

JOHN J. FOLEY SKILLED NURSING FACILITY

OVERSIGHT COMMITTEE

Verbatim Minutes

A regular meeting of the John J. Foley Skilled Nursing Facility Oversight Committee was held in the Rose Y. Caracappa Auditorium of the William H. Rogers Legislative Building, 725 Veterans Memorial Highway, Smithtown, New York on Wednesday, January 25, 2012.

MEMBERS PRESENT:

Dr. James Tomarken - Commissioner of the Health Department
Kathleen Reeves - John J. Foley Skilled Nursing Facility
Terry Pearsall - Chief of Staff - Presiding Officer Lindsay's Office
Kim Brandeau - County Executive's Budget Office

ALSO IN ATTENDANCE:

Presiding Officer William Lindsay - Legislature
Kevin Carey - Administrator of John J. Foley
Craig Freas - Budget Review Office
Legislator Kate Browning - 3rd Legislative District
Leslie Kennedy - Aide to Legislator Kennedy
Fred Pollert - County Executive's Budget Office
Tom Dean - John J. Foley Skilled Nursing Facility
Legislator William Spencer - 18th Legislative District

TRANSCRIPT TAKEN BY:

Donna Catalano - Court Stenographer

(*THE MEETING WAS CALLED TO ORDER AT 10:11 A.M.*)

CHAIRMAN TOMARKEN:

We will begin our meeting. I didn't print out an agenda, but it's pretty standard, so we're going to start. I think first, because we have new people here, we should just go around the horseshoe and introduce ourselves so that everybody knows who everybody is.

MR. DEAN:

Tom Dean, John J. Foley, nurse for ten years there.

MR. CAREY:

Kevin Carey, Administrator, John J. Foley.

MS. BRANDEAU:

Kim Brandeau, County Executive's Office of Budget and Management.

CHAIRMAN TOMARKEN:

Dr. Tomarken, Commissioner of Health.

P.O. LINDSAY:

Bill Lindsay, Presiding Officer. Welcome, Tom.

LEG. SPENCER:

William Spencer, 18th District Legislator, Chair of the Health Services Committee.

MR. PEARSALL:

Terry Pearsall, Legislature.

LEG. BROWNING:

Kate Browning, Legislator, 3rd District.

MR. FREAS:

Craig Freas, Budget Review Office.

CHAIRMAN TOMARKEN:

I just want to clarify, we have -- the Presiding Officer sent over a name for somebody from John J. Foley, and Mr. Dean was also here. So is there one that's official?

LEG. BROWNING:

I know at one of our previous meetings, we had talked about the need for a replacement when Chris left. God, how quickly you forget people when they leave. He is actually graduating on Friday with the Corrections Officers, so we're wishing him luck on that. However, we did discuss the need to replace him. I think that we were talking about posting it at the nursing home to see if there was an interest for a replacement. I don't know if we did that or not, I'm sorry, Kevin.

MR. CAREY:

No. But I was informed by Kathy Reeves that she was asked by the Presiding Officer, so we never posted it.

LEG. BROWNING:

Okay. I was not aware of that. I'm sorry, Bill.

P.O. LINDSAY:

I wasn't aware of it either.

LEG. BROWNING:

Tom is also a nurse in the nursing home. But again, we definitely need somebody. And I know the meeting is open to the public, so any John J. Foley worker is entitled to be here if they have the time off.

CHAIRMAN TOMARKEN:

That's fine. We welcome both. Thank you for coming, Tom. I checked this morning, and the minutes from the last meeting is still not available. We'll just have to wait until they get sent over. So we will have to postpone reviewing the minutes of the last two meetings. Next item we will do a facility update. Kevin.

MR. CAREY:

Kevin Carey, John J. Foley. The census as of yesterday is 207 residents with six in the hospital. December, we had 20 new admits. January -- to this day in January, we have 13 new admits. On February 2nd, I have a meeting with Katherine Morris from Stony Brook to discuss better communication with the new admits.

Adult Daycare, for December, our census is 48. December had two new admits and one discharge, so they're actually up one from December. They have -- from 47 to 48. Adult Daycare continues without an actual director. The social worker is the acting Director of Adult Daycare. Staffing, currently we have 213 employees; 17 out, Workers Comp; three on light duty. We're still in need of a permanent Director of Nursing. And we're still desperately in need of four RN Supervisors regardless of the size of the building. Recent tracking, one of our problems is chronic sick. HR has started a new tracking sheet to identify chronic sick and monitor with the ultimate goal in reducing the chronic sick.

MS. BRANDEAU:

Excuse me. Is that for employees?

MR. CAREY:

Correct, for employees, yes.

MS. BRANDEAU:

Can you just tell me again, you said you had 213 employees, and how many were out?

MR. CAREY:

Seventeen out with medical leave or Workers Comp, three on light duty.

MS. BRANDEAU:

Thank you.

MR. CAREY:

Recently we've been working on the CMI. The look-back period for Medicaid goes from the end of November to -- next week it ends. During that period is when we capture our score for Medicaid to reimburse us. Last year's score was 8.6. We anticipate -- .86. We anticipate going to .96 from the work we've done this month.

CHAIRMAN TOMARKEN:

What's the scale, is it one?

MR. CAREY:

Yes. It basically goes from .5 to 1.3. We are, right now, after last year, at .86. We're going to go to .96. That's our projecting right now on what the rehab and nursing has done to increase the score, which could mean the benefit of 800,000 next year in more revenue.

LEG. SPENCER:

You said 1.3 is the scale?

MR. CAREY:

That would be considered, like, the max if you were almost 100% rehab. It's based on rehab; how much actual care you're giving the resident. The majority of the score is based on how much rehab you give the resident, physical rehabilitation in the gym, is one of the main contributors.

LEG. SPENCER:

So a score of one is considered -- 1.3, is that like an extra above and beyond? What are you shooting for? What's the goal?

