# NEW YORK STATE DEPARTMENT OF HEALTH
# PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
# FULL COUNCIL MEETING
# May 7, 2026
# ESP, CONCOURSE LEVEL, MEETING ROOMS 2-4 ALBANY
# TRANSCRIPT

Dr. Boufford: Thank you. Thanks very much. I'd like to call to order the meeting of the Public Health and Health Planning Council and welcome our members, participants, and observers. As a reminder, I'll go through the reminders here for our audience viewing the public meeting via webcast. There is a form you need to fill out. If those of you that are here in person, it should be on the table outside the door. For those of you that are listening, please do go on the website of the department under certificate of need and download that form and send it in to Ms. Leonard.

I'd also like to remind council members, staff, and the audience, this meeting is subject to the open meetings law. It is broadcast over the internet. The webcasts are on the Department of Health website, and on-demand webcasts will be available no later than seven days after the meeting, for a minimum of 30 days, and then a copy will be retained in the department for four months.

I'm also welcoming the commissioner, Dr. McDonald. I just welcomed everybody else, and you came on over. So, anyway.

Dr. McDonald: Hi, how are you doing? Thank you.

Dr. Boufford: You're very welcome. So, some suggestions and ground rules for the meeting. Please keep yourselves on mute when you're not speaking, and obviously if your mic is open, papers are distracting, et cetera, for other noises. There is synchronized captioning, so please try to avoid talking over other individuals. First time you speak, you're asked to identify yourself and whether you're a member of the council. And I want to encourage the members, staff and public to join the department's certificate of need listserv, where there are regular set of updates on the status of various applications and their process. And there are printed instructions at the reference table outside on how to join.

Just a quick review of the agenda today. Department of Health reports, we'll hear first from Dr. McDonald, Commissioner McDonald, who will provide a report on the Department of Health activities. Dr. Fish and Ms. Deetz will provide a report on the activities of the Office of Healthcare.

I've got some contradictory information here. They don't run long-term care, so that's...

Ms. Leonard: So, it's going to be...

Dr. Boufford: Val's doing... Okay. So, Dr. Fish is not going to be... Okay, thank you very much. I didn't get that clear. Apologies. Ms. Deetz is going to provide a report on the activities of the Office of Aging and Long-term Care. I just saw Mr. Label come in, so maybe they'll have a tag team there. I'll provide an update on the activities of the public health committee and the ad hoc committee, which met yesterday.

And then project review recommendations and establishment actions. Mr. Robinson will be reporting on a number of CON applications that reviewed at the meeting of that committee. And just a little bit of the ground rules here for council members, to remind you that we do, in fact, batch applications under CON, and any of you, I hope you've had time to take a look at the agenda, and let me give you a few minutes if you would like to pull any of the applications out of the batch in which they sit and have them considered individually. Seeing no reaction from my colleagues, I'll assume that the batching holds for Mr. Robinson.

And next, I'd like a motion to adopt the February 19th meetings of the FBIC. May I have a motion? So, moved. Well, Mr. Berliner and Mr. Thomas moved and seconded. All in favor? Any opposed? Any abstentions? Those pass. And you also have been given the council meeting dates at the end of the materials here. I'd like a motion to adopt those meeting dates. I think I would add one for the public health committee on the 23rd of June. So, motion to R2. Dr. Watkins moved and Dr. Berliner seconded. All in favor of those dates, confirming the dates. Everyone. Any decline? Yes, Dr. Eisenstein?

Dr. Eisenstein: I just want to clarify on the calendar and the documents that you're referring to, it says the June meetings are in New York City. I think, is it correct they've been switched to Albany?

Ms. Leonard: That's the 27th.

Dr. Eisenstein: Oh, okay. I'm sorry.

Dr. Boufford: It's called advanced planning, here.

Dr. Eisenstein: It's the same dates.

Ms. Leonard: Now we know June is in...

Dr. Eisenstein: Thank you. My apologies.

Dr. Boufford: Yeah, the June meeting is in Albany. It's important to be aware of that. They also received proposals for revision of our bylaws, and I'd like a motion to adopt the revised council bylaws. Dr. Berliner moved. Mr. Thomas seconded. Any questions or concerns about the bylaws? I think Ms. Monroe had some questions, and my understanding is that Ms. Leonard has answered those questions satisfactorily. So, I think we're in good shape. I think everyone saw that email activity. So, all in favor, please, of the bylaw's revision. Any opposed, any abstentions? Bylaws revision passes. And now it's a pleasure to hear from Commissioner McDonald, who will update us since the last council meeting.

Dr. McDonald: Thanks, Dr. Boufford. Good to see everybody again today, and I see you've all found this meeting room, so we're across the hall as usual, here. So, the first thing I want to share with folks is that the New York State Department of Health last month earned a top workplace award, maybe something done through the Times Union. And I think I just want to get that out there.

Winning a Top Workplace Award, I think that's a big deal for the Department of Health. When I think about when I took over in January '23, we're a team of 4,000. Now we're a team of roughly 5,500, and the cultures really shifted. I think it is important to know that no one person was responsible for that. It was interesting to me just how this organization has transformed coming out of the pandemic. The governor was extremely supportive of the Department of Health. Anything I asked for, I got, and it's just been really nice.

And I think it's one of those things where organizational culture is really important to any organization. If you run a hospital, healthcare enterprise, you know that. If people don't feel comfortable at work, don't feel like they're part of a mission, it doesn't really matter what you do. But this is one of the things we see from our people, if they really feel like they're part of a mission, they're happy. And so, I'm excited about that.

I'd like to talk now a little bit more about something we've never talked about before, which is Hantavirus. Since Hantavirus is in the news, I thought I'd bring it to your attention a little bit from our perspective. You might be wondering, what does New York State Department Health have to do with a cruise ship somewhere off Cape Verde? And I just think I'd just talk a little bit about how public health works. So, this is normal. The World Health Organization works with CDC. CDC works with state and local health departments. So of course, I know what's going on a cruise ship in Cape Verde.

And I just want to talk a little bit about Hantavirus in general. The strain of Hantavirus that we're talking about is the Andes strain, A-N-D-E-S, which is common in Argentina and Chile. In other words, the disease Hantavirus occurs there not infrequently. And I just want to make sure this is clear. This particular strain is a known disease with known recommendations. There's no treatment for it. It's supportive care. And just important to have a perspective on this is, right now how we're working with CDC is, what CDC is doing is working with the state department, with other countries to how to get 17 American citizens repatriated to the United States. So that's something that we expect to occur in the next several days, which is what CDC tells us.

We do not see a nexus to New York state at the moment. The risk to the United States is really almost nothing. The risk of New York right now is nothing. There is no concern. But why do we care about this? I want to bring back a concept here. You might remember me talking a little bit about the Global Operator Alert and Response Network from the World Health Organization, that we joined earlier in the last year. So, we are on calls with them. We're on calls with CDC. This is all very normal. We're working through all this.

And I think it's just important to kind of just have a little context that the thing about the Andes strain that's capturing the news is its spread person to person. I think regrettably, when we think of person spread, your mind, if you're like the rest of us, drifts towards the pandemic, because that's what is fresh on our mind still. So, it's not contagious like that. It's not an airborne virus. It's sustained, prolonged, close, personal contact. Typically, a spouse would get from another spouse. So, it's not an efficient virus as far as transmission goes. So, we're keeping track of this scenario quite closely.

