

## **JOHN J. FOLEY SKILLED NURSING FACILITY**

### **OVERSIGHT COMMITTEE**

A regular meeting of the John J. Foley Skilled Nursing Facility Oversight Committee was held in the Conference Room of the William Rogers Legislature Building, 725 Veterans Memorial Highway, Smithtown, New York on Thursday, October 14, 2010 at 10:00 A.M.

#### **Members Present:**

Len Marchese, Chairman/Director of Management, Department of Health Services  
Presiding Officer William J. Lindsay, Legislative District #8  
Dot Kerrigan, John J. Foley Skilled Nursing Facility Representative /4th Vice President  
Kim Brandeau, County Executive's Budget Office

#### **Also in Attendance:**

Legislator Kate Browning, Legislative District #3  
Legislator John M. Kennedy, Jr., Legislative District #12  
Terrence G. Pearsall, Chief of Staff, Presiding Officer Lindsay's Office  
Dr. James Tomarken, Commissioner, Department of Health Services  
Dr. Eli Avila, Deputy Commissioner, Department of Health Services  
Dan Farrell, 2nd Vice President/AME  
Bill Gillick, Interim Administrator for Nursing Home  
Ken Crannell, Deputy County Executive  
Beth Reynolds, Budget Office, County Executive  
Robert Zielinski, AME Treasurer

#### **Minutes taken by:**

Diana Flesher, Court Stenographer

## THE MEETING COMMENCED AT 10:07 AM

### MR. MARCHESE:

Thanks everybody for coming. This is the monthly Oversight Committee meeting that was formed by the Legislature. And its main objective is to improve the efficiencies and spearhead some of the operational problems that we may determine and that might require a collective group decision. So this group has been helping in that regard for the past year or two, I guess, something like that. I'm not sure.

With that, I'd like to introduce Bill Gillick. He's the interim administrator from the last time we met. Jeff {Hochner} who was the administrator resigned. And we have appointed a new permanent administrator who's going to start October 25th. His name is Mel Hitt, H-i-t-t. But as everybody may or may not be aware, we need a licensed administrator on a day to day basis so the department engaged Bill as our interim administrator until the new one will start.

And so with that, I'd like to welcome Bill. And he can give us a little bit of update of what he's seen at the facility, talk about some of the projects he's working on and give us a general update.

### MR. GILLICK:

Okay. Thanks. I'd just like to start off I started last Monday in the middle of the Health Department's survey, their annual re-certification survey. And the good news is that the facility did very well in terms of what findings the Health Department had. I notice on the agenda the last meeting conversation focussed on the immediate jeopardy. The good news here is there is only four deficiencies. They all were, I'm going to say, isolated in nature, which means only one or two findings per deficiency. One is accidents and incidents, comprehensive care plans, CNA proficiency and consultative services.

The Health Department should receive their statement of deficiencies next -- by hopefully Wednesday of next week. Since most of these revolve around the nursing department per se, they're already beginning to craft their plan of correction based upon what the Health Department shared with us at the exit conference. The nursing home has ten days to turn that around to the Health Department. Hopefully the plan of correction will be accepted by them. And because of the isolated nature of the deficiencies, there's a good chance that the Health Department may or may not return for a follow-up survey; although it doesn't absolve the facility from maintaining their plan of correction for those items. But it's a good -- as you all know, the best policy is not to have people in the Health Department in your building as much as you can.

### P.O. LINDSAY:

Four is a low amount of --

### MR. GILLICK:

That's below the -- I think the state average is somewhere between six and seven. So four is low.

### P.O. LINDSAY

Okay.

### MR. MARCHESE:

We got a real shotgun approach -- when they came in, we put all the resources we could towards correcting problems while they were in the facility. We had DPW. Everybody was very cooperative in making sure we got through the survey without major problems. Jeff was a very good leader in that regard. We had to purchase some manuals immediately. I mean, there was things that we needed to implement like at the same time so we would not get written up for them. And I think that that helped a lot in a way. Plus we were very aware having just received an {IJ} in July that we needed to be on our toes and and so from July forward we've been really putting a lot of effort

into the patient care aspect of the facility in terms of medical staff and nursing and everything else.

**MR. GILLICK:**

I sat in on some of the meetings, which for the Health Department, the willing to sit in on some conversations with with the administrator staff during a survey is a little unusual for them. But Jeff did a, I thought, a nice job in sharing with the Health Department some of the initiatives in place in terms of bringing charge nurses into the building and some other equipment issues and your grant and those kind of things that were taking place. And I think that went well in terms of how the Health Department may have viewed how things were going. So I think that information was very helpful and they appreciated those efforts.

**P.O. LINDSAY:**

Very good.

**MR. GILLICK:**

So that's good. I just as I am here for a few weeks, my major goal is to participate in meetings where I can get as much information about what's going on with the building. I meet -- we have morning report, we have care plan meetings. We also -- the physicians who are now appointed, I know they get together at ten o'clock in the morning. But I try to meet with them when they get together as well as they're working through organizational issues as a new group of physicians. And so they're trying their best to figure out how best to bring everything up to speed and then move forward. So I've been trying to work with them.

**MR. MARCHESE:**

Let me just interrupt right there. We recently appointed a new medical director. We appointed a -- why don't you go?

**DR. AVILA:**

Sure. Dr. Crowley, Maureen Crowley's been with, I guess, the County for quite a number of years, a seasoned physician. We appointed her as -- they had her go live there a while, see how she liked the place. And we -- Dr. Tomarken and I just basically evaluated her. And we offered her the position and she accepted as Director. She's doing a wonderful job. And she calls me on a regular basis if she has any questions.

Then I hired a Dr. {Tempkin} who is -- this is major. She's got a -- she's board certified in geriatrics. And I had done screening. I checked with every chairperson all the way out towards Mt. Sinai where I trained in Manhattan. And I was not able to get anyone. Also at the salaries, I actually had some of the chairpersons laugh at me. But we were able to get that. And that's phenomenal, to have someone who's trained in geriatrics and cardiology, by the way. So I hired her and she's doing well so far.

Also hired a Dr. Klein who sold his practice over 25 years as a family practitioner, really dedicated, former carpenter, went to med school. He's been practicing 25 years. A really dedicated doctor. And I like that because he really wanted to be an MD.

**P.O. LINDSAY:**

That's an unusual combination.

**MR. MARCHESE:**

He put down the hammer for a scalpel;

**LAUGHTER**

**DR. AVILA:**

So that impressed me because it spoke of his character. And I like that. And he's very dedicated.

And I've also just hired, she starts on Monday, a Navy doctor. She is a a seasoned Navy physician with great recommendations; entire career through the Navy including medical school. And having trained with many Navy ophthalmologist I know how excellent the training is when you've gone through, especially the Navy. So we'll have Dr. Crowley who's working on a lot of the protocols. And then we have the two clinicians, two and a half clinicians there. I really wanted to make sure there was overlap. And we have the two nurse practitioners who've been there for a while. So Dr. Tomarken and I are pretty happy with that staff because there'll always be some sort of coverage including weekends.

**MR. MARCHESE:**

We thought we'd overkill a little bit on the front end. Let's get everything back in order. And then probably back off as we see it because the patient/provider ratio is actually very low, the way we have it. And you don't need to have it that high. So we're going to back off.

**P.O. LINDSAY:**

When you back off, what will you -- I mean do you move those positions to other spots?

**MR. MARCHESE:**

Yeah. Oh, yeah, we wouldn't -- there's plenty places within the Health Department that we could put them in a heartbeat. Initially we wanted to go in make sure all the charts were up to date. Everything -- that's one of the reasons why our survey results are so good. Because we've been attacking it at that point. That's where we had deficiencies in the past, our charts. So we made a conscious effort to make sure that the medical side of the house is taken care of.

**DR. AVILA:**

And when the Blackberry goes off at nine o'clock because of a concern, that to me is a good sign. Because that means that they're very -- they're concerned. They're conscientious and they're there. Dr. Crowley lives near the facility. So she'll make spot checks in the middle of the night, come in on the weekend. That's going above and beyond. I appreciate that. And they keep me in the loop.

**MR. FARRELL:**

Excuse me. All these hires we're talking about, they're new hires and not transfers?

**DR. AVILA:**

They're new.

**MR. FARRELL:**

They're all new?

**DR. AVILA:**

A-huh.

**MR. MARCHESE:**

I'm going to go over some of the hiring. Why don't you continue?

**MR. GILLICK:**

Okay. I think if I just go in terms of the census, the average census for September was 243.

**P.O. LINDSAY:**

243, did you say?

**MR. GILLICK:**

Yes.

**P.O. LINDSAY:**

Okay.

**MR. GILLICK:**

And through the 12th of the October 245. And the adult day program September census was 26.88 and they had 48 registrants. And it was my understanding they're in the process of now trying to move that census up again.

