

**JOHN J. FOLEY SKILLED NURSING FACILITY
OVERSIGHT COMMITTEE**

June 28, 2012

Verbatim Transcript

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, June 28, 2012.

Members Present:

Dr. James Tomarken, Chairman/Commissioner-Dept of Health Services
Terry Pearsall, Presiding Officer Lindsay's Representative
Kathleen Reeves, John J. Foley Skilled Nursing Facility Representative
Kim Brandeau, County Executive's Representative

Also In Attendance:

Legislator Kate M. Browning, 3rd Legislative District
Legislator John M. Kennedy, Jr., 12th Legislative District
Leslie Kennedy, Aide to Legislator Kennedy
Craig Freas, Budget Review Office/SC Legislature
Kevin Carey, Administrator/John J. Foley Skilled Nursing Facility

Minutes Taken By:

Alison Mahoney, Court Stenographer

*(*The meeting was called to order at 2:14 P.M. *)*

COMMISSIONER TOMARKEN:

Okay, we'll call the meeting to order. And the first order of business is review of the minutes of May 22nd which were sent by e-mail, and we didn't print them out, as usual, because of the size of them. Any additions, corrections, deletions? Can I get a motion to approve the minutes.

LEG. BROWNING:

Motion.

COMMISSIONER TOMARKEN:

Legislator Browning. Second?

MS. BRANDEAU:

Second.

COMMISSIONER TOMARKEN:

Kim Brandeau. All in favor? Opposed? Abstentions? The minutes are accepted.

We'll move on to update from Kevin Carey.

MR. CAREY:

John J. Foley, current census today is 193 with 13 residents in the hospital. Adult day-care, we have for the month of May 46 -- or maybe at 46 registrants, Monday through Friday average is 24, Saturday is 12, daily average, weekly 22. For June we have 45 registrants and the daily average came out to 22 so far this June.

Staffing. Total staff today is 204; 196 nursing home staff, eight day-care staff, and one IT. We also have 20 per diems; 10 employees out on medical leave, four employees on light duty.

We're currently working on electronic medical records. We completed the webinar for our trainers. They are currently working on training the different disciplines in what's called "notes", putting the progress notes into the computer. They are creating templates and creating training sheets or cheat sheets for the staff to use, and they're entering all the staff into the system.

LEG. KENNEDY:

Kevin, what do you have for an anticipated go live, set of dates?

MR. CAREY:

Go live for "notes" where the different disciplines will put the progress notes into the computer, that we're going to do as we train each discipline starting next week.

LEG. KENNEDY:

Okay.

MR. CAREY:

Right -- that's our goal for next week and the week after, is to get all the different disciplines into "notes", get all of the IT work done as far as getting everybody's data-entry and all the employees into the system, all the residents into the system, get all the cheat sheets done. And then we actually plan on, right after the survey, because sometime within the next two weeks we expect the annual survey.

LEG. KENNEDY:

Yes.

MR. CAREY:

So then as soon as the survey comes, right after that we'll start with the intense training of the aides and the nurses on the floor, and then a month after that going live on the floor.

LEG. KENNEDY:

So you figure roughly maybe by the end of September you should have the whole facility migrated over to the electronic format?

MR. CAREY:

Yes. We are still working on one problem with Theresa Saunders on Chem RX, our pharmacy, that we have to create the interface that we started two years ago and we never completed and we're back to creating the interface and working with Chem RX and ADL. Because that interface with the pharmacy is what allows our doctors to put their orders. Currently doctors put their orders into Chem RX.

LEG. KENNEDY:

Okay.

MR. CAREY:

That orders the drugs. But there's no way for the doctor to put their order into Chem RX after that order goes to ADL; that's the interface.

LEG. KENNEDY:

Okay. But the two software vendors are working with each other so that the two pieces of software --

MR. CAREY:

Well, they're beginning to right now. They're just beginning to communicate.

LEG. KENNEDY:

Okay. And we own both pieces of software?