And then as a side note, some of you know, I used to work on the Navajo Reservation, and I bet there's someone in here who's a medical historian who knows a little bit about 1993, when Hantavirus was first described in the United States. And I share this with you. It was described in Arizona. It was described among the Navajo people, because a Navajo healthy adult passed away. And what was interesting about the 1993 experience is Hantavirus wasn't described in the United States prior to that.

But what was interesting, when CDC came, they worked with the Navajo traditional leaders and traditional healers and learned a little bit about it. Because what they had known among the Navajo people was, when there's a lot of rain in the spring, you have to be really careful about interacting with deer mice, because you don't want to interact with deer mice or with prairie dogs.

One of the things you should know is, when I worked on the reservation, we oriented everyone who came to us about Hantavirus because Hantavirus was something we saw there. Not commonly, but you had to be ready for it. If you missed it, you missed it, right? We oriented people about plague as well, because that happened there too. There was other diseases we oriented people about because it's a different part of the country. You see different diseases. This was all normal. It's still the case today.

I just shared that illustration. I thought it was really interesting how CDC in '93 listened to the traditional healers at the time, and it helped them isolate the Hantavirus, which was first described in the United States in 1993. Having said that, we're following closely with this, and we're just going to see if there's any role for us to play like the New York State Department of Health.

I'm going to shift now, just to touch base on the Rural Health Transformation Program. Keep in mind, it's the Rural Health Transformation Program. It is not a grant. It's a cooperative agreement with us and the Center for Medicaid and Medicare Services. We have $212 million coming each year for the next five years, if we meet what CMS has told us to do.

One of the things that we need to happen during this budget is that we've got what's called notwithstanding language. In other words, it would be impossible for the Department of Health to enter into contracts if we have to go through the usual controller review and attorney general review. That typically takes 13 to 18 months. So, you have to have all the money obligated by September 30th of this year, 26th. So, we have to really move on this stuff. Having said that, you heard the governor announced this morning at 9:00 with the assembly and the senate, a handshake agreement. So, we expect the budget to be resolved in the next several days or sometime next week. So, we'll see where that goes.

The Rural Health Transformation Program though, we're still working on it. We just need that language. But just to refresh your memory, there's four big areas we're working on. One is establishing coordinated rural health partnerships. We have $77 million planned for this year. Strengthening rural committees and technology, enhanced primary care, we have $30 million planned for that. Building a sustainable rural healthcare workforce, we have $13 million planned for that. And investing in technology innovation and cybersecurity enhancements, we have $79 million obligated for that. Keep in mind, we've done a lot of stakeholder engagement. We're doing a lot to get this moving in the right direction, and as soon as the budget's passed, it will just let us move forward, as long as that provision is in place.

I want to just talk a little bit about the Master Plan for Aging. As you know, last June, the Master Plan for Aging was completed and submitted, and that was great to see that. Right now, we are having what's happening next, which is eight state agencies are having their steering committee meetings. The first committee meeting was March 26th of this year, and there'll be more steering committee meetings as decided by the State Office for Aging, working with the Department of Health.

One of the things we did as part of the Master Plan for Aging is our direct caregiver flexibility grant. That's to help strengthen the long-term care workforce by establishing regional training centers and support hubs. It's $19 million a year for the next five years. We've also created a Center for Hospice and Palliative Care in the department. Cara Travis leads that.

There's other things that the department's doing on the Master Plan for Aging. Keep in mind, the Master Plan for Aging doesn't have a line item in the budget. It's really up to the legislature and other stakeholders to bring forward things from the Master Plan for Aging and see if they can procure funding for it. And some of the things we can do don't require funding. Like one of the concepts that came out of the Master Plan for Aging was some of the scope of practice changes we've been advocating for. One of the things we heard from nursing homes is, why can't we have certified medication aids pass meds in New York State nursing homes, like occurs in 38 other states, and like we do in New York and the assisted living and in the office of developmental disability. So, we're hoping this year that we get that across the finish line.

And of course, there are also proponents in the Master Plan for Aging of hoping medical assistants could administer vaccines. As many of you know, New York's the only state in the United States that doesn't allow a medical assistant to give a vaccine. The other 49 states have been doing this for quite some time. And these are just a few examples of certain things that are policy-related initiatives that actually don't have a budget item attached to it but really do provide some labor relief. We have a healthcare workforce shortage. Every state has a healthcare workforce shortage, but one of the things we have to do is catch up with other states and let people work with the skills they were trained to do.

And just about workforce in general, one of the focus areas I have for this year is workforce. We have 25 different workforce programs at the Department of Health. Dr. Carrie Rosamilia runs the Workforce Innovation Center for the Department of Health. But of our 25 workforce programs, we have $570 million committed between now and March 31st of 2027. That's committed money. In other words, some of it came out of the '24 budget, '25 budget, but that's implemented money.

Really trying to just, I think, stop the vicious cycle of a healthcare workforce shortage and create a virtuous cycle of a healthcare worker surplus. This is funds that are going to be used for loaner payment for physicians and nurses, but there's money in the career pathways training to help people get into healthcare. There's money to help more people get into care. There's a lot of resources that we have going on this year.

But really, it's to help stop the vicious cycle, because when you have healthcare worker shortage, you have access to care problems. You have quality of care problems, you just need more regulatory actions, more workplace violence. It's just, there's all these problems that occur. There's all this undue pressure on Medicaid. It just isn't helpful. What you really want to do is create a virtuous cycle. We have more healthcare professionals, better access to care. People can have better quality outcomes. Less burnout among healthcare workers. You just see the stability of workforce. So that's really what New York is working on, and that's good.

I want to shift to a different topic completely. I think many of you know Dr. David Holtgrave who works for the department as our emerging drug threat coordinator. He's also one of our senior policy advisors, but Dr. Holtgrave and his team did wonderful work working on just really looking at drug checking in a veterinary anesthetic called medetomidine. They published an article last month in the New England Journal of Medicine and really just looked at drug checking and just really identified how common medetomidine is becoming in our illicit drug supply. Almost one in four samples that were tested had that. Now keep in mind, they're not testing every sample, but one in four quite a bit.

So, what the Department of Health has done about this over the last year is, we sent out a health alert about this to our healthcare providers. One of the things we just sent out last week was, what do healthcare providers need to know about managing people who've had medetomidine? Because really, what you see most commonly is Its people who are taking fentanyl, but also medetomidine. And keep in mind, it changes people's cardiovascular status, so people need to know how to manage what might be some hypertension. And what are some remedies to do that. We still advise people to, of course, give Naloxone.

But I think it's just an example of there's a lot of scholarly work that occurs in New York State Department of Health. This may surprise you, but our department publishes over 300 peer-reviewed articles a year. I highlight just this one just because it's interesting and it made the New England Journal of Medicine, and it was in the media quite a bit too. So, I think that's good.

I do want to foreshadow a little bit. You're going to see a regulatory package coming up today. Dr. Luddow and her team have been working on this, and I just thank them so much for doing this, but every once in a while we have to just update the list of reportable diseases, and so you're going to be seeing some things that are going to come forward to you in the regulatory world. Some of these are a little bit more common, like blastocytes will become laboratory-reportable disease. Keep in mind, when it's a lab-reportable disease, the lab has the information. They just need to share it through us electronically. So not as much work on the part of anybody.