**MR. MARCHESE:**

One of the -- some of our challenges at the facility, as you know, is staff turnover. Our Adult Daycare Director just resigned. So we're looking to hire a new Adult Daycare Director. They Adult Daycare Program is a large feeder into the facility so we really want that person to be out into the community getting us referrals, bringing patients in. So we're looking right now to hire that individual. So we're actively canvassing.

**MR. GILLICK:**

Okay.

**P.O. LINDSAY:**

The 245 number, are we still in bed hold?

**MR. GILLICK:**

No.

**MR. MARCHESE:**

No.

**P.O. LINDSAY:**

What's the number at bed hold?

**MR. MARCHESE:**

250.

**P.O. LINDSAY:**

250?

**MR. MARCHESE:**

(Nodding head yes)

**P.O. LINDSAY:**

So we've been out of bed hold all of September?

**MR. MARCHESE:**

Yeah. There's some issues with some of the patients that are in the facility, too. Even the current makeup of the patients, there are approximately 20 or so patients that are probably not necessarily appropriate for this facility. After Dr. Tomarken and Dr. Avila got involved looking at the patients' charts and reviews of their PRI's -- you can go into this. You know, the appropriateness of their placement in our facility is somewhat questionable.

**DR. AVILA:**

We had, for example, one individual, who I became aware, that has a job, goes to work. So I was forced to contact the office of Medicaid Inspector General and I happen to know, because I sit on the New York State Bar Associations Health committee also. And had to reach out to his office and report that. That individual is basically just camping out at the nursing home. Shouldn't be there. There are a few other ones that are in -- don't need the skilled level. It's more recreational.

Also, some of the patients have serious psychiatric issues. And they -- once you've accepted someone with psychiatric issues, you can't ever send them out again so they're there for life. And what is acceptable in the psychiatric facility, it would be appraised, like chemical restraints or even physical. You can't do that in a nursing home. That'll give you an IJ. The State will come down. So we've got a dilemma now. So we're working on trying to train the staff to understand these patients and even set up some references with maybe even contracts with psychiatrists in the area who have many privileges at hospitals. So if someone needs to be taken off medication, you don't do that at the nursing home. You have to have a hospital bed where they can try new medications, maybe help that individual.

And so that's a dilemma that we've uncovered. We have quite a number of them. In fact I was told that 80% of the patients at the meeting yesterday might have some form of anxiety or depression. And this has come to light. We're very concerned about that because we're -- being able to manage that requires being able to move them out of facility for one or two days in a hospital, get -- rearrange the, I guess, their medication and then bring them back. So we're working on that. And that's the appropriate -- we can't do that at the facility. You do that at the facility --

**P.O. LINDSAY:**

Not the 80%.

**DR. AVILA:**

No, not the 80%.

**MR. MARCHESE:**

No. We've identified about 20 individuals that probably are not appropriate for this facility for one reason or another. We can't just discharge them, but we're working through appropriate discharges. But as you -- it's a fine line between discharging patients and maintaining census. So we're trying to do that at the same time. So right now that's part of our plan, is to -- and at the same time is to try to improve relationships with Stony Brook, etcetera, to improve our -- to give us more referrals so --

**MR. FARRELL:**

Excuse me. Just to make it clear, though, it's because of that situation and not because they're actually having a problem billing and being paid for those people; it's just the psychiatric end of it that's covered or not covered?

**MR. MARCHESE:**

Well, no. There's a couple reasons why they're inappropriate for the facility. One is they can be a danger to themselves and other patients and our staff. Some of our staff have been assaulted by some of the patients.

**MR. FARRELL:**

No, I just want to make sure it's not on the payment end.

**MR. MARCHESE:**

No, no. The payment end is not what -- it's more of the appropriateness of them at at our facility for a lot of different reasons.

**MR. FARRELL:**

Okay.

**DR. AVILA:**

Dr. Crowley mentioned at the meeting she's been assaulted twice since she's been there. And we have, I'm told, a large number of Workers' Comp because of injuries. Just this week someone else was assaulted.

**P.O. LINDSAY:**

Certain nursing homes, they have a psychiatric ward.

**MR. MARCHESE:**

Yeah. We looked -- there's certain things that the -- you can actually have a lock down unit. We would need to apply for a CO on that and that's something that we're going to explore with the new administrator once he comes on board. And that might be something that we might want to do.

**DR. AVILA:**

But that opens up something else. And that is now you not only have the Department of Health, you have the Department of Mental Hygiene. In this case you have two audits. There are two state agencies that are showing up and two sets of rules that apply.

**MR. MARCHESE:**

Right.

**DR. AVILA:**

So it means also in-servicing. So it might benefit, but at the same time it could create problems.

**LEG. KENNEDY:**

Doctor, doesn't that also, since there is such a shortage of psychiatric beds now in Suffolk County -- yes, you have another set of criteria that you've got to be cognizant and sensitive to, but from a perspective of meeting health care needs, if we were to establish six or eight psychiatric beds in a unit, and there's degrees of how units are operated, psychiatric units; there's open units and locked units, as you know. And there's degrees of restraint that you have associated with a psychiatric unit as well, from just passive time-out types of areas to full --

**MR. MARCHESE:**

Physical or chemical.

**LEG. KENNEDY:**

Right. Sheet and tuxedo restraint. So there's multiple choices in that continuum as far as what might be appropriate for us to get into, but might also demonstrate we're helping to meet some of the need that's out there.

**DR. AVILA:**

I agree with you.

**LEG. KENNEDY:**

Beds are closing left and right. As you know Southside closed 20 beds and has yet to open them back up.

**DR. AVILA:**

That's an issue statewide. No, I agree. I'm just making -- just want to make sure that everyone's aware of that, that with it comes are the responsibility and duties.

**P.O. LINDSAY:**

So that's something that you're going to look at when you get a new administrator.

**DR. AVILA:**

Absolutely.

**MR. MARCHESE:**

And the State's DON process is something we would have to begin and go through. And we'll do a complete analysis on.

**DR. AVILA:**

And we'll do it.

**P.O. LINDSAY:**

What is the term, acuity level? That's a different acuity level?

**MR. MARCHESE:**

Well, it's a different level. Bill, you want to --

**MR. GILLICK:**

I think a -- when you look at their broad categories, research utilization group categories for each of our residents based upon the assessment tool, and when you look at the mix at John J. Foley, there's is a very large percentage that score in the lower acuity levels.

**P.O. LINDSAY:**

Right.

**MR. GILLICK:**

I looked at it the other day. I was surprised to see how many -- there's probably 70 or so who fall into that lower acuity level, which then -- that affects reimbursement as well.

**P.O. LINDSAY:**

Right.

**MR. GILLICK:**

And that doesn't necessarily address what Len was talking about, about the 20 people who probably could be somewhere else. I mean there's some more to be done. There are, you know, opportunities for that population to create a program. My impression that probably -- that's possible; would be a a really good direction to go in so that you can kind of bring talent and resources together, train the staff. Because right now these folks tend to be throughout the facility. So that's not in anybody's best interest. So if it's an opportunity to do that, I think -- my sense is the nursing home is going to continue to have to serve some of those people. That's not going to go away so --

**MR. MARCHESE:**

We separate them, by the way, so that they're manageable in an open facility. If we could put them all together -- but then it would be unmanageable the way we're currently laid out. So if we change the layout, then it would be a -- it could work out. That would be --

**LEG. KENNEDY:**

Are the majority of them on the fourth floor now in the Alzheimer's Unit?

**MR. MARCHESE:**

No.

**LEG. KENNEDY:**

Or are they spread throughout the facility?

**MR. GILLICK:**

No.

**MR. MARCHESE:**

No.

**LEG. BROWNING:**

You know, John, this is something that's gone on in all the public nursing homes. We're seeing that. It is happening. Mental health patients are winding up in the homes because there's nowhere else. We don't have Pilgrim State anymore, Kings Park. They didn't exist anywhere and that's why you got them.

**MR. MARCHESE:**

Part of the reason --

**MR. FARRELL:**

If they're not in jail.

**MR. MARCHESE:**

Part of the reason why we're having a hard time moving --

**LEG. BROWNING:**

Or jail.

**MR. MARCHESE:**

-- our inappropriate placements out is, as you said, Legislator Kennedy, there are no other places for them. We have one bed in South Oaks that we can do a discharge to right now. So of the 20, I only have one place to put a patient. Only because we cannot handle it. You know, we are not set up to handle it.

**LEG. KENNEDY:**

Because this patient's primary diagnosis is psychiatric; acute psychiatric now? Is that it?

**MR. MARCHESE:**

And they have behaviors -- physical behaviors that are threatening to our staff and other residents.

**LEG. KENNEDY:**

Well, they're acting out. But in other words, Dr. Avila, we're talking about schizophrenia or acting out?

**DR. AVILA:**

I don't know this particular individual's diagnosis.

**MR. MARCHESE:**

No. We had -- well, yesterday we had -- you know, you can actually brief them on the meeting we had yesterday.