MR. CAREY:

My personal goal for the building would be around -- a little over one. We go with 8.6. I do believe we'll be about 9.6 after the CMI period. This CMI period though, the building doesn't kick in until July 1st for what's being judged in this CMI period.

MR. PEARSALL:

Is there a standard there? Is there a standard in the industry, Kevin?

MR. CAREY:

Not published, to my knowledge. I think some of the outside consulting agencies have standards or have averages for the Suffolk County or the Nassau County nursing homes. If I'm just guessing, it would be somewhere around one.

MR. FREAS:

I know ours has been as high as -- I want to -- but the scale changes on a regular basis. I know we've up to -- at 1.08 or something like that, I believe. I also know that we had been warned over the last two or three years that we were going to go down as the scale itself -- as they move the goalpost, so to speak.

P.O. LINDSAY:

So what we're talking about here is what we get reimbursed per patient, is that what this --

MR. FREAS:

Correct me if I'm wrong, Kevin. It's basically a multiplier that affects our Medicaid rate based on the -- generally on the acuity of the patients. It works -- for Dr. Spencer, it's similar to RVU, but not exactly the same. A base RVU is one, but typically you don't go below one in the RVU scale, the relative value in the scale that Medicare uses, but you can certainly go much higher depending on the acuity of the patient. You bill on that basis. Well, the acuity scale, it apparently can go below where you might have more patients who have less acute problems or need less rehab and, therefore, less nursing care. Because the Medicaid system is much more cost-based, it's important that you have an accurate assessment of the acuity of the patient, because theoretically, at least, more acute patients are more costly to take care of.

MR. CAREY:

If I can just add to that. Medicaid can't possibly pay us -- look at each individual patient and pay us a rate for each patient. So what they're doing is they're taking a look at all of our patients in the building, and they're looking at all of the rehab we give, they're looking at all the doctor's visits, they're looking at all the care that our nurses and nurse's aides are giving to the patient, and they're coming up with an average number for us. And then regardless -- if I took in a patient right now that needed around the clock ten staff members, we get the average payment per patient to take care of the patient. So what they're doing is on the CMI score is they're looking at all the care we give to the patient, coming up with an average score for your building, and then when you tell them how many Medicaid days you have patients for, they pay you the average that they came up with. That's your score, that's your CMI score.

P.O. LINDSAY:

And just as an example to both of you, just so a layman can understand this. If we had a facility that just had skilled nursing, tending to elderly in their last years, your score would be very low. And if you had a different facility that did nothing but rehab for people post-op or a physical rehab, your score would be very high.

MR. CAREY:

Correct. But there's actually even -- besides just a regular geriatric patient with no rehab, they might require a great deal of nursing, with might give them even an average score. We do have a higher percentage of what we call -- they're just called PAs. Their patients were actually walking around the building that might have mild MR, they would have an extreme low score, because they're actually taking care of themselves; they're bathing themselves, they're actually giving themselves their own medicine, but they're not capable of taking care of themselves in the building. They're not going to rehab, they're not being taken care of on a daily basis, they would have an extremely low score of, like .4 or .5.

CHAIRMAN TOMARKEN:

How often is this reviewed?

MR. CAREY:

About twice a year. We're going through a period now where they're looking at it -- the look-back period is from the end of November until next week. They're probably -- what they've told us is that they are going to use this period to give us our rate from July 1st on.

LEG. SPENCER:

When they make this assessment, it seems like there could be a fair amount of subjectivity involved. Is it determined by one person? Is there a formula? And could you tell me in terms of real dollars a .9 versus a one? What does that translate into in terms of reimbursement? And is there anything that you are able to do to kind of increase that number besides just the condition of the patients alone?

MR. CAREY:

Well each -- correct me if I'm wrong, but I think it's -- for each tenth of a point, it's a dollar and change -- I think it's somewhere around a dollar and change for each tenth of a point. Now, if you were to -- you have 200 patients, and if you go up \$1.50, so that's 200 times a dollar -- one dollar-fifty times 365. So just going up a tenth of a point could be \$100,000 to your building, one-tenth of a point.

What these facilities do to maximize it is you look at every single patient and you give them a really good review. You take this opportunity to see everything that the patient needs, and you make sure -- the best time to do it is during the window -- you make sure the patient is getting everything

the patient is required to get; therapy, doctor's visits, follow-up doctor's visits. By no means are you giving the patients care that they don't need. What you're actually doing is you're making sure that while the window is open, if there's anything that the patient is scheduled for and needs, that you're giving it during the open look-back period.

And what's going on is our MDS coordinator, basically our clerical people, capture and write down everything they're doing for the patient during the look-back period. What we do right now during this look-back period is sent to CMS and Medicaid. They look at what we did this last two months. They look at the scores for each one of our patients; how much rehab we gave each one of our patients, how much nursing care, how many doctor visits that we gave each patient. They then come up with our score. And then they will use that score all next year to pay us.

What we can do is though, you have to have extra staff on the rehab to go around and constantly reassess the patients to make sure the patients are getting exactly what they need. You also need extra nursing to go around and review exactly what the aides are doing and exactly what the nurses are doing. And it's not just for the score. It's actually twice a year. It's a very good time to make sure you're taking a really good look at the patient and make sure you're doing everything possible that the patient needs. It's not just for the money, it's for the patient too.

But it takes a great deal of work knowing the system and knowing exactly what to look for to follow up on each and every patient. When you have 206 patients, you have to actually look at the entire 206 patients. You have to look at exactly what they are supposed to be getting; those doctor's visits, physical rehab, daily care with the aides. It's very easy to miss things. Some aides -- as the patient might get a little older, some aides will start doing everything for the patient; will start changing the patient, start feeding the patient. But since it happened as a gradual thing, it's never documented. They're just doing it for the patient. If it's not actually documented, you lost that tenth of a point, you just lost.

CHAIRMAN TOMARKEN:

That's why documentation is key, and that's where the electronic Medical Record was supposed to help you.

MR. CAREY:

By putting the Electronic Medical Records on the walls outside the patient's rooms, the aides automatically, as the exit the room, get into the habit of everything they do, punch it in.