And one of the things we're really trying to be very careful is, you don't want to shift work to a local health department if you don't have to. Local health department's already doing a lot. But you'll see other information with other like carbapenem-resistant organisms are going to be included, some chronobacter, some other things about cytomegalovirus.

There's some that I think people haven't heard of before, which is Hendravirus. If you didn't know what Hendravirus was, I didn't either. I had to look it up myself. But just catching up on this. Nipovirus is another one. And Hendravirus is a Nipovirus, in case you're into the esoteric in medicine, but some of these rare diseases we need to know about.

One of the things that's going to come forward though, which is a little bit different for us is a different tick-borne situation here. And I'm going to call it a disease. We check with legal. We do have the regulatory authority to do this, but we're going to be recommending actually tick-borne disease. In other words, organisms that are going to lead towards causing what's called alpha-gal syndrome.

So, when you think about why people get alpha-gal syndrome, which is really, quite frankly, an allergy to meat, or any meat from a mammal, like beef. The thing is, you're not actually getting infected with a disease from the tick. It's the sugar that's actually transmitted from the saliva of the lone star tick, that causes an allergic reaction to people, which is persistent. And there's no real treatment for it, other than you have to avoid mammalian meat. And some people, of course, can have anaphylaxis for this. Others just have dyspepsia. But it's one of those things where it's occurring.

There's certain parts of New York where it's more common, like Suffolk County, so getting lab reportable information will give us a better idea of prevalence. But one of the things we're also going to do, which is just interesting, as you know, we have the All-Payer Claims Database. So just because someone has a positive lab test for the Alpha-16 galactose sugar, doesn't necessarily mean they're going to have alpha-gal syndrome. So, by

using the All-Payer Claims Database, which I expect to have some data on this by Labor Day, we'll have another way of actually seeing what the actual prevalence of this is in New York State and locate it.

Keep in mind, if it's in the All-Payer Claims Database, it means somebody paid for the care and a healthcare provider made the diagnosis. So, it's two different ways of actually looking at this, and I think it'll give a better estimate of prevalence of this. And in case you're curious, there's other jurisdictions in the country that do use the lab reportable disease, about 13. Most of them are different states. I don't know of anyone yet who's using both, though. I think our approach will be a little bit novel, but I think it'll give us a better idea of prevalence, and then hopefully better to give information to the public and advise people to avoid ticks.

There's no reason to get bit by a tick ever. I don't think anyone wants to be bit by a tick, but part of it's just making sure people know to keep an eye on this. Like when you're outside, which I want people to do, just make sure you look to make sure you're not carrying a tick with you. Keep in mind, ticks are not our friends. We're their food source, and we don't want to have tick bites on us, but it's important to keep on top of that.

Anyways, just a couple other topics to bring to your attention really quick, with Black Paternal Health Week was last month and Mother's Day's coming up. So just want to talk a little bit about some of the work we're doing. We did some work in Brooklyn with some community stakeholders to just help bring attention to the issue about doulas. Some of you might remember, I signed a standing order so someone could access a doula if they chose to do so through Medicaid.

One of the things we're trying to do is help more people be trained as doulas, help more people become enrolled in Medicaid as doulas, help them get credentialed with managed care company to become doulas. This is how the department can really reach out and provide better customer service. And I kind of said to some of the people who are running their own doula training agency that we can be your doula with Medicaid, because really, that's what a doula does, offer assistance and guidance. A doula is a non-clinical assistant to help someone when having a baby. They visit with people before they have the baby, when they have the baby, and after they've had the baby. And it's great to see that, and we're happy to see that's occurring here. So, I think that's great that we're doing that.

The medical aid in dying issue, I just want to talk a little bit about. We're working on putting regs together for that. My team is working on that. They're not going to be approved by you, they're approved by me, but I'm just letting you know we're working on the reg package for that. And I

think that'll be done by the time it gets in place. The law goes into effect August 5th of this year. Our reg should be done by then as well.

And then some of you are following this summer, there's going to be all these FIFA events. In other words, all these events that are going to be talked about... People are coming to watch all these FIFA events. We're getting ready for that. There's other things occurring this summer as well. Like in other words, there's a lot of things that people come to New York City for this year in other parts of the state, not the least, which is just FIFA.

But we have just stood up incident management system a few months ago. We've been planning on this for a year, but we're just making sure that as more people come to New York State, we're ready. We work with the City Health Department, Department of Homeland Securities and Emergency Services. But just so as more people come here, we're ready for some of the public health possibilities that might occur, so if there's something, we can respond quickly.

And then, last thing I want to do is want to make sure that you know who the person is to my right. This is Darren Cohen. Darren is our new chief legal. Kathy Marks did not go anywhere. Kathy is working in a part of the department who's actually assisting me now as my special advisor. She's helping me with doing some of the administrative decisions, giving me advice on administrative decisions we do that come through our administrative law judges. She's also helping with the Northeast Collaborative. She's helping with artificial intelligence implementation in the department as well and just helping with some other matters that are directly assisting me. Kathy's now working outside the New Rochelle office, which is really close to where she lives, which is good for her as well.

But it's really great to have Darren who's got a lot of experience working in legal, and he's only been here, gosh, I think six weeks, but I feel like he's been here forever. It’s just been great to see him the way he's hit the ground running, and there's been no shortage of complex legal situations for him to actually deal with. It was so great to see Darren to my right today.

With that, let me stop for just a minute and just see if there's any questions for me.

Dr. Boufford: Okay. Floor is open. Questions from council members? Mr. LaRue?

Mr. LaRue: Good morning, Commissioner. I actually have two questions. The first is related to PACE. So, a couple of years ago, new regulations came before

this committee, then they expired before they were implemented. Is that under review? Is there a process in place that that's going to be revisited?

Dr. McDonald: Yeah. So, for Program for All Care Inclusive for Elderly, which is what PACE stands for... Val, where are we in the reg package? I'm going to put Val on the spot because I know Val's right there.

Ms. Deetz: Hi Val Deetz. Hey, Scott. So, yes, they're under review, more to come. Hopefully we can provide a little bit more information at the upcoming FBIC meetings. Thank you.

Dr. McDonald: Okay, great. Thanks.

Mr. LaRue: Thank you. And then secondly, and completely different question, as it relates to assisted suicide, how does CMS fit into this, in terms of what was passed legislatively versus what CMS allows in different programs regulatorily? How does that get resolved if there's a conflict?

Dr. McDonald: Yeah. So, it's medical aid in dying, it doesn't have an obvious nexus with Center for Medicaid, Medicare Services. It's a state that's doing this. It's not going to be covered by third party payers, it is my understanding. So, I don't see the obvious nexus with them.

Mr. LaRue: Yeah. If we go back to PACE as an example, which is regulated by CMS, just when they look at those regulations, I encourage them to keep in mind any conflict there might be with PACE.

Dr. McDonald: Yep. I mean, keep in mind, well, CMS isn't looking at medical aid in dying regulations, because there's no... These are state regulations promulgated by us. And just to let you know, really, the law that made medical aid in dying come together is very prescriptive, so there's really not a lot of regulations we need to make. It's mostly about reporting. And regulations are a minimum standard, so don't expect to see a lot of requirements from us regarding what this is going to look like. Because really, the law itself was very prescriptive. I know it wasn't without controversy, but it was very prescriptive. So, our part is very minimal.