**DR. AVILA:**

We met with one of our contractors, a psychologist who's been, I guess, under contract for 15 years; does a lot of the training and in servicing, came into speak to the staff. We have quite, I guess, new employees at the facility to try and see if he can do in-servicing. And doing an inservice for the staff so there'd be a unified approach, particularly to the psychiatric patients and those that are -- that have been hostile and actually have assaulted the staff. And he's working on a proposal to do the training.

**LEG. KENNEDY:**

Good.

**DR. AVILA:**

On that.

**MR. MARCHESE:**

What happens is the CNA might have a certain approach to handling a patient. Then the LPN comes in and maybe says, *no, I'm doing it this way.*

**DR. AVILA:**

Right.

**MR. MARCHESE:**

And then the RN comes in and does it a different way. We want to get everybody working on the same play book, *this is how with we deal with the patients that exhibit this behavior.* And so we want to set a standard protocol and procedures so we're looking to get a proposal from this vendor but we then probably would put an RFP together to try to get a --

**LEG. KENNEDY:**

Do you have a manpower protocol? In other words, if you have a patient -- because that's what they do --

**MR. MARCHESE:**

Yes.

**LEG. KENNEDY:**

-- in Mather in the psych unit and Kings Park and all the other places. When you have a patient that goes off, there's a way to mobilize staff to address that.

**MR. MARCHESE:**

Your point is well taken but -- I know your point but we do not have that in place right now.

**LEG. KENNEDY:**

There's no manpower protocol in that facility?

**MR. MARCHESE:**

No.

**LEG. KENNEDY:**

Are we going to get one?

**MR. MARCHESE:**

Yeah, that's part of why we're getting these policies and procedures in place so that we can set them up.

**LEG. KENNEDY:**

Good.

**MR. MARCHESE:**

The current medical staff which is basically all new are, it's now wrapping their hands around how we should handle all of the issues.

**LEG. KENNEDY:**

Housekeepers, dietary, everybody responding to a man power; everybody.

**MR. MARCHESE:**

Okay.

**MR. GILLICK:**

I think there's a code if there's an immediate situation where people would respond. But generally what I see going on right now is someone now would be put on -- would be assigned to that. That's a resident in a one-on-one.

**LEG. KENNEDY:**

One-on-one.

**MR. GILLICK:**

Which is prescribed.

**LEG. KENNEDY:**

A doctor's order is written for that; right?

**MR. GILLICK:**

U-huh.

**MR. MARCHESE:**

Yeah, we have a large number of one-to-one aides in our facility. So it becomes a manpower issue for our staffing as well.

**LEG. KENNEDY:**

But those one-to-one orders are reviewed as well. So that I mean -- I mean those are based on some kind of an acute and primary condition. Not that that's the patient's on going practice and protocol. Right?

**MR. MARCHESE:**

Correct.

**LEG. KENNEDY:**

Okay.

**MS. KERRIGAN:**

Can I just ask a question? With the one-on-one, those are doctor's orders. Is that protocol in the facility now that -- to have a one-on-one patient staff, it must be a doctor's order?

**DR. AVILA:**

I think that's the way it is right now. I'm not sure.

**MR. GILLICK:**

That assignment can be a nursing assignment. I think they talk to the doctors. What happened -- what the facility is doing, that person is on one-to-ones in the morning report everyday and it's reviewed in terms of the resident's condition, mental status and the determination whether or not that needs to be continued. The doctor is certainly made aware of those situations. But if there's an immediate situation the nursing supervisor can make that decision to assign someone there right away. And then, you know, certainly the doctor is contacted, informed of what's going on. And then it's monitored by the building.

**MS. KERRIGAN:**

If you were on 30 minute checks, let's say, because that does happen when they're going for one-on-one, does that standard protocol have a doctor's order for 30 minutes checks basically?

**MR. GILLICK:**

I believe so. I'd have to -- I don't know.

**LEG. KENNEDY:**

Two 15, two 30, whatever, for observation. That's usually that physician's order.

**MS. KERRIGAN:**

I'm asking if they have that?

**MR. GILLICK:**

I believe so but I'm not familiar enough yet with all that to be able -- but I know it's monitored very closely and doctors are informed of what's going on.

**MS. KERRIGAN:**

Thank you.

**MR. FARRELL:**

Could you tell us how many of those one-on-one's you have now?

**MR. GILLICK:**

I go to morning report, so that fluctuates. It's usually maybe one at a time. At this point it's not a large number.

**MR. FARRELL:**

Okay. But to follow that up, do you separate them and keep them on one unit in one area or is it every floor?

**MR. GILLICK:**

As I said before, right now it's wherever that resident resides. I don't think we have a spot to put people in.

**MR. FARRELL:**

Because really what I'm getting at is if you had them in all one contained area, then you could train and have those people on that floor to take care of the response of an emergency situation.

**MR. GILLICK:**

Well, I think that's what Len is talking about; that idea takes, you know, some processing.

**MR. FARRELL:**

It's still in development.

**MR. GILLICK:**

Right.

**MR. MARCHESE:**

It becomes -- if you have everybody with a problem in one area, it becomes very hard on the staff in that area unless you have specific facility modifications as well as a lot more specific training.

**P.O. LINDSAY:**

You'd have to get that certification.

**MR. MARCHESE:**

CON from the State.

Why don't you continue?

**MR. GILLICK:**

Okay. I just want to see if there's anything else. Capital projects Community Enhancement Grant Project, as of today we're -- our housekeeping supervisor is meeting with the company that's going to replace the carpeting in the front so we'll be setting a schedule together for that. I think that would be a great opportunity.

There are few more projects up on the 5th floor, unit five, for the -- to put a satellite PT department. They were in today to do carpeting and a couple other things so that's ready to go. I know Jeff had

put calls out to the Health Department for this driveway, the changes in the driveway where the handrails -- we were to re-do that, the sidewalks and that part. We're waiting to hear back from them. I'm going to call them this afternoon and see if we --

**MR. MARCHESE:**

They needed to approve our safety plan.

**MR. GILLICK:**

Right. They have -- they were given a safety plan so that there wouldn't be any incidents while there was construction in place.

**P.O. LINDSAY:**

Who was going to --

**MR. GILLICK:**

The Health Department. We're just waiting to hear back from them.

**MR. MARCHESE:**

Prior to us doing the front facility construction, we just need to -- just how we're going to handle admissions and people coming in and out of the front door so they're safe.

**P.O. LINDSAY:**

The carpet, that's just the lobby? When the carpet's done?

**MR. GILLICK:**

Yeah, pretty much.

**MR. MARCHESE:**

You know, the front entrance way is all going to be modified.

**P.O. LINDSAY:**

Yes.

**MR. MARCHESE:**

But the internal -- yeah.

**LEG. KENNEDY:**

Can we go back to the 5th floor project for just a second. In addition to that satellite PT area which I saw which probably will be a very nice addition, that should be a good thing, the software for the electronic medical records is up and operating on the 5th floor?

**MR. GILLICK:**

Yep.

**P.O. LINDSAY:**

That's next on the agenda.

**LEG. KENNEDY:**

Oh, did I jump ahead? Oh, I'm sorry.

**MR. GILLICK:**

Just real quick, we had other -- quite a bit of background in memory care programming so I'm going to before I leave spend some time with the staff on that unit to give them some other observations and try to do some work with them as well. So I'll make sure I do that.

The electronic medical record is up and running. The feature which permits the nursing assistants

to document what services they are providing to the residents, that's now -- that's in place. Care plan is in place, the MDS, the assessment tool that's in place. The next step would be progress notes. I think the Health Department visit may have interrupted a little bit of that training. So that's next. And then my understanding the big piece after that will be physician orders, which I understand needs some additional --

**MR. MARCHESE:**

We're deploying the tablets soon. They're actually going to do that in the next phase.

**P.O. LINDSAY:**

How about billing?

**MR. MARCHESE:**

This is all integrated into the same system.

**P.O. LINDSAY:**

Okay. But it's unrelated but is related for the last, I think, all of this year. The RFP Committee's been kicking around an RFP about medical records, medical billing.

**MR. MARCHESE:**

Medicare Part D billing.

**P.O. LINDSAY:**

Right.

**MR. MARCHESE:**

We're going to do. We still want to put that out.

**P.O. LINDSAY:**

But do we still need that?

**MR. MARCHESE:**

Yes.

**P.O. LINDSAY:**

Why?

**MR. MARCHESE:**

Well, the firm -- they actually do it a lot cheaper than we do.

**P.O. LINDSAY:**

Even with the new electronic system?

**MR. MARCHESE:**

Yes. They take what we give them and they turn it around and they prepare the bill very inexpensively. Like on a fraction of what we can do it for this particular size. So we experience that when we've had them do it for the last two years, where they were doing it for, say, \$20,000 and it was costing us two full-time people to do the job. So we were way ahead on the process. So, you know, we'd like to -- and they're experts in the Medicare billing.

**P.O. LINDSAY:**

Okay.