MR. CAREY:

No. We have a \$14,000 credit with ADL, that we paid them two years ago or three years ago, before I got there, to do this, which they never did. So now we're looking at -- ADL is looking at the 14,000, the credit we have to still cover creating the interface now, which of course our argument is yes.

LEG. KENNEDY:

Yes.

MR. CAREY:

(Laughter).

LEG. BROWNING:

Absolutely.

LEG. KENNEDY:

But you stay on that so then we'll know if, at the end of it, we've got to move some additional funding and have that interface piece worked out.

MR. CAREY:
Right.

LEG. KENNEDY:
And that sounds like -- I mean, you know, if they're talking about a couple of grand, that's almost something you could do with a simple inter-department.

COMMISSIONER TOMARKEN:
Potentially, yeah.

LEG. KENNEDY:
That probably wouldn't rise to the level of a resolution, right?

COMMISSIONER TOMARKEN:
I hope not.

LEG. KENNEDY:
Okay. All right, good.

MR. CAREY:
Well, because there is one other option which we're looking at, but I don't know if we want to wait that long, though. But the contract for the pharmacy is up to be renewed. Other pharmacies out there have built-in interfaces with ADL already. If we switch pharmacies, which is one of the things we're considering, then we keep the \$14,000 credit with ADL.

LEG. KENNEDY:
How -- when does the Chem RX contract run out?

MR. CAREY:
Right now it expires December 31st.

LEG. KENNEDY:
And have you started the process of -- are we in the RFP or --

MR. CAREY:
Right now we have started.

MS. MAHONEY:
Right now what?

MR. CAREY:
We have started the RFP for a new pharmacy.

MS. MAHONEY:
Okay.

LEG. BROWNING:
Let me ask you, though, because I know that we've had discussion in the past about having our own pharmacy on-site. When we do the RFP, should we not be including not just doing something like Chem RX, but also maybe the possibility of having an on-site pharmacy? Would it be more cost effective for us to do that?

MR. CAREY:

I have never done an in-depth study on it on the surface. I think not.

COMMISSIONER TOMARKEN:

Yeah, we've done this at the jail.

LEG. BROWNING:

Right.

COMMISSIONER TOMARKEN:

We've done a budget for a brand new pharmacy and it's expensive. I can't give you a dollar figure for comparison, but you have the pharmacies, you have the pharmacy aides, you have to have, you know, space and equipment. So it's not -- it's a major undertaking.

LEG. BROWNING:

Okay.

LEG. KENNEDY:

Craig, have you ever looked at it? Has BRO ever looked at the cost alternative between what we pay for an outside pharmacy service and --

MR. FREAS:

Versus our own pharmacy?

LEG. KENNEDY:

-- fulfilling the pharmacy function, if we had an in-house, you know, staff and bought the medications and did our own pouring and everything like that?

MR. FREAS:

We have not looked at it. The Health Department has some pharmacy functions. They don't have -- they don't carry the formulary. The formulary that they carry is almost entirely public health related and at this point, I mean, we have a pharmacist on staff. We used to have two or three -- Gail's still there, right?

COMMISSIONER TOMARKEN:

Yes.

MR. FREAS:

So you have Gail, but there used to be two more or one and a half more. We had that older gentleman and we had another pharmacist.

COMMISSIONER TOMARKEN:

We had the pharmacist at the jail.

*(*Mr. Pearsall entered the meeting at 2:21 P.M. *)*

MR. FREAS:

And there's a pharmacist at the jail; right, the other guy is at the jail. We have never looked at it in-house, or not -- BRO has never looked at it. I believe it was done probably by the department internally, maybe even before Dr. Tomarken.

COMMISSIONER TOMARKEN:

Didn't they go -- didn't they have a pharmacist at Foley?

MR. FREAS:

I don't remember there being a pharmacist at Foley.