One of the things that the law talked about was making sure the unused narcotics were destroyed. That regulation's already existed through the Bureau of Narcotics Enforcement. So there really isn't... We didn't do anything there because it's already done. So, all good.

Dr. Boufford: Dr. Friedrich.

Dr. Friedrich: Yeah. Thank you, commissioner, for your update. You mentioned something using the All-Payer Database for this Alpha-16 galactose. Are

there other use cases? I always feel we are not getting the full story. I think over the last, I think, 13 years, the All-Payer Database has been built and it's such a great resource for many things. Can you elaborate a little bit on that?

Dr. McDonald: I'd love to. So, the All-Payer Claims Database, so just so people know, I think one of the first things I want to say is, when you hear the name All Payer, would you think that would include all payers? It doesn't. So just so you know, it doesn't include ERISA. So, it covers about 80% of payers. So, I want to get that out there.

Now, your question was, have we used it for anything else? And this is legitimate, right? It's been over a decade of existence. What are we using this for? So last year, we created a Parkinson's registry, and there's a webpage for the Department of Health where we actually determined the prevalence of Parkinson's disease in New York State. There's a dashboard, and that data came from the All-Payer Claims Database. Other places we've used it for, we have limited use public files for the All-Payer Claims Database for pharmacy costs that you can access on our website now as well. The other thing that's coming soon for the All-Player Claims Database is going to be looking at certain types of care settings.

So, there's a whole team of people that work on the All-Payer Claims Database. They're all led by Anne Skatine, who runs the Office of Health Systems Quality and Analytics. Because I think one of your points, which is this, would be helpful health economic information, and it is. Because one of the things about, I think that people struggle with is, when you go to procure anything in our culture, you have a good idea of what it costs. Not healthcare. And one of the things about healthcare is, it'd be better if we could actually see transparency in what things actually... What are we going to be charged, right? And so, this is something you get information for.

But the pharmacy data has been out for over a year through limited public use research files, so you can access that stuff and go explore it if you'd like to. Ann Skatine's the one who leads that, so if people have questions, you can reach out to the department. We're happy to make connections and answer other questions.

Dr. Boufford: Any other questions from council members? Yeah, Dr. Soffel.

Dr. Soffel: Good morning, Commissioner. Always a pleasure to see you. I have a comment and a question. Yesterday at the public health committee meeting, we had a really interesting presentation by your staff in the Office of Public Health about the challenges to building up the public health workforce and the many programs that they have implemented to

try to encourage people to come into public health. And one of our members actually observed that part of the challenge is that salaries in the public health field are so much dramatically lower than in other parts of healthcare, and anybody who's looking at a financial trade-off is unlikely to opt for the public health option. And so that's my comment, is that it is certainly something that should be part of the Department of Health conversations and budget conversations, because the state hires so many public health staff, and if the salaries are not viable for people who are trying to start a career, they're not going to go there.

My question was, I saw recently that the United States has declared the measles outbreak is over. What does that mean for New York? And could you sort of update us? How many cases did we see, and what was the resolution, and sort of where you think we are in terms of measles?

Dr. McDonald: Yeah. So, in 2025, New York State had 20 cases of measles. So far in 2026, we have had 10 cases of measles reported to New York State. So, keep in mind, it's May, so we're on pace to have a little bit more than last year.

When we get cases in New York State, our cases are generally imported from somewhere else, and they're really contained. So, what happens in New York State is, we have local health departments, we identify the case, contacts are identified. People who haven't been immunized are offered post-exposure prophylaxis if they're eligible. And we then manage this, right? So, you haven't seen measles take off in New York partly because our immunization rates are reasonable.

One of the things about New York, and I think this is just one of the important distinctions that separating New York from other states where you've seen these outbreaks. So, you've seen outbreaks in South Carolina, Utah, Texas, I mean, just... Oklahoma. You've just seen these massive outbreaks. The one thing that these states have in common is they have a religious exemption to the vaccine, and that is the key difference here. New York doesn't have a religious exemption. This was changed by the legislature and the governor years ago. And this is really one of the main things that go forward here.

When I say our immunization rates are reasonable, we still have people who are choosing not to give the vaccine, but you need it for school entry. What I see in New York a lot of times is people delaying the vaccine, which concerns me, because when you really think about who's more vulnerable for measles having a bad outcome, it's really our little ones. So, the reason why measles vaccine is given it 12 months, or 15 months is because the little ones are really vulnerable. And I think it's just important to keep in mind that the measles, mumps and rubella vaccine's been

around for, gosh, 60-plus years, and it's really the best protection people have out there.

As far as the country, I don't really want to comment on what Health and Human Services is saying. We kind of go to our own drum over here at the New York State Department of Health.

Dr. Boufford: Any other questions for the commissioner?

Dr. Rugge: I can't help myself.

Dr. Boufford: Dr. Rugge.

Dr. Rugge: I can't help but bring up the rural health transformation program and where it might go. As you said, it's a cooperative agreement between Washington and Albany.

Dr. McDonald: CMS.

Dr. Rugge: CMS. True. What's the relationship between organizations inside New York and the state government? Is that cooperative, or are they grants, or how?

Dr. McDonald: Oh, no. So, yeah. In other words, when I say cooperative agreement, that means high touch from CMS. That means weekly meetings, a lot of questions and making sure that we're doing everything they say we're doing, and we are doing everything they're supposed to be doing. And right now, CMS has been very helpful and it's going well.

When we issue money, then we have to make sure the money is spent wisely, as well. So just keep in mind, that's always true. Whether it's a grant or a cooperative agreement, if we as the New York State Department of Health give you a dollar, we need to know what you spent the dollar on. And just so you know, we're very careful about public dollars, right? And the controller audits us to make sure we're doing all this stuff right, as well.

So, if you're fortunate enough to get money through this rural health transformation program, you should expect that we are going to make sure you are accountable to spend the money wisely. That's true for every dollar we give, though. I mean, we pay very close attention to how the tax dollars are used.

Dr. Rugge: Just as a related question, there's an expectation of building collaborative relationships among different kinds of providers in rural areas. Does this mean all the rural regions and areas in the state, or there'll be a few trials?

Dr. McDonald: So really, it's a five-year program, and so all rural areas are eligible, but there's actually... One of the first parts of this I talked about was rural partnerships. So, keep in mind... And by the way, most of New York is a rural state. It's funny, I think too often people think of New York City as New York City and then everything is on 87, 90. And although that is a great part of New York, most of New York is rural. New York has 25 million trees and 20 million people. It is a rural state, right?

But one of the things about the partnership is, urban areas could partner with a rural area. You could see a scenario where in Erie County, for example, they might want to partner with somewhere, and Buffalo might want to partner with someone else. So, there's all these rural areas in New York. So, I think New York is like 46 rural counties. So, we're really quiet a rural state.

Dr. Rugge: 47.

Dr. McDonald: 47. I forgot one, right? I don't know which one I forgot, but we're a very rural state here, so I expect to be a lot of partnership with this. And I think it's... $212 million is nothing to sneeze at. And I'll tell you, one of the things I've heard so many times from just rural counties is, "Could you throw us a bone?" And I think this is great. So hopefully we'll get the language we need in the budget and we can move forward. I know Dr. Fish and his team and Karen Madden have been working feverishly in all this work. We're chomping at the bit to get going here.