**MR. MARCHESE:**

So it's the resubmission of the denials, you know, and following up that they have the expertise to

do. And we found they're much more fruitful for us.

**MR. PEARSALL:**

When is the RFP going out? I know you've been out for two of them.

**MR. MARCHESE:**

Yeah, we didn't get enough response. There was not enough respondents who wanted it so we re-issued it. It should be going out now; like, again. It should be in front of you. We want to reissue it.

**LEG. BROWNING:**

What about the Tri-care?

**MR. MARCHESE:**

That contract's still in place. We're just not getting any referrals.

**LEG. BROWNING:**

Right. Do you have to renew that?

**MR. MARCHESE:**

I think it's automatic renewals for three years.

**MS. BRANDEAU:**

We haven't had any (inaudible).

**LEG. BROWNING:**

Well, but you don't want to lose it.

**MS. BRANDEAU:**

No.

**MR. MARCHESE:**

We don't want to lose any of these manage care contracts. Those are all in place. We worked too hard to get them. They're all, like, either three year contracts with one year renewals or -- and we have a contract monitoring system that notifies us when a contract's coming due, you know.

**LEG. BROWNING:**

Isn't that like three years since we got the Tri-care?

**MR. MARCHESE:**

It's been that long?

**LEG. BROWNING:**

I think it is.

**MS. BRANDEAU:**

Almost.

**MR. MARCHESE:**

Two-O-eight, yes.

**LEG. KENNEDY:**

Can I go back to that question I had before with the electronic medical records. So I had an opportunity to see it on the 5th floor and it looks phenomenal, it really does look very dynamic. But are all the floors in the facility utilizing it with those applications that you've spoken about?

**MR. MARCHESE:**

No, we're rolling it out; floor by floor as we're rolling it out. The process of training all the staff is difficult.

**LEG. KENNEDY:**

Absolutely.

**MR. MARCHESE:**

And we've experienced this in the Health Department because we've rolled out EMR's in other places.

**LEG. KENNEDY:**

Sure.

**MR. MARCHESE:**

You know, part of bringing on a bunch of new staff that we're going to be bringing on, we're hiring a bunch of new RN's. I think we're going to do a whole new facility push on training in the EMR, make it, you know, like go off the cliff, kind of say, because we've been kind of moving it along but not jumping it into full throttle. So I think once we bring on this next whole round of staff that should be in place in the next few weeks, I think, we're going to take that final push and go.

**LEG. KENNEDY:**

And all your direct care people are interacting with that software; your CNA's, your PN's and RN's? And what about the OT's and the PT's, as well as the physician?

**MR. MARCHESE:**

Well, the physicians aren't just yet. The tablets -- they have mobile tablets that we bought for them so they can actually walk through the facility and do their orders in a mobile setting. And they're not -- that hasn't been rolled out yet. That's like the last piece.

**P.O. LINDSAY:**

Totally paperless.

**LEG. KENNEDY:**

And you have applications on your medication carts, too, so your med nurses are able to go ahead and document their --

**MR. MARCHESE:**

Absolutely. And then with the therapy, you know, like when somebody's on, say, a treadmill, not 30 minutes, it's 27 and a half minutes.

**LEG. KENNEDY:**

It's capturing that --

**MR. MARCHESE:**

-- exactly what that time is. And that's what -- that's the requirement for us to bill. And so now that's able to do that instead of us manually having to enter it on a chart, then input it into a bill, and then get that transmitted. So this whole process should be streamlined.

**LEG. KENNEDY:**

This software, Len, do we own the software that's a platform for this?

**MR. MARCHESE:**

Yes.

**LEG. KENNEDY:**

We do, okay.

**MR. MARCHESE:**

I mean we pay an annual licensing fee, whatever.

**LEG. KENNEDY:**

As we do with any kind of software. But we have -- we own it and if we want --

**MR. MARCHESE:**

Yeah, we have, like, 400 licenses for everything in the facility.

**LEG. KENNEDY:**

So there's more than enough in the facility?

**MR. MARCHESE:**

Yes.

**LEG. KENNEDY:**

And if you find you want some modifications or something made with it, we're able to go ahead and get a programmer in to do that?

**MR. MARCHESE:**

ATL is a major leader in the nursing home systems. We bought one of the better systems that are out there.

**LEG. KENNEDY:**

Good.

**MR. MARCHESE:**

It does everything from front end admissions to {rou} dietary because we hooked it up with geri-menu which allows us to do our dietary interface right through to the billing, through the collections and through financial management on the back end where we run our general ledger and everything else on it.

**LEG. KENNEDY:**

Do you folks have the ability to dial into that remotely? In other words if you wanted to access just some of the generals for, let's say, like census count or something like that, can you get into the system from here in Hauppauge or elsewhere? Or you have to be in the facility?

**MR. MARCHESE:**

No, I would assume we could. But I get the e-mail --

**LEG. KENNEDY:**

You get the same thing that I get. She does a great job.

**MS. KERRIGAN:**

This is probably very -- too simplistic a question, but when the EMR is up and running, percentage-wise, what type of increase do you estimate that will -- the revenue? Will there be a large increase in revenue from capturing --

**MR. MARCHESE:**

Well, we're hoping-- well, we don't know. But we're hoping that the lower PR's -- not PR's, but lower rug scores that we have are a result of us not documenting what we are doing. So as a result of us now automatically capturing it as part of our workday, it should increase or rug scores because

we'll capture everything that we did. I think we're taking care of the patients and we're doing what we're supposed to be doing but we're not capturing it on paper very well.

**P.O. LINDSAY:**

How about the expense side? Less shuffling paper, does that free up somebody?

**MR. MARCHESE:**

Yeah, it should help us on our ward clerks as well as our medical record staff. And theoretically once a CNA doesn't have to be burdened with writing and they can just point and click, that should free them up to do more patient care. Yeah, it should help everybody. Once you get through the learning curve, it should help.

**LEG. KENNEDY:**

It should give you a little bit better assistance with your inventory control, too, shouldn't it? I mean right now you're purchasing based on a bulk census. But when you were able to, you know, drill down a little bit better to see what percentage you have using, I don't know, prothesis's or, you know, combinations of things like that, shouldn't you be able to tailor your buys a little bit better?

**MR. MARCHESE:**

Yes. But what we do is we maintain a par level on all of the units because at any given day the unit does not know what patients they're going to have particularly on that day.

**LEG. KENNEDY:**

Absolutely.

**MR. MARCHESE:**

So we keep, like if you would, like a closet with par levels, like supplies. Specialty supplies that are based on individual patient needs are ordered when that patient arrives at the facility. So that's already being down on a specialty level. The fact that we hired an inventory control clerk that we didn't have for a long time has really enhanced the inventory control of the facility. You know, we spread around the ordering and the responsibilities of that position while we had a vacancy. And we found that we were over ordering. We were over ordering on gloves, you know, paper towels, diapers, you know, things -- now that we have one central person that we can point to, it seems to be more under control. And I think that everybody would agree at the facility that that's happening.

**MS. KERRIGAN:**

The same line as -- I don't want to beat this to death -- but studies -- I know you're involved in management and research. And ATL --

**MR. MARCHESE:**

ADL.

**MS. KERRIGAN:**

-- ADL comes in, do they give you statistics like average, what type of percentage increase when you go from, you know, manual to this electronic medical recording? Do they estimate what the increase in revenue would be?

**MR. MARCHESE:**

No.

**MS. KERRIGAN:**

So there's no study that shows that?

**MR. MARCHESE:**

No, it's different in every facility because -- just because you're on a paper system, if you're a

proprietary facility, you're going to be making sure you're capturing everything you're doing even if it's on paper. It doesn't matter. So when you convert over to electronic, they probably wouldn't have experienced as much. We, I think, on the other hand will probably be on the high end of improved efficiency and we'll see it once we go through our rugs analysis on all of the patients in the house. So once we do that, I think we'll see our overall acuity level increase so that we should get more reimbursement.

**MS. KERRIGAN:**

Thank you.

**LEG. KENNEDY:**

Can I just bring up two other things under miscellaneous, I guess. One from the food purchase. We had a chance to go out and tour Cornell Cooperative and saw their beef production program there. And as you know, our jail is serviced by the cows that get raised out there. Apparently at one time we also supplied the beef for the facility as well, but we don't do that now; correct?

**MR. MARCHESE:**

I'm not aware of us buying stuff from Cornell Cooperative. I mean we buy from the County bid list on whoever's selling.

**LEG. KENNEDY:**

It's a favorable, I guess, arrangement with the jail right now. They produce several hundred thousand pounds, I guess, of beef for the prisoners.

**P.O. LINDSAY:**

On the County farm.

**MR. MARCHESE:**

Yeah, right. So we have access to that as well.

**LEG. KENNEDY:**

Absolutely. I think at the very least it would be worth a piece of correspondence.

**MS. BRANDEAU:**

I remember there was some problem that Fred had -- Fred Pollert had been looking at. They were doing it. But there was a problem with the consistency and the quality and the dietary requirements. And it wasn't as consistent with the -- nursing home patients needed a different consistency than the prisoners did so -- there might have been a study or something done on that. I remember something.

