing member to a new member. This has this application has a three-year expiration of the operating certificate.

Mr. Robinson Application 252019B, Hampton's Endoscopy in Suffolk County. Establish and construct a single specialty ambulatory surgery center for gastroenterology at 68-100 Old Riverhead Road in West Hampton. This application has a five-year limited life. The department and the committee recommend approval with the conditions and contingencies that I noted.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Application 252038B, Springbrook Wellness Clinic in Otsego County. Establish and construct a new DNTC Center at 5588 State Highway 7 in Oneana. The proposed primary care clinic will serve rural and medically underserved communities with a specialized focus on individuals with intellectual and developmental disabilities, an IDD population facing persistent disparities in access coordination and continuity of care. The committee was just exceptionally moved by this application and highly supportive of it.

Mr. Robinson Application 24213E, Ulster Dialysis LLC in Ulster County, transferring 75.5% from one withdrawing member to two remaining members with one new member LLC.

Mr. Robinson I'm going to move that batch. The department and the committee recommend approval.

Mr. Kraut I have a motion.

Mr. Kraut I have a second by Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Robinson Moving onto residential health care facilities.

Mr. Robinson Application 231002E, JCH Operations LLC doing business as Sands Point Center for Rehab and Nursing. This is in Nassau County to establish JCH Operations LLC as the new operator of Sands Point Center for Rehab and Nursing, which is a 180-bed residential health care facility currently operated by AGMA Inc. At 1440, Port Washington Boulevard in Port Washington. I'll note that there was a change in the contingency number five, which is the submission of a photocopy of an amended and fully executed lease agreement acceptable to the department, and contingency number six, a submission of executed consulting agreement acceptable to the department, have been satisfied and removed from the application.

Mr. Robinson Application 24101E, Kirkhaven SNF, OPCO LLC doing business as Kirkhaven Nursing and Rehabilitation. This is in Monroe County to establish Kirkhaven's SNF OPCO LLC as the new operator of Kirkhaven, a 147-bed residential health care facility, currently operated by Genesee Valley Presbyterian Nursing Center at 254 Alexander Street in Rochester.

Mr. Robinson 252050E, Maplewood Senior Care Inc DBA, the Maplewood Nursing Home in also in Monroe County, establish Maplewood Senior Care Inc as the operator of Maplewood Nursing Home Inc, a seventy-two-bed residential health care facility currently operated by Maplewood Nursing Home Inc and change the name of the facility to the Maplewood Nursing Home. The Department and the committee recommend approval with conditions and contingencies as noted. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson We're going through a series of health agent home health agency licensures, mainly around changes of ownership. I'm going to batch these as well.

Mr. Robinson 231227E, No Limits New York City Corp, transferring 100% ownership interest to a new shareholder.

Mr. Robinson 231279E, Exclusive Home Care Services Inc, transferring 90.1% ownership interest from one withdrawing shareholder to one existing shareholder.

Mr. Robinson Application 232007E, Crocus Home Care LLC, transferring 46.86% ownership interest equally from one existing member to two existing members.

Mr. Robinson 232067E, Affirmed Home Care, establishing Affirmed Home Care Inc as the new operator at 70 West 36th Street on the 6th floor in Manhattan.

Mr. Robinson Application 232 107E, Agent Care Home Care Services Inc doing business as CNT Home Care, transferring 90.1% ownership interest from a withdrawing shareholder to the remaining shareholder.

Mr. Robinson Application 232 114E Expert Home Care Inc, transferring 100% ownership interest from two withdrawing shareholders to two new shareholders.

Mr. Robinson We continue. Application 232161E, Constant Care 247 LLC establishing Constant Care 247 LLC as the new operator of a licensed home care services agency, currently operated by Integrity Home Care Services Inc at 813 Fay Road in Syracuse.

Mr. Robinson Application 232174, Silver Lining Home Care Agency, transferring 50% ownership interest to a new shareholder.

Mr. Robinson Application 23210E, Be Well Home Care Agency Inc, transferring 90.1% ownership interest from one withdrawing shareholder to the remaining shareholder.