Dr. Rugge: Just a fun final observation, and that is, what makes this especially important in rural areas are the Medicaid cuts, that we have to find new ways of working together, new ways of sharing experience than previously, because otherwise we can have medical deserts in big areas.

Dr. McDonald: Yeah. I'm worried about that. I mean, we are ready for what's coming, just so you know. And I'll talk more about this next time I come. But we're doing a lot of extremely intentional work to try to protect everybody as much as possible if they need Medicaid to stay on Medicaid, and we're trying to keep as many people insured as possible. HR1 was something we didn't support. We think the federal government could have handled this much better, but they didn't. But we are doing everything we can with our Office of Health Insurance Programs team and Mayor [inaudible 00:48:36] and others have just done a lot of work to get ready.

So, when we get the guidance the end of June of this year about what this work requirement's going to look like, and keep in mind, there are 14 exceptions to that, but I'll talk to you next time about how we've done this in a very detailed way. We'll have more specific details to announce then as well. But we're going to do our best to keep as many people insured as

possible. It's healthcare for people. It's stunning, this is what our federal government chose to go after, but nothing they do surprises me anymore.

Dr. Boufford: Any other questions?

Dr. Farrell: Yes. I have two, so I'm asking for others.

Dr. Boufford: Okay.

Dr. Farrell: Yes, thank you. Thank you. We're on a roll here. Dr. McDonald, the social care networks, they were slow to roll out, but we're really picking up speed and just so concerned that indeed, it's all going to end however many months in the future. Is there any thought about whether we might be able to extend or be able to continue this important work that we're doing with community-based organizations?

Dr. McDonald: So, social care networks are part of the 1115 Amendment, which does expire March 31st of 2027. CMS's posture right now is if you're going to do another 1115 amendment, it has to be budget neutral. So, we're looking at this. One of the things we have to try to figure out... You're right. And by the way, you're right that it was slow to start, but that's not a fault of the social care networks. I want to get that right up front. We have to go through contracting. They had to do stuff together. But they are making progress. So, I'm keeping track of what they're doing. But there's, the social care networks do a lot of important work. They're doing work that helps people stay out of those expensive rooms that we deliver care in. So obviously, it's important to us. We're going to see what's possible. I'm being as non-committal as I can to you because I can't promise spending money I don't have, but obviously it's important to us and I follow it closely.

Dr. Boufford: I have a couple follow-up questions to my colleagues' opening questions. First, on the issue of the Rural Transformation Initiative, is there funding for, or significant engagement for local health departments? Because it strikes me where pushing their prevention agenda issues, local health departments are in partnership with the healthcare providers, and in the rural counties, it's probably even more effective in many ways because the partnerships are more cohesive than in some of the larger urban areas.

Dr. McDonald: So, there's no specific funding that says this local health department gets this much money. It's possible, though. In other words, if local health departments partner... Because one of the things that we tried to do when we built the Rural Health Transformation Program was allow flexibility in New York, understanding that the needs of certain parts of New York aren't the same as other parts of New York. So, if the partner was going to be a local health department, then yes, that could occur. So, it's really one

of those things where this particular program for the federal government isn't designed to support local health departments, but there could be possibilities for them to get funding here.

Dr. Boufford: Could it be more explicit in the state language relative to at least inclusion, significant inclusion of local health?

Dr. McDonald: So, we're doing what we can do. I want to make sure this is really clear. We cannot do anything in this program that CMS doesn't authorize us to do, and it's a high touch program. And obviously, we're big fans of local health departments, and no one knows their needs... I mean, I've never heard a local health department say, "All good, plenty of money here." Never heard that. So, we understand that need, to be sure.

Dr. Boufford: Okay. My second question was following on Dr. Soffel's question earlier. We did have a really robust conversation about public health workforce, and as you may recall, the council each year not only fulfills our role in overseeing the prevention agenda but also selects one issue of concern that we try to work with your staff to kind of raise the profile, raise visibility. And there has been budgetary support by the governor for the healthcare workforce, personal healthcare workforce, but none really for the broader public health workforce.

And I think other than the salary issue, which Denise raises, I think one of the questions we heard yesterday was that a number of things like the Public Health Fellowship Program and others will sunset or will be expiring this summer or next fall because the money had come from the federal government. I wondered what your thoughts about department support or advocacy around the next budget cycle. This one, obviously, is done, but just some thinking about that.

Dr. McDonald: Yeah. I'll say this about the health department salaries. Government is never going to compete with the private sector. We are just not. And no one goes into public health for fame or fortune. Our salaries have improved quite a bit, though. When I think about when I started, there's been a number of pay grades in particular that have gone up quite a bit. We are not going to be competitive with the private sector for the amount of money they can offer, though. I mean, we just aren't.

Having said that, I've actually gotten quite a bit of support. If you look at state agencies, one of the things my colleagues at Division of Budget tell me is our average salary is higher than other state agencies. I think of that as more of a point of pride than anything else. But we do get people who are recruited to work for us more for mission than money, and yet, people need money to live.

Having said that, we are recruiting, you know what I mean? I don't have a lot of openings right now. I mean, when I started in '23, it was so many openings, they said, "Just hire who you want." Now I have, I think, 80 openings right now. And when we get people applying for jobs, we get a lot of resumes. So, we're recruiting. I think it's like, we could always... I'll always advocate for more funding, but one of the things I have to be conscious about is what does the budget look like for the following year?

I heard the same budget director you talk about for our years, and I don't think the out years so far look as rosy as this year did based on some of the things this federal government is doing. So, I'm approaching every tax dollar like it's got to be spent very carefully. And the governor's always been very supportive of me. She's really been a real champion of science and public health. I couldn't ask for more support. So, we'll see what happens.

Dr. Boufford: So, I think I want to go back to the non-salary question, which I think is an important one, which you addressed. I appreciate that. But some of these programs that were sort of pipeline programs to prepare are expiring.

Dr. McDonald: The Public Health Fellowship, that one has unsettled. We do have other programs though, right? In other words, we support a lot of interns from the School of Public Health in Albany, now called the College of Integrating Health Sciences. We have about $600,000 committed each year so we can hire interns who are graduate students and doctoral candidates as well. So that exists. And of course, the state has the Excelsior Fellow program, and we have several Excelsior Fellows working for us role. So, there's different paths of people to enter public health through that non-traditional route. So, I mean, I just saw a bunch of letters going out this morning for new Excelsior Fellows getting their appointments this morning. So that was exciting for me to see.

Dr. Boufford: Okay. Thanks very much. Any other questions for the commissioner? As always, thank you so much for being with us.

Dr. McDonald: My pleasure.

Dr. Boufford: And you're welcome to stay as long as you can.

Dr. McDonald: Well, I can stay right now and go upstairs. So, thanks, everybody. Have a good day.

Dr. Boufford: Thank you so much. Yeah, thanks so much. All right. The next item on the agenda is a report from the Office of Healthcare Delivery. I just acknowledged Dr. Fish is here, but my understanding is Ms. Deetz is going to be presenting on the issue of Aging and Long-term Care area.