**MR. MARCHESE:**

This is like just beef or steak or whatever, okay.

**LEG. KENNEDY:**

I had a chance to talk to some of the cooks. And the cooks said that, you know, they're getting five to seven pound types of, you know, roasts now. And you know, I mean if you got a beef cow that we're raising that's got the same equivalent to what we're purchasing out, and we have the opportunity to acquire that at a cheaper price per pound --

**MR. MARCHESE:**

I'll look into it. We'll looking into it and I'll get back to you next time.

**LEG. KENNEDY:**

Good. That sounds great. The other thing I just wanted to thank Dr. Tomarken for your response back regarding the patients that are out in the hospital when they have to leave the facility. You know, I'll confess complete ignorance there as far as an understanding to how that whole process

goes when there's a determination that a patient has to go out to the hospital, the duration they're out in the hospital, when they return to the facility. Obviously I mean patient care is paramount. But, A) that's an expense to us, I would believe, in lost revenue that we have for the bed in the facility. And then from your gentlemen's side of the fence, what's the medical process for them going out, the duration that they're out and the time that they come back?

**DR. TOMARKEN:**

Okay. They go out under the doctor's orders.

**LEG. KENNEDY:**

Okay.

**DR. TOMARKEN:**

And their treatment in the facility they go to is under the control of that facility. And generally the way it works is that the facility when they're finished with their treatment advise us. We then either send a nurse or have a physician or their discharge planner talk to our staff to find out the status of a patient to make sure that they're still appropriate to come back to the facility. Because they may have -- their health status may have changed, etcetera; their needs may have changed. So then it's agreed that the patient is or is not appropriate to come back. And then at a time convenient for both facilities, the patient is entered and then examined by either the LPN or the physician and resume their activities with whatever changes may be needed to be made. But it's really out of our control why they're there. All we can do is monitor and let the doctor find out, you know, what's the status improving, not improving. But the patients under their total control at that time.

**LEG. KENNEDY:**

Well, let me put it a different way. And I don't want to dance around it. In a perfect world, we would be able to have residents go to a facility, to a hospital, Brookhaven, Stony Brook or wherever and they're there for whatever period of time they're there. And they receive the care for whatever they have, whether it's a urinary tract infection or broken leg or who knows what. But I guess my questions are twofold. A) are you comfortable that we are not sending people out unnecessarily? And B) are they out in the acute facilities for a time necessary to treat them but only that much time and then they're coming back to the facility so that we get the bed filled?

**DR. TOMARKEN:**

First, it's a clinical judgement to send somebody out. And that's the physician's choice.

**LEG. KENNEDY:**

Absolutely.

**DR. TOMARKEN:**

And every physician is going to be different. But we don't see people going out what we would think of needlessly or inappropriately. One of the things you have to keep in mind is that with the elderly, they may have one symptom but they may have several conditions going on at the same time. It's very unusual for a an elderly patient to have just one condition. So if they have a urinary tract infection, you'd want to make sure that they don't have what's called sepsis, sepsis system or pneumonia or whatever. Much different than taking care of younger people.

In the hospital, most hospitals don't want to keep patients longer than they have to because they don't get reimbursed depending on if it's a manage care system.

**LEG. KENNEDY:**

Depending on the rugs.

**DR. TOMARKEN:**

Right. They won't get paid from the --

**LEG. KENNEDY:**

Manage care?

**DR. TOMARKEN:**

The government will pay per diagnosis but not per length of time.

**LEG. KENNEDY:**

Okay. Then let me just take one other pass at this then. Similar to where you're looking to do some training for different types of patient situations, whether it's, you know, management restrain or whatever, do you feel comfortable that your five medical folks there now are uniformly approaching a particular patient condition in the same fashion? Or is that an opportunity for some conversation?

**DR. TOMARKEN:**

I think that's something that -- first of all, they're all new as you know. And secondly I don't think they've had enough time to coalesce around that. And I think that's something Dr. Crowley had said she wants to move on so that people have a general approach to patients with certain conditions, whether they can be treated in the facility. And that would -- for instance, if we had more RN's where we could have intravenous medication, intravenous lines in patients, we might be able to treat more people within house than transferring out. So it has multiple inputs into it. But she is hoping that with the new staff that they would be reviewing cases, reviewing criteria for discharging people acknowledging the fact that every physician has their own level of concern and practices and different manner, but that there should be some consistency. But that's going to take some time because they're all brand new.

**MR. GILLICK:**

Right now everyday the physicians who are on duty meet on a daily basis and review any cases that Dr. Crowley deems to be -- or if they just have clinical rounds everyday, which I think is a good start, so people on report, Dr. Crowley goes to morning reports so she'll have an idea if any unstable. And so every day now they sit down and go through those cases to make sure they're being attended to. So that's a good start.

**DR. TOMARKEN:**

Right. And I would be more concerned about patients coming back, that we have an appreciation of what the condition is when they're ready to be discharged back to us. That's more of a concern to me.

**LEG. KENNEDY:**

I understand. You don't want a patient back that's vulnerable, compromised or not able to be out of and be supported by the facility. No, I understand. How quickly are we going to get the nurses who can inspect?

**MR. MARCHESE:**

Well --

**P.O. LINDSAY:**

Before we get to that, though, can I just ask how many people do we have in a hospital now?

**MR. MARCHESE:**

Ten.

**MR. GILLICK:**

Ten.

**MR. MARCHESE:**

That's pretty consistent. We've had five -- somewhere between five and ten on a regular basis. You know, it could turn.

**P.O. LINDSAY:**

Okay.

**MR. GILLICK:**

The list I have here, they haven't been in other facilities along the way. You know, one thing you want to look at is what's the length of stay of patients if they're in the hospital for a long period of time, my sense is there's something pretty wrong with them. And here so far it ranges, you know, from one -- but that was somebody that went the other day up to 25 days. And there's quite a few people here. Two, four, six who are there -- who have been there anywhere from 8 to 25 days. So it's got to be something pretty significant going on with them, I would think, because as you said, Dr. Tomarken, the hospitals are certainly -- they want to get people out as quickly as they can. And that's the challenge when they come back maybe a day or two early.

**LEG. KENNEDY:**

So, in other words, we're bringing RN's -- I missed that part -- I'm sorry but those RN's that we're bringing on, that's one of the things we're looking for is proficiency with intravenous skills?

**MR. MARCHESE:**

There's a whole plan to upgrade the facility's staff in terms of professional staff from RN's to LPN's to RN supervisor to Assistant Director of Nursing. We're planning on hiring two new Assistant Director of Nursing. We have six new RN's that will be starting. We have a RN supervisor position that just was hired, started on October 4th. Occupational therapy we're still looking to fill. We hired a new social worker who's going to be starting this week. And a social work assistant was just hired. In addition to that, unfortunately as quick as we hire, we lose staff. And we've lost our adult day care director, we lost some LPN's, we lost --

**LEG. KENNEDY:**

Do you pick up the PN's that were the CNA's? Did you do the conversion for them?

**MR. MARCHESE:**

Yes. So that doesn't -- what happens there is I gain and I lose. So the facility doesn't get ahead, but we promote from within and so it's good for our staff but it's not so good for the overall because now I still have recruit on the CNA. I have to go through that process as well. And every time you hire a new group of CNA's there's a training delay, you know, once we bring them on board they have to learn our policies and procedures. And there's a recruitment delay. So, you know, you're looking usually about three to four to six weeks on that loop where we're filling those gaps.

**LEG. KENNEDY:**

There's still a number of nurses that, new grads from over in Suffolk that are looking and actively out there.

**MR. MARCHESE:**

Yeah, we have an ad on Monster.com. And we're getting -- we're getting responses. I mean, you know.

**LEG. KENNEDY:**

Good.

**MR. MARCHESE:**

Again, you can only cycle so many people through the facility at a certain time, too, you know. What happened, what slowed us down in hiring was that the survey over the last week, week and a half, all the staff that would have been interviewing were tied up with the state survey. So we

couldn't -- we had to cancel all those interviews so we kind of got delayed. So now we're back on track. We're hiring as well.

**LEG. KENNEDY:**

Good.

**DR. AVILA:**

Some of the responses have been incredible, the credentials of some of the people that are applying. It's amazing.

**LEG. KENNEDY:**

Good. But to just say one last -- beat the dead horse one more time, so we're going to get RN's in the facility who have proficiency with doing IV's so that if it comes to hydration or intravenous medications or something like that, they'll be there and can do it in the facility. And that's not necessarily rationale to send them out to the hospital. Yes?

**MR. MARCHESE:**

(Nodding head yes)

**LEG. KENNEDY:**

Okay.

**P.O. LINDSAY:**

Maybe this is a stupid question, but why do we need an occupational therapist for?

**MR. MARCHESE:**

What do you mean?