P.O. LINDSAY:

I just want to make an observation. First, we've been joined by Kathy Reeves and Legislator Kennedy's Office is in the audience. Is he on his way?

MS. KENNEDY:

We were delayed because Senator Schumer's people are in our office.

P.O. LINDSAY:

Okay. But is he on his way?

MS. KENNEDY:

No, he is not.

P.O. LINDSAY:

He's not coming, okay. First of all, Kevin, it sounds like a positive thing that our score is going up, because I think one of the complaints or one of the things that have been said about the facility is not that we're not giving excellent care to our patients, but we're not capturing all the dollars that

we're entitled to. So this is a good thing, and it's a progressive thing. And why I was looking for Legislator Kennedy, that's kind of his specialty that he's been griping about for a while, about if we're capturing all the dollars we're entitled to out there.

LEG. BROWNING:

Just a quick question. When I've been in the nursing home, I've seen the Electronic Medical Records up and at one point operating. I'm now seeing that they're not all up and not operating. Can you tell me what's going on with that?

MR. CAREY:

Yes. It's not operating at all. Just prior to my arriving there is when we were closing, and the decision made not to do the last part of the follow-up, final stage to initiate it. I've spoken to Bob Greenblatt from ADL, that's the company we contracted with to train us. We have all the equipment. It's basically all in the basement or in the storage room. We just basically need about \$70,000 in training. ADL will come -- they actually send a team that stays in the local hotel, I believe they're from Upstate, New York somewhere.

They will come, they'll send a team, they will stay in the local hotel. He needs about a two month period -- in other words, if I called him right now and said, "We are ready to do it," he'll have a team in about one to two months staying in a hotel for a couple of weeks. And it's about \$70,000 in training. At this point we have to actually retrain the entire staff completely again, though. It's been over -- for most of them, it's been over a year and a half. But all the equipment is there, it's just training.

LEG. BROWNING:

I just want to know what we can do to get the money and get that done, because -- you know, what bothered me, because I've been in the building and I saw the Electronic Medical Records. We actually got a presentation, Legislator Kennedy and I, of putting them up. They had them up showing, and they were showing, you know, how they operate. And then I was back another time and I'm looking on the walls saying, "Where are they?" You know? The ones that were there were just completely shut down. So can we find a way to get that \$70,000 to get them up and get them running? Because obviously, that was one of the things even with our health centers talking about Electronic Medical Records, you know, we're spending the money, but we'll make money by doing this.

CHAIRMAN TOMARKEN:

We can look at our budget and see if we can do that. The hardware was taken out of the floors to make sure it didn't get stolen, because, at that time, it was decided not to move forward. But as Kevin says, we have it. It's just a matter of getting it going.

MR. PEARSALL:

For the record, could I ask who made that decision not to move forward?

CHAIRMAN TOMARKEN:

The previous administration directed us not to implement.

P.O. LINDSAY:

I am shocked by the revelation, because I thought it was up and running. And, I mean, we installed this system with a Federal grant, right, wasn't it Federal or State?

MR. FREAS:

No. The State was the community facility enhancement money. Part of that funding that paid for some of the other improvements to the building paid for the EMR.

P.O. LINDSAY:

But, Craig, am I wrong? I don't think the State would be very pleased if we took over a million dollars worth of their money --

MR. FREAS:

I would imagine they would not be.

P.O. LINDSAY:

-- and they found out it's in a box somewhere.

MR. FREAS:

We should probably go ahead and find some way to execute the training, whether through another grant scheme --

P.O. LINDSAY:

Doc, who do you need to go ahead and do this?

CHAIRMAN TOMARKEN:

Let me look at it, have our Budget people see if we can find the money, then we just need --

P.O. LINDSAY:

Because for one thing, the \$70,000, I don't know the dynamics of it, but one of the things when the system was sold to us was that we were going to enjoy a lot more revenue, because it would capture every pill, every service for proper billing automatically, you know? Kim, do you know anything about this?

MS. BRANDEAU:

In terms of it not going through? No, that was not something that I'm aware of. But I have a question for Dr. Tomarken or Kevin. Len Marchese had stated at previous meetings there were two costs for the EMR; one was the training and one was a software upgrade or something that was over 100,000. Because I remember you needed -- do you remember -- in total over \$200,000 or something to get it running.

MR. FREAS:

I don't remember a software upgrade. If you do, I would imagine that that may have been needed, but it may already have --

MR. CAREY:

No. My understanding was it's just the training, just getting the ADL team to come here for training.

MS. BRANDEAU:

I'll look through the minutes.

CHAIRMAN TOMARKEN:

It may be different modules you may be referring to.

MS. BRANDEAU:

There were two costs that he had stated, because I remember it was more than 70,000 when we had discussed it previously in terms of finding the money, because at the time, the facility funding at the 2011, you know, I don't know that there was any extra money lying around to do a transfer.

MR. FREAS:

There has never been -- those costs related to the EMR had come out of the CFA grants and had been -- not in the regular appropriation, which is 4530, but they had been in 4531 or 32 or 33 or 34. I was not aware there was -- I was not aware there was the additional 100,000 that you mentioned. It may just not be in my head, or we may have covered it under some other way before the system was shut down. I don't know.

CHAIRMAN TOMARKEN:

So we will look to see if we have the funding to get it going.

P.O. LINDSAY:

Yeah, Doc, please get back to me, because -- with a full report. If you don't have the funding, I think it would behoove us to try to find it somewhere.

MR. CAREY:

Also recently new, the owner of the Marriott, a Mr. Lee Browning, no relation.

LEG. BROWNING:

No relation.

MR. CAREY:

Has graciously started donating furniture to John J. Foley. About a week and a half ago, we received the first floor of his hotel, the Marriott Courtyard. He's redoing it, so we took out all the furniture on the first floor. And we have -- we actually have that in the building right now. It's 30 rooms worth of desks, nightstands, dressers, lamps. We're going to start -- we've inventoried it all, and we're going to start swapping it out for the old furniture in the building. We'll take it day-by-day, but he probably plans on giving us four more floors of furniture for a total of 120. We can't possibly use it all, but I think we're discussing the rest of Suffolk County using it, because it's unrestricted.