Dr. Fish: Yes. And just to organize folks, to remind folks about our organizational structure. So, we have the Office of Healthcare Delivery, in which now the Office of Aging and Long-term Care exists, our Office of Primary Care Health Services Management. Val is Deputy Director for OALTC, Office of Aging and Long-Term Care. Mark Hennessey, to my right, you stepped away, Office of Primary Care Health Systems Management. We also have two other offices in the Office of Healthcare Delivery. The third is the Office of Health Facilities Management. So, you may recall that the state operates for veterans' homes, as well as Helen Hayes Rehabilitation Center in Haverstraw, New York. So that's the...

Dr. Boufford: That's really helpful. This is new, and I think part of my confusion anyway, so that's super helpful. Thank you.

Dr. Fish: Yeah. And then the fourth is medical provider management. We broke out separately outside of the office of Primary Care Health Systems Management. This happened a year ago, January of 2025. Our Bureau of Narcotic Enforcement and our Office of Professional Medical Conduct. And why did we do that? Because they are practitioner-facing as opposed to facility-facing. The other offices are more regulatory in function, or operational, and that office is around doctors and healthcare workers and providers. So, with that, I'm going to turn it over to Val Deetz. We have a history of alternating kinds of reports between the hospital side and the long-term care side. And so, this time falls to Val, so I appreciate her updates. So over to Val Deetz.

Ms. Deetz: Thanks, Dr. Fish. Thank you, Dr. Boufford. Good morning, everyone. I'm Val Deetz. I'm the deputy director of the Office of Aging and Long-term Care within the Office of Healthcare Delivery. A couple of updates. I know you have a written report, so I won't go straight into that, but I do want you to know that our nursing home and adult care facility surveillance program leaders have been making their rounds around the state in a non-regulatory capacity to touch base with our providers out there, find out operationally what's working, what's not working, innovations that they may be endeavoring and any concerns that they may be having, so that we can work together in a non-regulatory fashion and try to help them with either resolving issues that may have come up, expanding best practices and model innovation concepts they may have, and then replicating the best practices as well.

We also do a lot of teaching in our Center for Residential Surveillance. All of our modules are posted publicly and available to both the public and our survey staff on www.nylearnsph.com. Recently, we did a three-part foundational series on Legionella, one set for nursing homes and the other set for adult care facilities. We have additional webinars coming up on nutrition and social work, which are some of the foundational aspects of

both nursing home and adult facility care. Later on, this year, we'll be working on emergency preparedness training and webinar series, as well as bed safety, as we are starting to see a rise in the use of bed rails.

Improving efficiency and data reporting, removing from the old HERDS reporting, which was the Health Electronic Response Data System, to the new SMART platform, which is the Survey Management and Response Tool. What this does is it creates less of a burden when the providers are submitting their weekly surveys, including bed census, demographics, COVID information, across all provider types in long-term care, nursing homes, adult care facilities, licensed home care services and hospice agencies.

I'm also proud to talk a little bit, and Dr. McDonald mentioned it briefly, about our Center for Hospice and Palliative Care, which last month did a great big celebration for National Healthcare Decisions Day, in which there were a great deal of social media posts. There was a YouTube video that was shared. There was an article in the Empire Report and an educational video that was released on Medical Orders for Life Sustaining Treatment.

We are also proud to say that we have worked across our office with our health facilities management partners that oversee the veterans' homes, and we have worked to connect our veterans' homes with hospice agencies in order to provide and ensure that hospice services end of life care are available for our veterans of our facilities.

We also partnered with our adult care facility and assisted living industry partners, submitted and received approval of a state plan amendment, which effectively allows us, for the first time ever, to continue Medicaid assisted living program services and provide hospice services while that person still resides in the Medicaid assisted living program, also known as ELP. So, we're very proud of that.

Previously, ELP residents would either have to disenroll and oftentimes leave the adult care facility. Now they have the opportunity to stay. The state plan amendment was submitted in response to a need just to make sure there was no duplication of Medicaid services, and that each of the programs had clear expectations of what services were being provided by what sector.

And then last, we just finished our first phase of an educational study on health equity in the hospice space, and we look forward to reporting a little bit more on that in future FBIC meetings, but we are working with our student interns from the university at Albany in this project. I think that's it. Dr. Boufford, thank you.

Dr. Boufford: Any questions or comments from the council members?

Ms. Monroe: I have one.

Dr. Boufford: Please, Ms. Monroe.

Ms. Monroe: Thank you for that report. Just on this last study, when you're looking at health equity, are you looking at it as a staffing issue or as a patient issue? Where are you looking at whether or not the hospice program is addressing health equity?

Ms. Deetz: Yep. So, the first area that we are focused on was language and religious barriers to access. So, as soon as we... Can you hear me, Ann? Sorry.

Dr. Boufford: Only when your mic is near your mouth.

Ms. Deetz: So again, focusing on our first phase was on language and religious barriers to hospice care and access to hospice care. And as we move forward, we'll continue to provide you information on what's our next goal, and that'll be in subsequent written reports.

Ms. Monroe: So, you're looking at both staff and patients?

Ms. Deetz: Correct. Utilization, and barriers to that utilization.

Dr. Boufford: Okay. All right. Any other questions or comments? Yeah, Dr. Lim.

Dr. Lim: I actually have a question about another section of the department report, and I think it's probably for Dr. Fish, just really quickly. I was very interested to see, so there's new regulations for community paramedicine. Are those living yet, or if not, when will they be effective?

Dr. Fish: Yeah, we're still working through those and working on that, but we are excited about that. They've been in development for the development, so working through the various stages of approval, but soon.

Dr. Lim: And they won't be coming through FBIC for approval per se. Doesn’t it come through codes?

Dr. Fish: Correct.

Dr. Lim: Okay.

Dr. Fish: That's right.

Dr. Boufford: Any other questions? Okay, seeing none. I will call on myself to deliver the public health committee report, put on a different hat. We had a full day yesterday. Just a reminder to the council, the public health committee really acts on your behalf to fulfill our statutory responsibilities for oversight of the prevention agenda, which is the state health improvement plan. We're now in the fourth cycle of the prevention agenda, and it has been modified quite significantly for this cycle to address not only particular priority areas, 23, I think, exactly, which are more in the immediate purview of local health departments and the state health department, but also five domains, which were the first time the CDC has issued a sort of... Felt that there was strong enough evidence based to focus on social determinants of health, such as in the educational, economic development and other spaces. So those are both articulated as part of the new prevention agenda.

And the idea for the prevention agenda is it is led by partnerships between the local health department and the local hospitals in communities, sometimes at county level, and sometimes counties collaborate, and sometimes at local level. And the idea is for them to pull together as many partners as possible at the local level to advance the priority areas that they select for the work that they will be doing.

And so, this next cycle is to cover 2025 to 2030. Through federal law, the hospitals had to submit their community health needs assessment and service plans by the end of December of this past year. We had tried to get the cycle in sync with local health department submissions. We missed a beat, but we'll hopefully get back in order in a year or so. But the local health departments, their deadline is now July 1st. We learned yesterday that about 30, 35% of the departments did submit by the end of December in conjunction with their local healthcare delivery systems or hospitals, and the others are being encouraged to collaborate with their local hospitals and systems as they modify and finalize their own plans, which they'll be submitting in July. And so, we were pleased to learn the progress there. We do have a meeting on June 23rd, and so we'll be hearing near, almost final report on that work.