**P.O. LINDSAY:**

I mean are we trying to get them jobs?

**MR. MARCHESE:**

No.

**MR. GILLICK:**

Occupational therapists generally try to do rehabilitations above the waist.

**MR. MARCHESE:**

If you're cooking, you're turning the gas on and off is an occupational therapy.

**MR. PEARSALL:**

I asked that years ago.

**MR. MARCHESE:**

Yes.

**MR. PEARSALL:**

When we have long-term people in the hospital, how long do we have to hold that bed for them?

**MR. MARCHESE:**

We don't. We don't have bed hold. They're just open. Our bed's are open because they're there. But the whole concept behind bed hold is so that person has a place to go back to when you're almost full so you don't rent their bed per se or give away their bed. That's the concept behind that.

**LEG. KENNEDY:**

Why do we not have bed hold? I misunderstood. Doesn't she throw that red slug on that daily census so we do have bed hold?

**MR. MARCHESE:**

Yes.

**LEG. KENNEDY:**

So we don't have it now because we're down to -- well, what was it, 245, I think, 244?

**MR. MARCHESE:**

Yeah, that's correct.

**LEG. KENNEDY:**

And so what's our number at this point?

**P.O. LINDSAY:**

250.

**LEG. KENNEDY:**

250?

**MR. MARCHESE:**

Plus the State has increased the bed hold requirements now. You want to talk about that? You used to have an unlimited -- so when a patient went to a hospital, say that patient went for 20 days, you would get bed hold for all 20 days. Now it's an annual 15 day cap, 14 day cap. So if that person goes back a second time, even though theoretically you get bed hold, you don't get bed hold on that person.

**LEG. KENNEDY:**

Right.

**MR. MARCHESE:**

So the state is rationing down bed hold policy as part of their budget process.

**MS. BRANDEAU:**

What's the percentage?

**MR. MARCHESE:**

95 percent.

**MS. BRANDEAU:**

95. Because they were looking at increasing it, weren't they?

**MR. PEARSALL:**

It went up from 90 to 95.

**MR. GILLICK:**

I think they were looking to increasing it.

**MR. MARCHESE:**

I think that was the proposal but --

**MR. GILLICK:**

There was other mechanisms that did the same thing.

**MR. MARCHESE:**

Yeah.

**LEG. KENNEDY:**

We've had two beds open in the HIV for quite sometime now, too. I see there's one out in the hospital, we have two vacancies?

**MR. MARCHESE:**

Yeah.

**LEG. KENNEDY:**

And that's just -- there's been no referral over or contact to the facility for people that need care with those diagnosis?

**MR. MARCHESE:**

Yes. And we just renewed our relationship with the Long Island Association of AIDS Care or something like that. We just signed the agreement the other day. It facilitates referrals and stuff like that.

**LEG. KENNEDY:**

How about Nassau County? I know NCMC, as a matter of fact, has a primary HIV AIDS acute care component there. And do we dialogue with them at all?

**MR. MARCHESE:**

That I'd have to find out. I'm not sure about Nassau County Medical. You're saying Nassau County.

**LEG. KENNEDY:**

Medical Center.

**MR. MARCHESE:**

Yeah. I would have to check on that.

**LEG. KENNEDY:**

Okay.

**MR. FARRELL:**

I'd like to go back to Tri-care. Have you been actively pursuing any patients through Tri-care? And if not, why not? Are there problems with that?

**MR. MARCHESE:**

The way manage care companies work is you don't actively pursue anybody. You get enrolled in their network and the patient picks where they want to go; just like when you pick what doctor you want to go to, you decide where you want to go and that's where you go. You can come to me because I'm in your network. Like, you know, you look in your book and say who's in my network? That's the same thing. So we're in the Tri-care network. So if there's a patient in Tri-care that wants a facility, all they do is open up their book and they'll see that Foley is part of that facility and they will come to us.

**MR. FARRELL:**

So then I can assume that we don't have anybody in that situation that actually lives in this area that would want to go to Foley? Is that a fair assumption?

**MR. GILLICK:**

Let me talk to our admissions people and just see what activity's gone on, if they've gotten any inquiries.

**MR. FARRELL:**

If you could, I would appreciate that.

**LEG. KENNEDY:**

How about one other suggestion? And I can do this. I deal with the PR guy over in Northport all the time Joe Sledge. What if I reached out to him and asked him if some of their discharge folks might want, you know, take a trip over to get to see the facility and just do a walk-about?

**MR. MARCHESE:**

That will be fine.

**MR. FARRELL:**

That sounds great.

**LEG. KENNEDY:**

I'll call Joe today. And I'll suggest maybe we can put together, you know, some type of opportunity to do a little bit of a tour and -- it seems that when the admissions folks have that degree of comfort and knowledge, that they are a little bit more apt maybe to pick up the phone and want to reach out to you guys first.

**MR. MARCHESE:**

Love to have them.

**LEG. KENNEDY:**

Good.

**MR. FARRELL:**

And, you know, I would appreciate that because maybe if you get one, one will tell two and two will lead to three and maybe four and five; people will be --

**MR. MARCHESE:**

Most of our referrals -- manage care referrals -- the big thing that we got was into the Blues, Bluecross/Blueshield network, which is like -- it's like 150 times more of a population than there is with the Tri-care population. So by us entering that, which we did successfully, that's really a primary source of our referrals at this point.

**LEG. KENNEDY:**

Good.

**MR. MARCHESE:**

You know, I can't emphasize enough the adult daycare care stuff. That actually, if you look at our statistics, a lot more of our referrals come from adult daycare. So I don't know how we can better advertise our adult daycare program. But not only is that a big profit maker for us, it's our biggest referral source.

**LEG. KENNEDY:**

Okay. I got another one for you.

**MR. MARCHESE:**

So that's any area -- if anybody wants to help, that's an area.

**LEG. KENNEDY:**

Parish outreach, Catholic charities. As a matter of fact I just jotted a note to Jan {Jamraz}. As a matter of fact, she does the oversight for all the parish outreaches throughout Nassau and Suffolk (inaudible). They often times dealing with, you know, parishioners and people right in the

communities that are struggling with all these health care types of decisions. There again, I think if we can get a couple of the folks from parish outreach out, get an opportunity to see the facility, maybe do a little bit of a walk-about again, that's a very tight network amongst all the parishes where, you know, they'll go back and forth. Some know. I mean right out there, Farmingville, you know, I knew the outreach coordinator there, St. Sylvester. But how far does your transportation then go?

**MR. MARCHESE:**

Right now we actually -- we go all the way out on the East End. On the north fork we have patients coming from Greenport.

**LEG. KENNEDY:**

Honest to God?

**MR. MARCHESE:**

Yeah, on adult daycare. Patients don't like to be a bus more than an hour. So, if you -- but that's a pretty wide area.

**LEG. KENNEDY:**

It is, it is.

**MR. MARCHESE:**

The problem is, it's not like you get in your car because they have to make stops. So an hour's longer than you think on a bus. I mean it's a shorter distance than you think because you might go like, I guess, 30, 40 mile radius is an hour. It's no more than that. And we do provide bus transportation so it's not like they have to drive to us so really if you can get anybody that's willing to stay on a bus, we'll take them.

**LEG. KENNEDY:**

Okay.

**MS. KERRIGAN:**

And to that, I think the last time you mentioned something about a new transportation contract for that or --

**MR. MARCHESE:**

Yeah, we're putting out to bid a new transportation contract that will provide a different way for us to pay for our transportation. And hopefully that will save us money.

**LEG. KENNEDY:**

We have reimbursement on that? In other words, we can bill for the adult daycare? Or is bundled in whatever our day is, the reimbursement for the day?

**MR. MARCHESE:**

It's a carve out. We bill it separately. And it's \$45 per day. Unfortunately right now the transportation is costing us about 60 a day.

**LEG. KENNEDY:**

Is that because of the way the contract is? Because we ought to breach that bad boy right now; deal with the damages, bust the contract.

**LAUGHTER**

**MR. MARCHESE:**

No. Well, we are -- that's part of what we -- we were being reimbursed 65 a day. Then the state changed their methodology on how they were going to pay us effective September 1st of this year.

And then what we did was we asked them for an extension through the end of this year to allow us to put the RFP on the street to get a bid. And they agreed to that. So we're still getting reimbursed what's costing us through the end of the year. And hopefully when we redo our contract, we'll lower our costs to about \$45. What we're planning on doing is have the -- getting the facility out of the billing portion of that altogether and let the bus company bill Medicare and Medicaid for that. So we have no risk, but there's no profit margin for us. But that's okay; just no cost exposure. And that's kind of where we're going with that.

**MR. FARRELL:**

And, I'm sorry, in regards to adult daycare, in the last three months has the patient level been declining, remaining the same, increasing?

**MR. MARCHESE:**

I don't have numbers in front of me.

**MR. GILLICK:**

What did I say? 48 registrants, 26.8 average census for September.

**MR. FARRELL:**

Is that up or down from August?