CHAIRMAN TOMARKEN:

Right. The administration wants to keep it. They were going to use some of it for those homes that they were renovating. And there's no reason we couldn't use it in any office or space. It's unrestricted, it's not limited to just Foley so. It will probably be stored at the nursing home, they can hold it all.

LEG. BROWNING:

Okay. And as far as the excess furniture, the old furniture coming from the nursing home, I know that some of it's really not in that bad of condition. I believe we have to have it declared surplus. Because I did get a call about what to do with that, because obviously, you don't want to throw it in the dumpster. I talked about maybe some of our domestic violence organizations, homeless shelters that could possibly use some of that furniture if we're going to surplus it. So can we -- I guess -- who do we need to contact to surplus? Is that Kathleen?

CHAIRMAN TOMARKEN:

DPW, isn't it?

LEG. BROWNING:

Kathleen Koopenhoefer. I guess start with Kathleen Koopenhoefer, because I think we have to declare it surplus before we can actually -- and then we can do a resolution to donate it to whatever organizations that we find would probably use it. I know I recently was contacted by the Lighthouse Mission, because they had some clients that had no furniture. So we know there's people in need. I'd rather see something being done with it than throwing it in the dumpster.

CHAIRMAN TOMARKEN:

So we will need an inventory of that.

MR. CAREY:

Right. I'm also told by Finance that it's all original furniture from the building, it's 17 years old, it's all fully depreciated, so it's just a matter of the paperwork with DPW to give it to somebody.

P.O. LINDSAY:

I should note we have Fred Pollert, Deputy County Executive.

MR. POLLERT:

Just with respect to the surplus equipment, there's a form called the GS 103, it's completed by the Health Department or by the nursing home. You identify what the equipment is that you want to surplus, the serial number if it's on the bottom, it gets sent to the Purchasing Department, and then the Legislature, by resolution, can do a distribution to any not-for-profit group.

MR. CAREY:

We'll take care of that and get it to the Purchasing Department then.

MS. BRANDEAU:

Can I just clarify? I went back, I looked at the minutes, and it was in August when Mr. Marchese said it was about 100,000 for the training. So it wasn't two costs. It was just more than you had just stated. So your new estimate is 70,000 as opposed to 75, 80, 100?

MR. CAREY:

Yeah.

P.O. LINDSAY:

Let me pose this to Fred, because it was a previous subject we were talking about. The Electronic Medical Records System that we purchased with a State grant. We were under the impression it was operational. We were just informed that it is not operational. And, in fact, some of the units have been taken off the wall. And it seems that the last administration directed that it not become operational because of the need for additional money to train personnel on it.

So it's probably going to have to take an Executive decision somewhere's along the line to reverse that. The issue here is the value of the system, is the automatic billing of every service that we give a patient that's picked up. So I don't know whether Health can do a financial analysis. But besides cutting down on potential liability from, you know, services or drugs -- I mean, it really stops you from overmedicating somebody accidentally or doing -- you know, it captures everything you do besides the billing aspect. It would probably more than pay for itself, the \$70,000.

MR. POLLERT:

I would agree with you. That was something that we had looked at a number of years ago, and clearly, if we have a grant for it, we have an obligation under the grant. So I have a meeting this afternoon with Gary Quinn to be talking about IT issues. I'll put it on the agenda, find out what the story is, if they have the resources, if they don't have the resources, where we can come up with whatever we need to try to make it operational.

P.O. LINDSAY:

Well, I think -- Kevin, is that an existing contract that we cancelled with the trainers on this system, or they represent the manufacturer, where trainers come from?

MR. CAREY:

It's a software company, ADL. We had a contract with them that's basically -- they actually came and trained everybody prior to me arriving at the nursing home, but it was never fully implemented. And once it was never fully implemented, the staff didn't use it. Now it's been a year and a half since their training. And that's kind of what you mentioned earlier about the different numbers, between 70,000 and 100,000. The component that's left is strictly training; how long it takes for their staff from ADL to come to Long Island, stay in a hotel and train our staff, they can't just put a number on it and say they'll give us 20 days of training and then we're on our own. They have to stay until the actual -- our staff get it and are using it and working it, which means it's not a set amount of money. We are ball-parking.

Last year we guessed about 30 or 40,000, because it was six or seven months since they were trained originally, to give them a refresher and get them on board. Now, it's been a year and a half to two years since they were trained originally. So now we're guessing -- last year, we guessed about 100. I sat down with Bob Greenblatt from ADL, he says he thinks we can do about 70, 75,000. But we can't just say it's 70,000. If it's not up and running, we have to spend the extra 10,000, because we can't have them leave the building if it's not up and running and everybody using it, because then it's another waste.

MR. FREAS:

Is the training program a train-the-trainer, where you get super-users as well, or is it every individual user is trained or both?

MR. CAREY:

It's actually both. They're going to give everybody a two or three day refresher course in the building, and then they're going to give trainers a full week or week and a half so that the trainers can then go back on the floor with the people who have been trained once and stay on top of them and help them with the minor problems.

P.O. LINDSAY:

Kathy and Tom, did you take the training initially?

MR. DEAN:

Yeah. I had the training. The system was up and fully running for a period. And what we were doing is we were backing up the system still using the paperwork, the old-fashioned paperwork, and then the system just -- they stopped the use of it.

P.O. LINDSAY:

Did you get the training, Kathy?

MS. REEVES:

I had very minimal training with it, because at the time, I was doing just strictly MDS, and I only got the part that pertained to what we used. I do know if they get it up and running and it's used properly, all the information will feed into the MDS, which then goes to CMS, and that's our reimbursement.