MS. BRANDEAU:

I know the Oversight Committee did look at it at one point years ago. The committee --

MR. FREAS:

The very first year that --

MS. MAHONEY:

One at a time. One at a time.

MS. BRANDEAU:

And I believe Len had done a study. I have all the old minutes, I can go through and see if we can find it, because I know we did the analysis. And what ended up happening was -- the Health Department did the analysis and what ended up happening was it was too expensive to go in-house, but they were able to renegotiate the existing pharmacy contract and save some money there and the pharmacy costs had gone down, but that was 2009 or so.

MR. CAREY:

I read that, 2009 I believe it was, but I believe it was 385,000 was expected in staffing alone, for two full-time pharmacists, an assistant and billing.

LEG. KENNEDY:

How did the medications come to -- how do you get them on the floor?

MS. REEVES:

We get them in blister packs and they basically prescribe for between -- depending on what narcotics, two weeks at a time, other than that it's 30 days at a time. And if the medication changes, depending on what it is, some we can return to Chem RX for credit, no narcotics can go back. And others, if they can't go back, they have to be destroyed.

LEG. KENNEDY:

How significant is the waste factor? I mean, is it --

MR. CAREY:

It's actually -- it's new for the last two months. We have what's called pass-through with Medicaid; everybody on Medicaid, if we stay within the formulary, everything gets passed right through the Medicaid. So the actual loss --

LEG. KENNEDY:

No cost to us.

MR. CAREY:

There's no cost to us at all right now.

MS. REEVES:

We're calling in an awful lot for prior approvals.

MR. CAREY:

Yeah. It's a constantly changing thing with each resident, because if the resident has Medicare, Medicaid, private insurance, it's different. And if the actual drug for this resident stays within the formulary and the doctor agrees, when the doctor wants something out of the formulary, well, that's a constantly moving target.

LEG. KENNEDY:

Yeah, but didn't they used to -- when you were over in Mather they did unit dosing, didn't they? Didn't they prepare --

MS. REEVES:

Yeah.

COMMISSIONER TOMARKEN:

What is it?

MS. REEVES:

It's unit dosing in the sense that in 30 days, you know, you have to punch it out.

COMMISSIONER TOMARKEN:

Right.

MS. KENNEDY:

But one day --

MS. MAHONEY:

Guys, you have to speak up.

MS. REEVES:

We did it one day at a time, unit dosing. But we had pharmacists that made it up at night. We had three shifts of pharmacists. It was very expensive, it was a hospital versus a nursing home.

LEG. KENNEDY:

Okay. All right.

MS. REEVES:

Even back when I worked in Nassau County Medical Center, and this is going back, they had unit dosing. The difference was if medication was not used it would go back to pharmacy and, you know, be reused.

LEG. BROWNING:

Right.

MS. REEVES:

The way it is now, if John Doe gets 30 Dilantins and they can't be used and we can't return it, they've got to be destroyed, even if there's only one taken out. Even if there's none taken, they've got to be destroyed.

LEG. KENNEDY:

Well, I guess we should probably have some sense of whether or not they would be valid. It would be hard for me to believe that it would be cheaper for us to have our own personnel than to be, you know, buying bulk and pouring our own drugs. We should have some sense that, you know, it's cheaper to go out and to use an

outside outfit. And I think we probably shouldn't spend five cents to build an interface, then, because who knows whether we're going to have Chem RX in January. We'll just have to, you know, lump them in and tell them it falls within the credit.

MR. CAREY:

I also have our pharmacy consultant that we're required to have, Larry Millman. He actually used to run a pharmacy in the nursing home, so I can get more information from him for the next meeting. Maybe I'll have him give me a quick synopsis, a one-page bullet list of comparison between having in-house as compared to --

LEG. KENNEDY:

That would help. And it would also help, I assume that he worked with Purchasing to draw up the RFP request?

MR. CAREY:

For the new pharmacy?

LEG. KENNEDY:

Yes.

MR. CAREY:

Not that I'm aware of, but they're in the process now.