**MR. MARCHESE:**

Well, the census was running about 32 to 33 visits per day prior to us realizing that our license was only for 24 slots back in the early part of the year. And then we discharged a whole bunch of folks back then. Then we got our license back in July or June. So then our census was a low of 24 in June. And now we've been billing from 24 and now we're up to 27. It takes a longtime to build census again. It's just not easy.

**MR. FARRELL:**

Okay. Thank you.

**MR. MARCHESE:**

Now, as you know, we have a license to serve 60. So we have a long -- a big growth potential, but we need to get the word out. That's a big area that would improve the facility bottom line by the way, the adult dare care program. There is a large profit margin in that.

I just wanted to report on some other things. We still -- the facility receives what's called a IGT, intragovernmental transfer, from the State of New York. We have not received it yet for this year. We have not received it for last year. We're still waiting. There's been some discussions with the State also with regard to us receiving the enhanced amount on the FMAP percentage. I'm not sure if everybody's familiar with that. The federal government as part of the stimulus package increased their participation in Medicaid so that the states have paid less as a way to funnel federal stimulus monies to the state and then to the counties. Our percentage was typically 50 percent, but now -- the feds percentage was 50%, but now they raised their percentage up to 56, 57. That six or seven percent means a lot to the County.

And what happened is we budgeted also the IGT based on that higher percentage. And they're arguing that the IGT should be based on the year in which it was supposed to be paid, not the year in which they are paying it. So they want to take back the seven percent. So there's currently an argument going on because it doesn't only affect us, it affects the State of New York big time. So there's an argument between State of New York and the feds. And that argument is probably leading towards the delay in releasing of all these funds. So there's a whole big process.

**LEG. KENNEDY:**

How much are you talking about, when you talk about a difference with them?

**MR. MARCHESE:**

The IGT is about three and a half million dollar annual revenue. So 7 percent of that? Seven times three is 210 -- \$250,000 on an annual basis.

**LEG. KENNEDY:**

So we're talking about over what, a two, three year period?

**MR. MARCHESE:**

\$750,000.

**DR. TOMARKEN:**

But they owe us --

**MR. MARCHESE:**

They owe us three years. Somewhere around three million per year for three years. They us for nine, they owe us for ten. And we don't know what we're getting in 11.

**DR. TOMARKEN:**

But somewhere six, eight, \$9 million?

**MR. MARCHESE:**

Yes.

**LEG. KENNEDY:**

The total that's outstanding or that's subject to the swing?

**DR. TOMARKEN:**

Swing.

**MR. MARCHESE:**

The whole thing is outstanding. But in addition the argument of the seven percent or so is still out there, too.

**LEG. KENNEDY:**

The last time that we got IGT was 0 --

**MR. MARCHESE:**

Eight.

**LEG. KENNEDY:**

But it was reflective of five, six and seven?

**MR. MARCHESE:**

Yeah, there was some retroactive. They did the same thing. It was like three years and then --

**MS. REYNOLDS:**

Six, seven and eight.

**MR. MARCHESE:**

There was three years worth of retroactive.

**LEG. KENNEDY:**

And the disagreement is between --

**MR. MARCHESE:**

CMS and the State of New York.

**MS. KERRIGAN:**

Legislator Kennedy, from what I understand that's the norm as far as the state goes with reimbursement. They don't do it every year, but they get around to it every two three years.

**MR. MARCHESE:**

We've been receiving IGT monies for a long time, yes. We used to receive it like clock work on September 1st and April 1st every year. It was not the norm.

**MS. KERRIGAN:**

And when you say "used to", how long ago was that?

**MR. MARCHESE:**

Since I've been with the County; fifteen years.

**MS. KERRIGAN:**

So it just started you're saying in '06?

**MR. MARCHESE:**

Well, it started in '02, '03 where there was some changes in the methodology of calculating it. And then we got it retro in '07, '08. And now this is another issue that they're futzing around with in methodology. And when they do that, it affects the County. So it directly affects our facility.

**LEG. KENNEDY:**

But if we reached out to, you know, let's just say we reached out to Schumer's office or Gillibrand or something like that, this is an issue that they would be cognizant of because they're the ones that shouldn't be dumping on CMS. Okay.

**MR. MARCHESE:**

Yes.

**MR. FARRELL:**

Could it be they just don't have the money?

**MR. MARCHESE:**

It's federal money. They are clamping down on federal distribution of federal funds. It's part of that.

**LEG. KENNEDY:**

Right. But the whole premise with IGT is is that you're making whole local institutions that are providing care for difficult populations and --

**MR. MARCHESE:**

Well, not exactly. But the IGT program is to make up for the shortfall between the Medicaid rate and the Medicare rate per se of the amount that you could have received had you charged a full Medicare rate. That's the concept of this. And it brings in whatever it brings in. It brings in three million. It's not to make it say if we have a \$5 million deficit, it's not to make us \$5 million whole; it brings in three. So you're still 2 million short. That's the concept there.

**LEG. BROWNING:**

Is that money that's only available to public nursing homes?

**MR. MARCHESE:**

Yes. Private nursing do not get it.

**LEG. BROWNING:**

Right.

**MR. MARCHESE:**

Okay. All right. So we talked about the hiring plans. You know, I don't know if there's any other deficiencies or anything like that that we want to bring up or talk about that could improve --

**LEG. KENNEDY:**

Did you get anything on the survey? And again, if you spoke about that before I apologize. Preliminarily?

**MR. MARCHESE:**

We don't have a written statement of deficiencies yet from the state of New York but --

**MR. GILLICK:**

That should come sometime next week. They have ten working days. But there were just four areas: Accidents and incidents, comprehensive care plan, CNA proficiency and consultative services. And under each one they really only found one circumstance. So that's pretty isolated in terms of a plan of correction, that should be relatively easy to put in place. And the hope would be that the Health Department would not necessarily come back and do a resurvey to make sure your plan of correction's in place because they're isolated in nature. They'll look to see that what you did as part of the plan of correction is still in place in some fashion when they come back to their next survey. So really, and I think, Len, a lot of activity that went on in terms of what issues were brought forward, different staff member, you know, put things in place or had conversations with the surveyors which kind of remedied their concern. So there is -- I thought staff was all involved. We had a meetings, you know, after the Health Department left everyday, they were engaged in terms of -- making sure things were in place the next day.

**MR. MARCHESE:**

We have, also just on another note, we instituted a nighttime security guard perimeter. I don't know if you've heard.

**LEG. KENNEDY:**

No.

**MR. MARCHESE:**

We had some security issues at night. And so we in instituted our security to start evening coverage.

**MR. FARRELL:**

Issues with employees or patients?

**MR. MARCHESE:**

Both. So we're hoping to --

**DR. TOMARKEN:**

This is outside; to police the outside area.

**DR. AVILA:**

One of the things that was brought to our attention is that they found a box full of Marijuana right outside the facility. And there was more than you would normally, you know, for civil use. So we're concerned about possibly dealing; something we're actively pursuing. Because we can't have someone dealing Marijuana at the facility. We are concerned about that.

**MS. KERRIGAN:**

Are there cameras in the parking lot that could help with that?

**MR. MARCHESE:**

We don't have the cameras in the parking lot. We have them at the doors and stuff. We're dealing with a lot of issues on a bunch of different levels. And often you don't know if it's an employee problem or a patient problem. So we're -- part of why we want to hire two assistant directors of nursing as well is to one, have some overlapping shifts so that there's some nighttime supervision over and above our RN supervisors.

**LEG. KENNEDY:**

Is that what's been in charge in the house up to this point after a certain time?

**MR. MARCHESE:**

RN supervisor runs the house, yes.

**LEG. KENNEDY:**

Lot of folks for an RN. So what are they going to do? Are you going to have an evening nursing supervisor and then a graveyard nursing supervisor, too?

**MR. MARCHESE:**

No, I don't know about -- well, there always is an RN supervisor in house at all times, but I don't think we're going to have the Assistant Director of Nursing working in a graveyard shift. I think we're going to have an overlapping shift somewhere in the late -- starting in the late afternoon going through early evening so that there's coverage and then there's somebody there.

**LEG. KENNEDY:**

Like a two to ten and then somebody starting like five, six o'clock in the morning going up?

**MR. MARCHESE:**

Seven. Probably seven AM shift. And then that will allow the ADON to interface with family members and what not that might come in after dinner or something like that.

**LEG. KENNEDY:**

Absolutely.

**MR. MARCHESE:**

All right. Does anybody have anything else?

**MR. FARRELL:**

I do. AME's been advocating for years now at this point to have some audits done. Have there been any audits done on the facility, Medicaid audits or anything being done?

**MR. MARCHESE:**

The facility has an outside auditor.

**MR. GILLICK:**

Not for Medicaid. You mean independent auditor coming in?

**MR. FARRELL:**

Yeah.

**MS. BRANDEAU:**

Don't we already do that now? We've handed out the audits at previous committee meetings, haven't we?