LEG. SPENCER:

I wanted to just share a couple of perspectives. I have been involved in implementing a medical record system I did in my office six years ago. And now, I'm part of North Shore, I'm on the Medical Board at Huntington Hospital where we're implementing an EMR. A nursing home is one of the most difficult places to implement an Electronic Medical Records System, because your weakness is your weakest technology-savvy staff person.

There's a huge amount of recidivism in terms of going back to paper, even with training. And there are some things that are important, because as far as a financial perspective is concerned -- and I was just referencing an article that helped, and it's the [Use of Bedside Electronic Medical Records to Improve Quality of Quality of Care in Nursing Facilities, A Qualitative Analysis](#). And a couple of things. It does increase the score you were referencing earlier by about point two. So in terms of the financial benefit, it's there, but in terms of seeing the change in quality, it takes about 12 months to see a difference.

And the only way that it can be done, it has to be done almost through departmental mandates, and it has to be laid out in a step-wise fashion. The problem as you're implementing it is you do have a drop in patient care because of the focus on the medicine record. It's extremely painful as you are doing the process, but -- unless you have kind of a very strict schedule in terms of rolling out -- in terms of how you're going to transition in each department, it's not going to happen. And you can spend the money and they can come out and they can spend the weekend and do the training and the staff -- unless they are strongly encouraged or guided, they will revert back to the paper habits.

MR. CAREY:

My understanding from talking to the staff when I arrived there last year, that's exactly what happened; they didn't give them hard deadlines and basically force the system into play. They kind of were waiting for everybody to get it, and it didn't happen. But I am aware of that, and I discussed that with Mr. Greenblatt from ADL that if we start this again, there will be hard deadlines and we will make it happen on those deadlines.

MR. DEAN:

The good thing about the system was that the way it was set up was that the aides inputted the information as they exited room, as Mr. Carey stated, and then if they had a problem, they were responsible to contact the nurse. The nurse then would have to intervene to get the information. And then at the end of the shift, they couldn't leave because the nurse was required to go through the assignments, and you would get an alarm that somebody wasn't done or the information was incorrect or it was incomplete. So by the end of the day, the nurse -- so the trip would fall to the nurse. So the nurse had to go in and make sure everything was implemented correctly. So the system, for the short period it was up, was running smooth on two of the floors. And the other two floors, they were still trying to get it implemented, and then it just, you know, disappeared.

MS. BRANDEAU:

Did you say that it's mounted outside of every room?

MR. CAREY:

It's spaced out. There would probably be one for every two or three rooms would be on the wall.

MS. BRANDEAU:

So if you were going to go through with it now, you would go ahead and put it in the wing on 4 that you don't have patients in, you would do the whole facility, that would be the plan?

CHAIRMAN TOMARKEN:

Well, that raises a question, because we're obligated under the budget to downsize to 150 patients. So we have to gear our training to that as well and our staffing to 186, I think it is. So we wouldn't be putting it on every floor, especially those that are already vacant and those that might be anticipated to be.

MR. POLLERT:

One of the comments made is that there was equipment which is missing, it was on the wall and,

you know, now it's gone. Who is the point person in the nursing home that is responsible?

CHAIRMAN TOMARKEN:

Let me correct that. It's not missing. It was just taken and put in storage.

MR. POLLERT:

Okay. So we have it. Who is the point person where I can get background data with respect to the installation, voided out contracts, that type of stuff?

MR. CAREY:

With the contracts or where the stuff is in the building?

MR. POLLERT:

Who is responsible for the Electronic Medical Records on both the Health Department side? And I'll find out from Gary Quinn on the County side. Who do I go to to find out what the status of the things are, whose responsibility?

MR. CAREY:

Me for the entire building. And my IT guy in the building is Rich Palazzo. He actually -- I deal with him.

MR. POLLERT:

Okay.

MS. REEVES:

Also, part of the problem when they first started the EMR was they were having everybody doing the EMR and the paper. And it got to the point where people were doing one or the other, but not both. So depending on who the person was, they were either doing the paper or the EMR, so it was really not effective.

CHAIRMAN TOMARKEN:

Kevin, any further updates?

MR. CAREY:

No, that's it.

P.O. LINDSAY:

I have a question. Where are we with marketing?

MR. CAREY:

Marketing meaning advertising?

P.O. LINDSAY:

Meaning putting people in the empty beds.

MR. CAREY:

I've been cycling through several employees. I don't have a budget for a marketer, so I've been going through several employees attempting different things to get a marketer in the building. The last one I put in in the beginning of December was an RN off the floor. She's actually done very well. Our census has gone from 192 at the beginning of December to 206 right now. And she's done very well with marketing. That's been our primary focus. But right now, we're -- first we have to decide what to do with it; whether we're downsizing or -- but we've actually been increasing the census steadily. I'm meeting with Catherine Morris next week on the second for that same

purpose, to improve communication. But we're holding off on anymore marketing until we decide to do it.

P.O. LINDSAY:

Which brings up -- I know -- maybe Greg knows this. Where are we with the RFP public/private partnership?

MR. FREAS:

We have not moved forward with the RFP since the initial meeting. We were waiting -- I'm actually opening my e-mail to check with Kathleen to see if we've gotten any questions regarding the Brookhaven -- I don't -- we had an initial meeting for the public/private partnership RFP. As you know, there was one respondent. In the course of the meeting of the RFP, there were some questions by some of the committee members, the RFP selection committee members, as to whether the single response was fully responsive to the RFP. If it's not, we would then have to not use the RFP. The decision was made in the RFP Committee that -- that we would get the respondent in for a presentation and then make a decision. We have not yet opened the bid. After we got the respondent in to make the presentations based on the questions of the some of the committee members, we would -- we would make a decision whether to go forward or reissue the RFP or do it as an RFEI.

P.O. LINDSAY:

What do we have to do to accelerate that?

MR. FREAS:

We can just simply set a date for the meeting, get the respondent in and get it done.

P.O. LINDSAY:

My opinion, let's do it. If we don't have the questions, let's bring somebody in and see what they are talking about.