The other issues that we discussed in that meeting were the issue of community benefit reporting. The public health committee has indicated that they want to really focus on not, within the context of, if you might call it, the portfolio of the prevention agenda, the issue of community benefit, which is really the obligation, if you will, of voluntary organization of nonprofits in the state who are relieved of paying income tax, sales tax and real estate taxes in order to invest in their communities, hospitals being the largest nonprofit sector in the state and nationally, certainly get a lot of attention. And there has been new requests that the

Schedule Hs, which are submitted by the hospitals to the Internal Revenue Service, be submitted to the department and voluntary.

Well, you learned yesterday as well, thanks to Dr. Fish, he was kind enough to come and present this and discuss it, that the plan for July 1st is the due date for the submission that the voluntary hospitals will be asked to submit to your office, Doug, their Schedule Hs as they are submitting them to the federal government. There is also a separate questionnaire being created for the public hospitals who do not have an obligation to submit to IRS, to have them answer a set of questions that would articulate what they are doing in terms of community benefit.

And our interest in the public health committee is around a category of that work, which is called the community health improvement section, which is pretty much aligned with the goals of the prevention agenda. So, we have had a lot of good discussion with Dr. Fisher's office, and the plan is that we will, hopefully, maybe even by the June meeting, we'll be able to take a look at the document that the public hospitals are being asked to complete as kind of a baseline for further discussion for the next cycle, which will be due next July 27th, to really focus on the specific items that are relevant to our concerns, relative to community evidence-based investments in local health improvement aligned with the prevention agenda. So, we're happy about that prospect and we'll be busy doing that.

The other presentation we had was on the public health accreditation process. New York State was one of the first states and first large states, I think, to seek voluntary accreditation about five, six years ago. That cycle is now coming around again, and the state will be submitting for statewide certification. We had a good discussion with a number of local health departments who are also certified. Dr. Watkins' department is certified, and what that process was like and what the positives and challenges were in doing that. He was the star yesterday with everybody. He showed a picture of him with a plaque for being recognized.

But I think one of the important links here, so we will, the public health committee will be tracking that process very closely. And it sort of segues into the other report I'll give in a minute. I want to finish up the other agenda item on public health workforce. But when the original voluntary accreditation was pursued, one of the requirements is to have a public advisory committee, and that is the origin of the ad hoc committee. So, the ad hoc committee for the prevention agenda reflects that entity, which is required for voluntary accreditation. So, we had a discussion of that and what we might wish to do or need to do in terms of working with the department to prepare for that process, which I think is fall '27 through into the summer of '27, is the next sort of decision-making cycle. So, we'll be working on that.

And then, as Denise mentioned, we did have a very good discussion on the public health workforce issues. That is the one priority area, if you recall, the council had identified maternal mortality a few years ago. And we'd like to think that the work we did there really involves bringing people together, having panels, having public sessions, using our, if you will, bully pulpit to raise visibility of issues that are important.

And so, we had decided that public health workforce was one of the issues that we wanted to work on, and we had a good discussion strategically about some of the options on a call to action that we might make, that we might enable and work with the department on, including trying to think about developing an academic network of schools and programs of public health statewide there that does not exist, even though there is one for medical and nursing, medical deans and dental deans, et cetera, talking about some of the fellowship programs, internship programs, and others that need to be supported. So, we will be bringing that conversation back at our June meeting to think about what the priority action steps might be to support the department in advancing the visibility and importance of the public health workforce.

Yesterday afternoon was the first meeting of the newly revitalized ad hoc committee for the prevention agenda. And I really had a good time. It was a really, really, really interesting meeting. Thanks to Mark Waldenmaier and Liza Whalen, and their staff, Zara Ali, have done a fantastic job really, it's not an easy task to take... An ad hoc committee, to remind you, is the state level organizations of nonprofits, professional associations, advocacy groups, and they're state and regional to some degree, and sort of taking a look at who was in charge two years ago, three years ago, which was the last time it was updated, and finding out very meticulously who gets the letter, who are they asking for designees, et cetera.

So, they did a fantastic piece of work in getting that done, and we had 38 state level state and regional level organizations convened yesterday afternoon along with 14 state agencies. And Colleen advised me this morning that we had over 220 people online listening to the meeting. So, it was really, really exciting in terms of developing these partnerships.

It was an active meeting, really focusing on the sort of five social determinants areas, which are economic stability, social and community context, neighborhood and built environment, healthcare access and quality, and education access and quality. And everybody at the meeting had a chance to sit in on two of those domains. We had 30 minutes for each domain and then a report out at the end. And I have to say it was really exciting. We've had core partnerships to the prevention agenda historically with Office of Mental Health, OASIS and NYSOFA and the Department of State, and they were represented, but bringing in these

other agencies is really crucial to getting any leverage in these other, broader determinants of areas.

And so, that material will be pulled together. Thanks to staff and the department, we had facilitators at each of the tables and rapporteurs who are putting minutes together, and we'll have that report hopefully for the public health committee when they reconvene. And our plan would be to reconvene the ad hoc committee in September.

The goal of that group is to say, okay, you all are state and regional organizations. Many of you have local members, you have local divisions, you have local infrastructure. We want you to hook up with the counties or communities or cities with the local health department and hospital partnerships to sort of expand the leverage on addressing health problems in your communities. And I think folks were really quite responsive, and I think, excited to be invited really by the department to collaborate.

I have to mention one thing that was especially terrific, because one of the major social determinants of health, probably the number one, is education, and we had representation from the Department of Education and the Board of Regents, which was spectacular, and they were really, really excited to be invited. Along with other agencies that I don't want to... Economic development, transportation and others, which was great.

So, invite any of my colleagues that might want to comment. Obviously, you can tell I was enthusiastic about it. Okay, great. So, we'll move on then, and the next item is to turn it over to the established committee, Mr. Robinson.

Mr. Robinson: Thank you very much. As Dr. Boufford mentioned at the beginning of the meeting, we will be batching these applications.

Ms. Monroe: Is your mic on?

Mr. Robinson: Pardon me?

Ms. Monroe: Is your mic on?

Mr. Robinson: It is, but I need to stay close to it. Thank you, Ms. Monroe for that admonition. So, just a reminder, you can pull out, ask that we address an individual application separately, so please feel free to do that. Otherwise, I'm just going to move along. Okay. This is the first batch, which concludes only one application. Application 252188C, Rosary Hill Home, Westchester County, decertifying 13 residential healthcare facility beds, and perform renovations to modernize the facility. The department and the

committee recommend approval with conditions and contingencies, and I so move.

Dr. Boufford: Motion, Dr. Berliner, motion and second from Dr. Watkins. Any comments, questions? All in favor? Aye. Any opposed? Any abstentions? Onward, Mr. Robinson.

Mr. Robinson: Okay. On we go. These are applications for ambulatory surgery centers. Application 25226B, Access Surgical Care LLC in New York County, establish and construct a multi-specialty ambulatory surgery center at 4778 Broadway, New York, and certify lithotripsy outpatient services. The Center will specialize in cardiology, vascular surgery, facial plastic reconstructive surgery, GI, general surgery, ophthalmology, orthopedics, otolaryngology, pain management, and urology. The department and the committee recommend approval of conditions and contingencies, with an expiration of the operating certificate five years from the date of issuance.

And application 261017E, Dutchess Ambulatory Surgery Center, LLC, doing business as Dutchess Ambulatory Surgical Center in Dutchess County. This is to transfer 6.66% ownership interest from the 1315 current members to one new member. Department and committee recommend approval with the condition. I move both applications.