Mr. Robinson Application 24101E, Efficient Health Careers, Inc, doing business as Unicare Home Care, transferring 100% shareholder interest to a new shareholder LLC.

Mr. Robinson Application 242154E, Bay Shore Health Care Inc, transferring 100% shareholder interest to a new shareholder LLC.

Mr. Robinson Application 242-238E, Accent Healthcare Services, transferring 100% ownership interest from one withdrawing shareholder to a new shareholder corporation.

Mr. Robinson Application 251172E, Meadow Hills Assisted Living LLC, establishing Meadow Hills Assisted Living LLC as the new operator of an existing licensed home care agency operated by Midway AL LLC doing business as Castle Senior Living at Forest Hills, which serves the residents of the Assisted Living Program ALP.

Mr. Robinson The Department and the committee recommend approval of this batch. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Are there any questions?

Dr. Ortiz It's my endless quest of whenever we get these batches and there's adjectives that have quality indicators in the name of the organization that bothers me.

Mr. Kraut Yes, best, very best, triple A best, extraordinary. I would say this is an issue of law.

Mr. Kraut Are their certain names that we---

Ms. Monroe I agree with you, Dr. Ortiz. We at a very at a point in time, since I've been on the council made a very strong recommendation to applicants that they not come in with this in their name. Whether that meant they wouldn't get consideration or not is we never got that far, but that they should not have these things in their name.

Mr. Kraut I would suggest this is from a protecting consumer point of view. I have a feeling this is under New York State corporate law, not in the in the Secretary of State. Could you come back and maybe instead of putting you... Listen, instead of putting you on the spot today.

Ms. Ngwashi Good afternoon. Marthe Ngwashi, Attorney at the Department of Health. These are entities that are just doing changes of ownership. You've already approved these names. You do have the ability to not approve a name, but that would... It would be great if you could have that discussion at the Establishment meeting and then you can bring it to the full council.

Mr. Kraut Let's differentiate between entities that are approved, which is essentially these batch, and anything that new comes for us. If there is a name for Establishment that has an adjective that is potentially misleading to the public, we will put that in a separate category of discussion. We could choose or not choose to approve it based on the name. I think just making this statement alone should solve the problem, if you get my drift out there public. That's one way to solve the problem.

Mr. Lawrence Rather than have an applicant show up with a name that it is likely to be this not approved, is there something that the department can do in advance to let an applicant know that you may run into a name.

Mr. Kraut They heard what we said. The state the Secretary of State approves the name. The department typically doesn't see that until a little farther in the process. We'll just get the word out.

Mr. Robinson Just to make a point that we actually at the committee have raised this issue many times. I think the strength with which you made these comments, Mr. Kraut.

Mr. Kraut We'll put it in a new lane.

Mr. Robinson Will maybe give it a little bit more energy and I really appreciate your actually aligning with the general sentiments of the committee on this. We've been after this for a while. Thank you.

Mr. Kraut We have a motion. We have a second.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Nay?

Mr. Kraut Abstained?

Mr. Kraut Motion carries.

Mr. Robinson I don't see any problems in the certificates that I'm going to run through, but feel free to call 'em out if you see them.