**MR. MARCHESE:**

Yes.

**MR. FARRELL:**

Those are done every year.

**MS. BRANDEAU:**

Who is the audit firm.

**MR. MARCHESE:**

Ernst & Young.

**MS. BRANDEAU:**

Yeah, Ernst & Young.

**MR. FARRELL:**

And when do you get those reports back from the previous year?

**MR. MARCHESE:**

We've already distributed them.

**MS. BRANDEAU:**

It's a separate audit.

**MR. MARCHESE:**

It's a separate audit just for that facility.

**MS. BRANDEAU:**

I know that we actually reviewed one of the audit reports at one of these these meetings that we've had.

**MR. FARRELL:**

Can we get the report then for the next --

**MS. BRANDEAU:**

You should have it.

**MR. MARCHESE:**

It's probably on our website. It's actually on the County website probably somewhere. The comptroller would post our audit.

**MR. FARRELL:**

But you know with all the issues with Medicaid and all, I mean is there an audit that can be done on that to make sure everything is being billed properly, collected properly? Can we look into doing something like that?

**MR. MARCHESE:**

We have an outside auditor that the County pays \$80,000 to do our audit. Part of their function is to --

**MR. FARRELL:**

And it's extensive. It runs everything?

**MR. MARCHESE:**

Well, they're signing their name to our financials. They do a review of internal controls. They do a review of management practices. They write a management letter. They do a full audit.

**MR. FARRELL:**

Okay.

**MR. MARCHESE:**

Ernst & Young is not a small outfit.

**MR. FARRELL:**

No, they're a big firm. Okay.

**MR. MARCHESE:**

Terry.

**MR. PEARSALL:**

Can somebody give me the reasoning behind buying a thousand dollar popcorn maker and a thousand dollar snow cone machine for the facility?

**MR. MARCHESE:**

\$8,000 popcorn maker?

**MR. PEARSALL:**

No, a thousand dollar popcorn maker and a thousand dollar --

**MR. MARCHESE:**

This was out of the grant money.

**MR. PEARSALL:**

Popcorn nationally is known to be one of the choking hazards of the elderly. How could you justify buying a popcorn maker? I grant you now that snow cones they have a sugar-free syrup. It's on the market.

**MS. REYNOLDS:**

I have to check on with purchasing on that. I think they have to buy through certain vendors, too.

**MR. MARCHESE:**

A popcorn maker? A thousand dollar popcorn maker?

**MR. PEARSALL:**

Yeah.

**MR. MARCHESE:**

You're questioning why we would buy it?

**MR. PEARSALL:**

Why would you buy it?

**MR. MARCHESE:**

Therapeutic rec? I don't get in charge of the --

**MR. GILLICK:**

That's a good point. In general the therapeutic rec department will have a list of the residents who would have any swallowing problems and wouldn't do that. It is sort of a popular event, popular in facilities. And it's a good point but generally there's a process to -- whether it's other kind of food as well that people can --

**LEG. BROWNING:**

I know they have their summertime fairs.

**MR. MARCHESE:**

Outside Bar-B-Que's and picnics and stuff like that.

**MS. REYNOLDS:**

Which families come to and the kids come to visit.

**MR. MARCHESE:**

It's \$588.

**MR. PEARSALL:**

Yeah.

**MR. MARCHESE:**

There's a whole bunch of stuff we brought here.

**MR. PEARSALL:**

Yeah, you bought the cart and the machine.

**MR. MARCHESE:**

Laura Stein is our therapeutic activities nurse.

**DR. TOMARKEN:**

The real question is who approves that.

**MR. PEARSALL:**

Yes.

**DR. TOMARKEN:**

Who reviews that?

**MR. MARCHESE:**

She's in charge. Laura Stern is in charge of --

**MR. PEARSALL:**

Whether it's grant money or not, we're trying to make the facility viable, in the black.

**MR. MARCHESE:**

So this would be something that they would use for the patients. Now if the therapeutic activities worker feels that this is important to them, she's in charge of all our therapeutic activities, so she asks for a popcorn maker.

**LEG. BROWNING:**

I can take you to Price Club and buy you a case of popcorn which you can throw in the microwave.

**MS. BRANDEAU:**

So, Len, you'll look into the popcorn incident and report back?

**MR. MARCHESE:**

It is what it is. I don't know what -- the popcorn maker was --

**MR. PEARSALL:**

Somebody had to approve this. Anybody out there has cart blanche? They can order what they want?

**MR. MARCHESE:**

No, but there was a whole bunch of stuff.

**MR. PEARSALL:**

You all shook your head when I brought it up; you knew nothing about it.

**MR. MARCHESE:**

Correct.

**MS. REYNOLDS:**

That stuff doesn't go through the Budget Office, I know that.

**MR. GILLICK:**

This is part of the grant?

**MR. MARCHESE:**

Yeah. There was a pre -- when we did this grant, what we did was we submitted a list of all the things that we thought were appropriate for the grant. The State reviews it, signs off on it, yes, we'll agree to reimburse you for all these things as part of our application. That was part of that whole process. And whenever that planning process started back two years ago when we got that dormitory authority grant, that's when -- this was all was pre done. So there was all -- every item was listed in detail that the State then approved. And then we went through purchasing. Okay. I mean that's just what it is. You know, do the patients need a popcorn maker?

**LEG. BROWNING:**

No.

**MS. BRANDEAU:**

Maybe you can find out from the person why they ordered it.

**MR. MARCHESE:**

I can have Laura Stein give me a written report on that. You know, she's the person that's in charge of this whole area.

**MR. ZIELINSKI:**

I would just think when you purchase something, you actually maybe they granted it in the past and maybe they found out they've done it so many times per year, maybe it was actually more cost effective to purchase something like that.

**MR. FARRELL:**

They're not cheap to rent.

**MR. ZIELINSKI:**

We've done them at our AME meeting. I don't know how many events per year. So maybe if you're going to use them year in and year out, it probably is cost effective to buy it. That's what I would think.

**MR. PEARSALL:**

If I was the administration I would not have bought a popcorn machine. Not when we're getting ready -- some people are getting ready to close this and turn all this stuff over to Rosenberg.

**MR. ZIELINSKI:**

I would think the head administration of the actual management site must have approved that. Said it was okay but for the grant money.

**MS. KERRIGAN:**

I know I must have missed this, but I just wanted to compliment some of the hiring. It's just amazing the talent, Gary {Bernosky} and Richard Stern with the billing. And I wanted to bring it up

because you mention at the last -- the reimbursement for the lab. And it had to be a significant savings if it's all being billed through Medicaid and being reimbursed --

**MR. MARCHESE:**

Yes.

**MS. KERRIGAN:**

And how much does that amount to annually, approximately?

**MR. MARCHESE:**

Three hundred something thousand. \$375,000.

**MS. KERRIGAN:**

Thank you.

**MR. MARCHESE:**

Gary was a big addition to us. When I interviewed him, he came to us from.

**MS. BRANDEAU:**

{Sam Simeon}.

**MR. MARCHESE:**

Yeah. And he had a long history of nursing home experience so he brought to us a lot of private sector stuff so he was a very good catch for us.

**MS. KERRIGAN:**

It's stick in my mind when Mr. Rosenberg testified that he does bring in what he called talent at times of when -- when legislation changes or the billing changes or any changes in Medicaid. And is there a possibility that that might be cost effective for us to do or does Gary have that ability now? Is there an ongoing education process?

**MR. MARCHESE:**

The education process, there's a continuing education process that you have to avail yourself to and you have to be members of the associations. And that's usually where you get it. And it costs money. Unfortunately we've stopped being members of a lot of the associations.

**MS. KERRIGAN:**

Because we're saving \$300,000 with Gary, it might be --

**MR. MARCHESE:**

Yeah. You know, it's one of those things when you look at to spend 30 or \$40,000 to be a member of an association, is it worthwhile? And that's an annual appropriation. You know, we've in the past have been members. And then recently we thought that it would be better if we didn't.

**MS. KERRIGAN:**

It's a difficult situation. But to bring in then possibly at a time when the reimbursement is changing, to bring in temporarily just someone to work with -- it's just an idea.

**MR. MARCHESE:**

Well, we have a contract. We actually have an RFP in place to award a contract to an outside independent financial advisor. You guys -- we have a meeting coming up soon on that.

**MR. PEARSALL:**

Yes.

**MR. MARCHESE:**

And the way we are attempting to get the knowledge is by having an outside consultant be available to us.

**MS. KERRIGAN:**

Thank you.

**MR. MARCHESE:**

Why don't we just set the next meeting. Is that okay? A month from now?

**MR. PEARSALL:**

After the budget's in place so we have something to talk about.

**LAUGHTER**

(Off the record discussion about setting new date)

**MR. MARCHESE:**

We'll do it here again. Ten o'clock, 30th of November. Thanks everyone.

**THE MEETING CONCLUDED AT 11:29 PM**

**{ } DENOTES SPELLED PHONETICALLY**