Dr. Boufford: I'll get a second, Dr. Berliner. Any comments, concerns, questions from the council members? Seeing none, I'll approve the voting. All in favor? Any against? Any abstentions? No. Motion passes.

Mr. Robinson: Okay. Continuing with our batching. 252184B, New Windsor Family Care LLC in Orange County, transferring 99% ownership interest from one withdrawing member to one new member and certify medical services, especially primary care. Department and committee recommend approval with a condition and a contingency.

261044E, Gamms LLC, doing business as Zelle Care Family Healthcare Network, LLC in Orange County, transferring 25% ownership interest from the three current members to one new member. Department and committee recommend approval with a condition. Application 252144E, Hospice and Palliative Care Inc. This is to merge Hospice and Palliative Care Inc and the Hospice of Chenango County, Inc, with HPCI being the surviving operating entity. Department and committee recommend approval with a condition. And I moved that batch.

Dr. Boufford: Okay. Second, Dr. Berliner. Any comments, questions from the council members? Seeing none. All in favor? Any opposed? Any abstentions? Motion passes.

Mr. Robinson: On we go. 21102E. Rockville Holdings Operating, LLC, doing business as Rockville Skilled Nursing and Rehab Center in Nassau County, establishing Rockville Holding Operating, LLC, doing business as Rockwell Skilled Nursing and Rehabilitation Center. As the new operator of Rockville Skilled Nursing and Rehabilitation Center, which is a 66-bed residential healthcare facility located at 50 Main Avenue in Rockville Center. Here, the department is recommending approval with a condition and contingencies.

Moving on, including a change of ownership, 231045E, Medford Hamlet, LLC, doing business as Medford Hamlet Home Care, transferring 66.667% ownership interest from two deceased members to two existing members and three new members. Department and committee are recommending approval with a condition.

Application 231252E, First Home Care of New York Corp, transferring 90.1% ownership interest from one withdrawing shareholder to the remaining shareholder. Department and committee recommend approval with a condition.

241067E, SNA Unified Home Care, Inc, transferring 90.1% membership of one shareholder to the remaining corporate shareholder. Department and committee recommend approval with a condition.

Application 241102E. Kyranga... Kyronaga Home Care in Manhattan Inc, doing business as Synergy Home Care, transferring 100% ownership interest to a new shareholder LLC. Department and committee recommend approval with a condition.

241125E, Novel Home Healthcare Services of New York Corporation, transferring 75.25% ownership interest from one shareholder to three current shareholders and one new shareholder. Again, department and committee recommend approval with a condition.

Application 251019E, CareLink, Inc, transferring 80.2% ownership interest from one withdrawing shareholder to the two remaining shareholders. Department and committee recommend approval with a condition.

I move the batch.

Dr. Boufford: Okay. Second, Dr. Berliner. Any questions, comments from council members? Seeing none. All in favor? Aye. All opposed. Any abstentions? Motion passes.

Mr. Robinson: Continuing on with diagnostic and treatment centers, 252207B, Roche Medical Management LLC, doing business like Roche Medical Center in Kings County. Dr. Calcutt, who is not here, declared an interest, established and constructed a new diagnostic and treatment center at 670 Flushing Avenue in Brooklyn. Department and committee recommend approval with conditions and contingencies. I moved that application.

Dr. Boufford: Second, Dr. Berliner. Any comments, questions from council members? Seeing none. All in favor? Any opposed? Any abstentions? Motion passes.

Mr. Robinson: Application 252172E, Pace at Hudson Headwaters, Inc. Interest expressed by Dr. Rugge, establish a licensed home care services agency to serve individuals enrolled in the PACE program. Department and committee recommend approval with a condition. I'm going to continue on.

Application 23239E, OLPS and FOPOCO, LLC, doing business as Our Lady of Peace Nursing Care residence in Niagara County. This is to establish OLPS and FOPOCO, LLC as the new operator of a 250-bed residential healthcare facility currently operated by our Lady of Peace, Inc at 5285 Lewiston Road in Lewiston Department, and committee recommend approval with condition and contingency. I'll note here that one member abstained from the committee vote. And I moved that batch.

Dr. Boufford: Okay. Second, Dr. Berliner. Any comments or questions for staff? Seeing none. All in favor? Aye. Any opposed? Any abstentions? Motion passes. Oh, one abstention. Mr. LaRue.

Mr. Robinson: And finally, the application we heard at the special committee meeting this morning, application 26111B, transitional living community at the Center for Discovery in Sullivan County, establish and construct a new 40 bed residential healthcare facility at 195 Lake Louise Marie Road in Rockville. The department recommended approval with conditions and contingencies, and this morning the committee did as well, and I so move.

Dr. Boufford: Okay. Second, Dr. Berliner. Any comments or questions from council members? All in favor? Aye. Opposed? Any abstentions? Seeing none, the motion passes. Thank you, Mr. Robinson.

Mr. Robinson: Thank you. And with that, I conclude the report of the establishment and project review committee.

Dr. Boufford: Thank you. Next meetings, not for '27’, for '26’ are at the bottom. And I would just add that the public health committee is scheduled to meet on June 23rd, which is the day before the next council meeting. And I think we will now move into executive session. Do I adjourn and move into it?

All right. I'll adjourn Public Health and Health... I'm sorry. Ms. Monroe has a question.

Ms. Monroe: This is for EPRC. At our last meeting, we had quite a contentious discussion about an applicant that was in some people's minds doing unsupported work, and would we bring them into Article 28? And I think we deferred that decision. And my question is, deferred to when?

Mr. Robinson: The department, I think, is considering that. Ms. Glock, is that you that... No?

Ms. Ngwashi: Are you talking about which? Hyphen care.

Mr. Robinson: Do you remember the application?

Ms. Ngwashi: Was it the one that was for alternatives?

Mr. Robinson: Yes.

Ms. Leonard: Okay. So, it is.

Dr. Fish: Yeah. This is Doug Fish from Department of Health. Yeah. I think you're referring to the Hype Care application, where there was conversation about outcomes and how we would know if they were successful. So, yeah, we have taken that back, given them the charge, and they will be coming back at a future meeting. I think Colleen, is it scheduled for... Do we know which meeting yet at this point? Okay.

Ms. Monroe: Okay. Thank you.

Dr. Boufford: Okay. Dr. Berliner, do you have a... Somebody else here had something. It was on the same issue, I guess. For the good of order, any other business that people would like to raise, or any other issues or questions they'd like to raise? It didn't mean to rush the adjournment. I'm seeing none. I will now adjourn the meeting of the Public Health and Health Planning Council, and we'll now move into executive session. Can I have a move into move into executive session, please? I'll move it. Seconded by Mr. Thomas, just for diversity there, Dr. Berliner. All right. And so, we'll take... Those that are not involved in the executive session would be asked to leave the room, and we will convene an executive session to discuss professional approval matters. Okay? And Hugh, you're the lead on this? Okay.

Ms. Monroe: Well, I'm going to say hi to Denise.

Mr. LaRue: Dr. Boufford.

Dr. Boufford: Sir.

Mr. LaRue: While we were waiting for the transition, just ask a question. Has the prevention committee looked at the Master Plan for Aging for where there's overlap...