Mr. Robinson I'm now batching the certificates. I'm just going to designate them by name, and then because all of these applicants have already had a recommendation from the department and approval by the committee. These are all certificates of amendment of incorporation or certificates of assumed name. I'm just going to give you the labels. Mercy Hospital of Buffalo, Fresenius Kidney Care, Home Dialysis of the Bronx, Fresenius Kidney Care, Woodstock Bronx Dialysis Center, Fresenius Kidney Care Norwood Dialysis Center, Fresenius Kidney Care Park Slope Dialysis Center, Fresenius Kidney Care Hutchinson Metro Dialysis Center, Fresenius Kidney Care, Morris Park Dialysis Center, Fresenius Kidney Care, St. Albus, Albans Dialysis Center, Fresenius Kidney Care, Greenwich Village Dialysis Center, Fresenius Kidney Care East Harlem Dialysis Center, Fresenius Kidney Care, South Slope Dialysis Center, Fresenius Kidney Care, Crown Heights Dialysis Center, Fresenius Kidney Care, Benson Hearst Dialysis Center, Fresenius Kidney Care, Maspeth Dialysis Center, Fresenius Kidney Care, Jackson Heights Dialysis Center, Fresenius Kidney Care Home Dialysis of Queens, Fresenius Kidney Care Jamaica Queens Dialysis Center, Fresenius Kidney Care Center Reach Dialysis Center, Fresenius Kidney Care Port Jefferson Station Dialysis Center, Fresenius Kidney Care Bayshore Dialysis Center, Fresenius Kidney Care Park Hill Dialysis Center, Fresenius Kidney Care, New Rochelle Dialysis Center, Firstline’s Kidney Care, Bayside Dialysis Center. Under certificates of merger, Clinton Springs Hospital and Found Clinical Foundation, Inc and Rochester Regional Health Foundation into Rochester Regional Health Foundation, United Memorial Medical Center Foundation, Inc and Rochester Regional Health Foundation into Rochester Regional Health Foundation, and Newark Wayne Community Health Hospital Foundation Inc and Rochester Regional Health Foundation into Rochester Regional Health Foundation. I will make a point that with regard to the Fresenius ones, we actually

think that this is actually good consumer labeling and that these changes are actually a positive thing because they reflect what's actually going on. With that, I move this batch.

Mr. Kraut I have a motion.

Mr. Kraut I have a second. Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstained?

Mr. Kraut Motion carries.

Mr. Robinson I'm going to take this next one individually. Application 251185B, Hempstead Multi-Specialty ASC LLC in Nassau County. Noting an interest by Mr. Kraut. I will also note that we had two members of the committee abstain on this vote to establish and construct a multi-specialty ambulatory surgery center at 274-278 Fulton Avenue in Hempstead, specializing in orthopedic spine pain management and ophthalmologic surgery. The department and the committee recommend approval with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut Hearing none, I'll call the vote.

Mr. Kraut All those in favor, "aye."

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstain?

Mr. Kraut Motion carries.

Mr. Robinson Application 252056E, New York Surgery Center in Queens, LLC, Queens County, noting an interest to Dr. Lim, transferring 52.5665% approximately. Ownership interest in four withdrawing members and one withdrawing member LLC and 32.4% interest from two remaining members to the three new members and one new member LLC. The Department and the committee recommend approval with conditions and

contingencies with an expiration of the operating certificate five years from the date of issuance. I so move.

Mr. Kraut I have a motion.

Mr. Robinson I have a second, Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Robinson Our final application, 251167E, Eger Health Care and Rehabilitation Center doing business as Arch Care at Eger Health Care and Rehabilitation Center. This is in Richmond County, noting a conflict and recusal by Mr. La Rue, who has left the room to establish Catholic Healthcare Systems as the sole member and active parent of Eger Health Care and Rehabilitation Center a 378-bed residential health care facility at 120 Meisner Avenue on Staten Island, and rename it Arch Care at Eger Health Care and Rehabilitation Center. The department and the committee recommend approval with a condition. I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Abstention?

Mr. Kraut The motion carries.

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

Mr. Kraut A very productive committee report at that.

Mr. Kraut I'd like to thank everybody and the Department staff for what was a very productive and fulfilling meeting today and all the committees that made the report and Ms. Kim and Ms. Deeds and the Commissioner for the information they shared with us. The

next regularly scheduled committee day is on January 27th, and the full council is going to convene on February 19th. Both of these meetings will be held in Albany due to the construction that's occurring here in Church Street. Just remember, as I said, please try to make these meetings. We need a quorum. We're going to take up the recommendations of several weeks and months of two committee's work. I think we'd benefit from everybody's involvement in in that discussion. I want to thank the committee members. I want to thank PHHPC, the DOH staff for their service. This has been a remarkable year. I think we have made a lot of progress and doing things that are very meaningful, and I just want to take the opportunity to wish everybody a joyous and a meaningful holiday surrounded and celebrated with the warmth of family, friends, and community.

Mr. Kraut May I have a motion to adjourn?

Mr. Kraut All those in favor, "aye.".

All Aye.

Mr. Kraut We are adjourned.