LEG. KENNEDY:

His input would be invaluable, I would think, for Purchasing. If you could ask him to do that, I think that would be a good thing.

COMMISSIONER TOMARKEN:

Maybe, Kim, you can give us an update on the renovations.

MS. BRANDEAU:

Yes. I checked with DPW today to get an update on the capital improvements for the electrical installation and the smoke tight wall and was told that the electricians will be on-site, start to work on July 9th. The general contractor will be there in two weeks. All the materials have been ordered, everything is on schedule. There were two PO's that were issued, one to All Service Electric for \$84,900 and one for Austin Interiors for \$140,000. So it looks like both things are continuing to be on track.

LEG. KENNEDY:

Excellent. Very good.

COMMISSIONER TOMARKEN:

Kevin, you want to talk about the WanderGuard?

MR. CAREY:

The WanderGuard. The new system is being installed for the last three days and tomorrow they're finishing.

LEG. KENNEDY:

How is it working out?

MR. CAREY:
Good.

*(*Laughter*)*

MS. KENNEDY:
It was working.

MR. CAREY:
It was working; as of this morning it's working.

MR. PEARSALL:
Slowing down the elevators, but it's working.

LEG. KENNEDY:
Okay. All right. We like that.

COMMISSIONER TOMARKEN:
Any old business?

MR. PEARSALL:
I apologize for being late, but I was meeting with the Presiding Officer. Did we get a quarterly report from the first quarter, a national report?

COMMISSIONER TOMARKEN:
Not today. I'll check and see if that's been completed. Have you seen it, Kevin? I haven't seen it.

MR. CAREY:
Actually, no. That was supposed to have been taken care of, yeah. Actually, Gary Vonatski is out until Tuesday; I think he's coming in Tuesday, he's off on Wednesday, coming in Thursday.

COMMISSIONER TOMARKEN:
Let's check with him and check with the Finance Department.

MS. MAHONEY:
Check with who?

COMMISSIONER TOMARKEN:
I'm sorry. The Finance Department.

MS. KENNEDY:
Gary.

LEG. KENNEDY:
V as in Victor, Vonatski.

MS. MAHONEY:
I got it. Thank you.

LEG. KENNEDY:
Okay.

COMMISSIONER TOMARKEN:

Any new business?

LEG. BROWNING:

Actually, yeah, the HEAL Grant. I know that I spoke with the County Executive's Office and I saw, John, your e-mail --

LEG. KENNEDY:

Yes.

LEG. BROWNING:

-- also, which I had a conversation with the County Executive's Office already with the HEAL Grant. And I know they're talking about maybe using some of it for the John J. Foley Nursing Home, pay down the debt, whatever it is we're going to be using it for. I did make a request that I be kept in the loop with and maybe to allow some of the Legislators involved, to be involved with the decision on what money is being spent. And I would like to see that the Chair of our Health Committee would certainly be involved in decision making with that HEAL Grant.

I think it's important to look at everything that we have within the Health Department and kind of break it down in some ways of what can we use this money for and where can we use it. But certainly the nursing home, I was wondering, can we use any of that money for the electric in the firewall, or do we have a grant for that?

COMMISSIONER TOMARKEN:

It's a capital fund, so my understanding is yes. But it has to do --

LEG. BROWNING:

Because we bonded that, right?

COMMISSIONER TOMARKEN:

I'm sorry?

LEG. BROWNING:

We bonded the money for the electric and firewall?

MS. BRANDEAU:

The work that's being done right now is capital funding, so --

LEG. BROWNING:

Right. But if we can use HEAL money so we don't have the debt service on it --

MS. BRANDEAU:

What we're doing now is Phase I, there's other phases that have to be paid for so.

LEG. BROWNING:

Right.

COMMISSIONER TOMARKEN:

That's my understanding. But I think ultimately it has to go back up to the State and they have to --

LEG. BROWNING:

Approve it. Okay.