MR. FREAS:

The second thing is, Mrs. Brandeau, are you continuing as the County Executive's representative on that committee?

MS. BRANDEAU:

I have not been informed that I'm not at this point. So I would say that I'm still continuing on as the representative. Mr. Pollert, do you have any comment on that.

MR. FREAS:

Is Mt. Chamberlain -- or do you know who is replacing Mr. Santiago as your representative?

P.O. LINDSAY:

It would be Mr. Chamberlain.

MR. FREAS:

He's going to need the forms from Kathleen then.

MS. BRANDEAU:

Craig, I do have questions from the first meeting. You are collecting the questions, correct?

MR. FREAS:

You can send them to Kathleen.

MS. BRANDEAU:

Okay, I'll send them to Kathleen.

CHAIRMAN TOMARKEN:

This does bring up the whole issue of downsizing our patient population, which takes several months, partly by attrition and partly, if we have to, an actual transfer out of patients, and that takes several months. I've written to the State last week asking their direction on what kind -- usually they want a plan, and I haven't heard back, but I will call them this week. But at some point, we're going to have to potentially close admissions and let -- maybe even go back to some sort of consultant who can help us with this downsizing, because it's very similar to a closure but obviously not.

LEG. BROWNING:

And the other part of it is the Jail Medical Unit, because I know that that's where we were looking, there was a need to transition some nurses to the Jail medical Unit. What's the timeline for that with the jail?

CHAIRMAN TOMARKEN:

Well, it hasn't been decided whether it's going to be privatized or the County will run it, number one. And then number two, the actual timeline is still in question because of a variety of issues. But it's several months away is the safest I could say.

P.O. LINDSAY:

The point is that we need -- we need to know what we're doing one way or another. The other -- you know, I know the prior County Executive had put out another RFP to sell everything, sell the assets or whatever. Do you know how that fared?

MR. FREAS:

Some of those respondents were deemed unresponsive, but I would ask Ms. Brandeau directly.

MS. BRANDEAU:

There were three responses to that RFP. The RFP Committee had one meeting, and that was it. Because of the change in administration, a decision was made to not continue the discussions at that point. I have not been told that that RFP is dead or that it's been cancelled or that it's continuing. It's sort of in a state of limbo. But I will inquire as to the new administration's desire to continue it, because it was a County Executive proposal. I don't know if there's any additional information.

P.O. LINDSAY:

The point of the matter is we need to know what we're going to do with the facility before -- and, with all due respect, I don't want to hire any more consultants. There's more fringing consultants got rich over this place than you can shake a stick at. You know, if downsizing isn't -- the public/private partnership RFP isn't viable, you know, we have to decide what we're going to do. But until we decide what we're going to do, if we got people in the beds paying everyday, I don't want to throw them out, you're just going to make the fiscal system worse. It seems like, Kevin, that the staff has downsized to almost match your population now. I think isn't that the ideal thing in a nursing home, one staff to one patient?

MR. CAREY:

That is the ideal thing. We're still using agency though, but yes, that is the ideal thing.

P.O. LINDSAY:

Again, I'm not -- I just can't express to everybody that we need to know where we're going.

MR. FREAS:

Kevin, have you been able to grow the temporary pool at all versus the agency nurses?

MR. CAREY:

You're talking about the per diem versus the agency?

MR. FREAS:

Correct.

MR. CAREY:

Hold on one second. We were slotted for five RNs, ten LPNs, 17 CNAs and one clerk typist in the per diem pool. Recently we've hired two RNs, eight LPNs and 15 CNAs in the per diem pool.

MR. FREAS:

I have a follow-up question. Last week, some of the temporary staff was let go, I guess, throughout the County. Were you directed to let any temporary staff go in the course of that action?

MR. CAREY:

Negative, nothing.

MS. BRANDEAU:

Can I ask a question about the way the budget was adopted for the downsizing, Craig? Was there funding included for a closure consultant or the consultant they would need to help place patients if necessary?

MR. FREAS:

No.

MS. BRANDEAU:

Thank you.

MR. FREAS:

Not as a specific line item, I should say.

CHAIRMAN TOMARKEN:

Any further discussion on any of these issues?

LEG. SPENCER:

I think as I've listened to the downsizing argument, at least my understanding of someone that's kind of looking in and getting into the nuts and bolts, balancing between services that are, I guess, profitable and you can downsize to where you just have your least profitable clients that are there, but also providing services that no one else is going to provide, there kind of has to be a kind of guidance there that I'm sure there's kind of a magic number where you're maximizing your revenue and services and trying to keep the best paying population. Is there any sense of how we are going to do that or who is kind of guiding that process?

CHAIRMAN TOMARKEN:

No, we haven't gotten to that detail yet. One of the things to keep in mind though is that all patients have to participate in this process and have the right to have their choice being heard. And ultimately, if they want to appeal -- so it's like as if we have the right to just go around and identify individuals. So - and that's partly why the State actually asks for a plan, because they would want to know that detail. And I'm waiting for them to tell me exactly what kind of plan. We have done

a closure plan previously, so we have a rough idea of what they're looking for, but this is a little different because it's going to be certain patients and not others, maybe it will be open to everybody as a volunteer basis first to see who steps forward. So we're still waiting to get that answer.

P.O. LINDSAY:

The public/private partnership is so important. Is it possible that this could be something that will develop through attrition, for a lack of a better word? We have the fourth floor empty now, there's no patients on four?

MR. CAREY:

Half of the fourth floor, Four South is closed, Four North is still open.

P.O. LINDSAY:

And the rest of the floors are all filled?

MR. CAREY:

Just about. We have about seven empty beds on the HIV Unit. The HIV Wing we have seven empty beds. We have two or three empty beds on the rehab unit, and maybe one long-term bed. The rest of the building is full.

P.O. LINDSAY:

I'm just thinking out loud, and maybe you could jump in Greg, maybe without displacing any patients, we could consolidate everybody we have and free up a floor and lease that floor out for medical use.