COMMISSIONER TOMARKEN:

Yeah, I think that's --

LEG. KENNEDY:

The other thing that I would like to -- and I agree with Kate, Doctor. You know, look, I mean, we've been in this, you know, for the thick of it now for the last six or seven years. So what I would like to ask BRO to do is just somebody needs to confirm -- and Kevin, maybe you know this. Our daily reimbursement rate for just straight care through Medicaid is based on two components, I think; it's the actual cost we have to care, plus a fixed cost reduction. I think that's one of the reasons why we're at whatever we're -- 280, 290, 300, something like that.

MR. FREAS:

It's two components, it's based on our cost and it's based on our case mix index, those are really the two main components. But we have a third component within our rate that's a capital piece, it's about \$16 and change within our -- that's within our rate.

LEG. KENNEDY:

Okay.

MR. FREAS:

Okay. So we get 200 -- I was looking at it this morning, about 268.52, and then there's another \$16.60 and something like that that's our capital piece, so that brings us up to about 284, 285.

LEG. KENNEDY:

Well, my question then is let's just say if we took the 16 or 17 million --

MR. FREAS:

I think I can -- okay. The bonds used for this, for Foley, are not callable, okay.

LEG. KENNEDY:

Okay.

MR. FREAS:

So we can't take the 16 million --

LEG. KENNEDY:

Even if we wanted to?

MR. FREAS:

Even if we wanted to. And this was one of the problems when the attempts to divest the facility were going on; you had to get at least \$16 million, pretty much, before you even came close to breaking even.

MS. BRANDEAU:

You put it in a trust and agency and pay it off.

MR. FREAS:

And it has to go into a sinking fund to defease that debt. And what we would do is we buy slugs with it and then pay off the debt over time, just like -- right, it's -- the sinking fund is a defeasement for that debt. You can't just pay the \$16 million, or whatever the current debt is, you can't do it. The debt's not structured that way. So theoretically, if we could -- and I don't know where we're at with this. If we could use that entire \$16 million, or whatever portion of it, that would have to go into a sinking fund to then pay the debt year-to-year. The debt's covered, but it's not -- and we -- and if you're going with would we still get that rate; I would think yes because we have to establish that sinking fund. We're no longer -- we still have the debt, right, we're just paying it off.

MS. BRANDEAU:

We don't --

MR. FREAS:

If we get sold \$16 million in tobacco funds, we would still have that debt.

MS. BRANDEAU:

But we don't pay the annual debt service through operating funds anymore.

MR. FREAS:

Yes, you do, because you can carry the -- you carry the sinking fund within -- you have to carry the sinking fund within the enterprise fund. You almost have to, because you carry all the other costs in the enterprise fund.

MS. BRANDEAU:

Not a charge to the General Fund.

MR. FREAS:

It's not a charge to the General Fund.

MS. BRANDEAU:

If you take the money to pay down the debt, you put it in a trust and agency account and you pay down the debt as callable, you're taking your annual need to fund, I think it's like \$2.3 million a year.

MR. FREAS:

Yeah, give or take.

MS. BRANDEAU:

Now you don't have to pay that. So there is a benefit to it.

MR. FREAS:

Right, there's a benefit.

MS. BRANDEAU:

It can be done.

MR. FREAS:

But what you're worried about is that we're going to lose that 16 bucks; no, I don't think we are.

LEG. KENNEDY:

Well, I think it would be important for us to know, so that if we make that decision -- I don't want to forfeit or reduce --

MR. FREAS:

The rate.

LEG. KENNEDY:

-- for something that ultimately, through the State reimbursement, we're going to wind up getting anyhow.

MR. FREAS:

I don't know for sure, but I don't understand why it would go down. Because it's not -- again, we can't pay the debt off. The rate is there to help true us up because of the capital cost.

LEG. KENNEDY:

Well, is there somebody that you could talk to up in Albany?

MR. FREAS:

We'll start with Robert and we'll go to Bond Counsel too.