MR. FREAS:

I would think, as Dr. Tomarken says, that that attrition might take some time, especially given our patient population, which is younger and not necessarily --

P.O. LINDSAY:

Okay, but we're down almost 50 patients now from max capacity.

MR. FREAS:

We're down 50 patients -- more than -- 55, right. And that's over a year. I don't think we've been at max for probably about 18 months, maybe two years since we were up at bed hold. So, you know, natural attrition would take some time. I think kind of what Dr. Spencer was saying, the most profitable patients have the highest turnover, the rehab patients and the Medicare patients. So then your remaining patients who, if they've qualified to be in a skilled nursing facility, belong there, but their acuity levels in a public home especially tend to be much lower. So what happens is you get -- you have to make a policy decision as to whether you're willing to spend what it costs to run the place, because it's unlikely that you are going to run it at a net zero and even more unlikely that it's going to be profitable.

The public/private partnership would mitigate some of the cost. It would not eliminate it. I think that's very fair to say. On the other hand, there's a need for these places all over the country. There are fewer than there were for quite some time. But the mission of the place is probably the same as it's been 100 or 125 years since it was opened. There is a certain population that because they are not good fits for other skilled nursing facilities don't have anywhere to go.

CHAIRMAN TOMARKEN:

Just keep in mind, what's driving this is the budget. You know, if at some point we chose just to do the attrition route, and then come July 1 we're not at that goal, then additional funding would have to be secured.

MR. FREAS:

I would say there is some, but not much flexibility in the budget for the nursing home on the expenditure side as a whole, not necessarily in every line, but based -- it's based mostly on the staffing, because obviously we have more patients with more -- we're going to generate more revenue. So we could hopefully or theoretically keep the -- keep the cost -- you know, the cost of the General Fund at the same level if we have 200 people and 200 patients versus 185 staff and 150 patients.

You know, as Dr. Tomarken and Kevin, you know, who helped us plan this -- the downsizing know, you can't go below a certain level, because even if you could reduce the care staff, you have -- you know, you have to keep the lights on, you have to feed patients that are there. There's a minimum staffing level that you're going to need just to do those things so that the building runs correctly. And because we're a single entity and we don't get any economies of scale, I can't get rid of all the mechanics, you know, the maintenance mechanics and I can't get rid of the food services workers, you know, unless we were to do them as concessions, which would require another RFP process that we haven't begun yet.

CHAIRMAN TOMARKEN:

And we'd looked at the numbers that make the public/private partnership even feasible, and 150 is not a good number. We lose too much, plus the way the building is laid out, you end up having floors open and closed. You know, so it doesn't work. So the numbers that really are helpful are 184, and basically increments of 40, because that's the way the building was built. So the 150 is an arbitrary number and is not a very good number to shoot for. So if it's decided that we want to not go down that low and go up to maybe 184, it makes more sense economically, plus the deficit is reduced.

LEG. SPENCER:

Following up to what Bill said, which I think is a good idea, laying aside attrition, because you have indicated that that takes awhile, if there's not a whole floor available -- you know, you indicated that Four South was open -- how about leasing out that space privately, because then if you brought in some other medical sort of service that's there, then they're going to kind of share in the overhead. As we open up sections, could we put out RFPs looking for a private partnership for someone that would utilize a wing of a floor?

MR. FREAS:

That was more or less the intent of the original RFP, that, you know, a portion of the building would be leased by another provider. Whether it would be -- ideally it would be a provider that would be in some way complimentary to the long-term care setting, but not necessarily, again ideally, and that they would either -- they would lease the space.

Ideally -- I think we run into trouble -- we run into uncharted waters if it's a for-profit group, you know, Huntington Medical Group or Mount Sinai Medical Group, we don't know exactly what the rules are. I know there was trouble when we wanted to do that at our DNTCs. So, you know, ideally, we would have a hospital and they would maybe do another rehab and do it themselves. But we're not along that process yet at this point. Yeah, we could do other RFPs, but that eats into the time that we don't necessarily have.

P.O. LINDSAY:

Let's get back to Kevin. The day-hab program, your number was like 40, right?

MR. CAREY:

Forty-eight registrants, I believe they average about 24 a day.

P.O. LINDSAY:

Okay. We're licensed for 60, right?

MR. CAREY:

Correct.

P.O. LINDSAY:

So that population is up then, right or is it shrinking?

MR. CAREY:

It's actually basically holding its own right now. It's been holding about 48 registered with 24 a day showing up on average for several months now.

P.O. LINDSAY:

And I'm just thinking out loud, but isn't that one of the areas where Medicaid cut funding to?

CHAIRMAN TOMARKEN:

They proposed it, hasn't come true. That's what the initial vendor walked away from, that potential --

P.O. LINDSAY:

Just to Fred, just think about it. To me, if we were going to downsize the facility, that would be the logical place to go because they have a separate entrance, it's on the First Floor, and the core mission of the nursing home really could be kept in tact.

MR. POLLERT:

Just with respect to some of the conversation, if I can just go backwards just a little bit. You are exactly right, a lot of this is really dependant upon where we are going overall with the nursing home. One of my concerns about attempting to bring someone to rent space is it's a long-term commitment.

Number two, I have preliminarily reached out to Newmark Frank to find out what the approximate rental cost would be in the Yaphank area. They had made the point that we have to do basic renovations, and the cost of doing that, doing an RFP, it's not a short-term type of thing to come up with. Hopefully within the next month, we will have better ideas with respect to where the budget is going. We are looking at a lot of different alternatives. I'm just trying to come up to speed on the nursing home. I've been dealing with the overall problem. I'm now starting to focus on the nursing home. So hopefully at the next meeting of this group I'll have some better data with respect to what we can do option-wise.

MR. CAREY:

If I can just shed a light on that also. You run into a lot of security problems when you rent out portions or upper floors. We have Fourth Floor, Four North, is the entire dementia unit; patients are capable of walking out the door, and then you have an elopement. You have patients in the building who have Order of Protections maybe against their spouse, which we're required to honor and not let the spouse in the building. So you run into a lot of security problems. I mean, I'm not saying it can't be done, but you get a lot of extra costs because you're hiring extra staff to account for the extra outside visitors walking through the lobby going up your elevator. How do you control who gets off on what floor? So you have people throughout the building. So your security problems double, triple. It can be done, but you have to keep that in mind.

CHAIRMAN TOMARKEN:

We looked at the space, and it's clear that the First Floor and the Second Floor are the places you're going to want to rent out. And we even looked at putting an external elevator for those so that we didn't run into the issues. So we have identified potentially up to about 45,000 square feet that we could make available, but it would be on the First Floor and the Second floor and the nursing home facility would be above that.

P.O. LINDSAY:

I just can't stress enough that we have to do our due diligence on the RFPs and follow up on them as quickly as possible, because if that isn't an option, we have to move on. Anybody have anything else? Okay.

MS. REEVES:

This is totally separate, but it's something that we've been talking about in the facility for quite awhile. I don't even know if it's feasible, but we spend a tremendous amount of money to the drug supplier. A lot of it's covered by resident's Medicaid and Medicare, a lot of it's not, we have to cover it, we have to eat it. And if we had our own pharmacy within the building, it doesn't have to be 24 hours, they can dispense the drugs to the floors on a daily basis, what's not used would go back to pharmacy, instead of now where it has to be discarded, I think it would save a tremendous amount of money, because Chem-Rx is making a fortune off of us. Just food for thought.

P.O. LINDSAY:

Kathy, when this committee first started, I guess it was two or three years ago, I raised that issue and even to the point of I had this wild idea we were going to have a pharmacy right next door in the jail. Is there some benefits of scale, because the jail buys pharmaceuticals cheaper than any wholesaler than anybody because of some kind of contract with the jail system. And Mr. Fein was there at the time, and he negotiated a new deal with the drug supplier that he told me was very, very beneficial and that it almost wouldn't pay to do what we were talking about doing. So something that -- I don't know whether, Kevin, you looked into it or not.

MR. CAREY:

We were looking into it, but as of January 1st, there's actually a whole new system in place. All of our Medicaid patients, the drugs now are paid for directly by Medicaid. It used to be that Chem-Rx billed us, and then we got reimbursement from Medicaid, which we were losing a lot of money on. We lose less, we still lose -- waste the drugs, yes, we always will, but it's a lot less. I don't know the numbers, whether or not they would pay for a pharmacy.

P.O. LINDSAY:

So we couldn't supply the drugs through the jail pharmacy and get reimbursed from Medicaid?

MR. CAREY:

For all the Medicaid patients now, no. All Medicaid patients now are paid for -- Medicaid is paying Chem-Rx directly for them, so there is no more benefit for us for the Medicaid patients. Private insurance and Medicare patients, we still pay for the drugs. But our drug bill is considerably down now since Medicaid is paying directly for Medicaid patients.

MS. REEVES:

Yeah, they're paying directly by Medicaid, but there's also still drugs that are being ordered that is not covered by Medicaid, Medicare or the private insurances, and we have to eat those, and those we're always going to lose on. If we have our own pharmacy where it's in the facility -- right now, the way it is, say, a drug is DC'd and we have a 30 day supply, some we can return, some we can't. The ones we can't, we have to dispose of, and that can run into -- I mean, I've seen where they've had to dispose of bags and bags and bags of drugs, for one thing.

And if we had a pharmacy -- like I said, it doesn't have to be 24 hour, it could be Monday through Friday, 9:00 to 5:00, that if somebody comes in on the weekend, that they have drugs that the supervisors can get to get this resident started until the pharmacist comes in. But the drugs would go to the floors on a daily basis or even on every two days or three-day basis. And what's not used can go back and go into the stores of the pharmacy. This is how it's done in a hospital, and the drugs aren't wasted. They don't get thrown away. They get put back into the system. And I can't see why we can't do that.

MR. FREAS:

Do we have a particular class that we are paying a lot of money for out of formulary drugs that they're not covered by Medicaid or Medicare? Is there a particular type of drug that we're buying -- that we're throwing away especially?

MR. CAREY:

No, not to my knowledge.

MR. FREAS:

How much are we ordering that's off the Medicaid/Medicare formulary? I mean, again --

MS. REEVES:

There's two weeks worth being ordered at a time. But if the doctor orders, say -- - I'm just using this as an example -- asked for 85 milligrams once a day today, and they blood work and they find it's not enough, and tomorrow the doctor orders aspirin 325 milligrams, that aspirin 81 has to be disposed of if it can't go back to the pharmacy. And if it's a drug that we're paying for, we're throwing that money away. We can't use it for another resident.

MR. FREAS:

Kathy, are you using that as a real example, or is it --

LEG. BROWNING:

No.

MR. FREAS:

So it's not even like OTC stuff that we're buying that we're throwing away, it's just stuff that for some reason is not on the Medicaid formula.

CHAIRMAN TOMARKEN:

Kevin, can you ask Gary to look into that, get us some numbers?

MR. CAREY:

Sure. We also have our outside pharmacy consultant that can look into it.

P.O. LINDSAY:

A consultant on staff now, under contract now?

MR. CAREY:

It's a contract. We're actually required to have an outside pharmacy consultant look over what the doctors are prescribing. It's a regulation.

P.O. LINDSAY:

Anything else?

CHAIRMAN TOMARKEN:

We need to schedule our next meeting, it's a monthly meeting. So late February?

LEG. BROWNING:

That's a week there is no school, that's the Presidents' Week.

P.O. LINDSAY:

Can we move it up a week, the 29th?

LEG. BROWNING:

We actually have a 29th this year. That works.

MR. FREAS:

Go with the 29th.

P.O. LINDSAY:

Yep.

CHAIRMAN TOMARKEN:

No additional business, we will adjourn. Thank you.

(*THE MEETING WAS ADJOURNED AT 11:18 A.M.*)