LEG. KENNEDY:

Okay. Yeah, I would like to have a dispositive answer for us to point to as to whether or not that's something that --

MR. FREAS:

It's actually probably a Medicaid Health Facilities Agency question. But I would think they won't care.

LEG. KENNEDY:

Okay.

MS. BRANDEAU:

Craig, within the rate structure, hasn't there been some discussion of dropping the capital portion of the rate to go to regional rate?

MR. FREAS:

I would assume that there's been discussion about dropping the capital portion of the rate along with all the other rates. I don't know off the top of my head.

MS. BRANDEAU:

The proposed new rate system for nursing homes is a complete game changer, isn't it, in terms of how we get reimbursed? Is it averages?

MR. FREAS:

They haven't fielded it yet, though.

LEG. KENNEDY:

Yeah. But they've also postponed that because of so many of the local facilities that have really, you know, raised some significant opposition and concern. So while the department has looked to propose to go to that, I think that there's dynamics going on certainly in the Senate, I know there's dynamics going on in the Senate, that are encouraging the department to not move to that regional

methodology.

MR. FREAS:

And it's just not the publicly homes. The public homes rates are actually probably -- there's less pressure on the publicly home rates that way it's going to be the privates and non-profits that it really significantly affects.

MS. BRANDEAU:

I have a --

MR. FREAS:

And in which case, the State lobby a lot better than we do, but that may slow the process, to make the process more deliberate as to whether we're going to go through a rate change. It's already happened -- there's already been a rate reduction in HIV, and I don't know if that's because of us individually, but the rate -- I mean, it's like 10% less than it was before.

MR. CAREY:

Yeah.

MR. FREAS:

It used to be up over 500 bucks and now it's around 460, and that's -- because of everybody being on better medication, there's less -- they're not in the same -- there's less requirement for long-term care for AIDS patients.

LEG. KENNEDY:

Well, I guess, you know, we'll see where it goes.

COMMISSIONER TOMARKEN:

You will be able to get back to us, Craig?

MR. FREAS:

I will talk to Robert as soon as the meeting is over and see if we can talk to Bond Counsel about it, but Ms. Brandeau will also have access through one of the Deputy County Executives to Bond Counsel as well.

MS. BRANDEAU:

Certainly.

COMMISSIONER TOMARKEN:

Thank you.

LEG. BROWNING:

I have a question. I know we talked a little bit about the Medicare issue, and it was a person that ran a nursing home and she was asking me, "Well, why aren't you trying to bill Medicare for some of your residents?" And she said if they worked and have been on paid Social Security, if they have been more than two years deemed unfit to be able to work, she said we should be applying for Medicare for them because that's where the private nursing homes get so much money is through Medicare. And she said, "You have people who are probably on Medicaid who would be eligible for Medicare."

I have like very little time, I have to get to Port Jeff, but I'm trying to understand why. Because I know you said there's 90 minute -- a 90 day timeline.

MR. FREAS:

Generally speaking, generally speaking, Medicare only covers about 90 days of long-term care services. The VA is the same thing, by the way, which is one of the reasons why we don't really have VA patients here. The emphasis in those two insurers is on rehabilitation care and getting you home. Once you -- once you get past that 90 days mark, 90 day mark, if you are still not well enough to go home or be discharged to a lower level of care, if you have private money you get private money or your private insurance picks it up if you have a secondary insurance. But eventually you run out of money because long-term care is crazy expensive and you end up on Medicaid.

So whether a patient is on Medicare or not with respect to long-term care services isn't as relevant as to whether they are dual eligible, and that's the term of art. And especially for a publicly owned home, which typically has a higher rate of what they call day one Medicaid to start. Our day one Medicaid means you start with Medicaid as opposed to a private insurer or you're out of pocket where we're like 30, 35% and your typical proprietary or home run by a voluntary hospital is probably under 10% that they take a day one Medicaid person.

LEG. BROWNING:

Well, what's the difference?

MR. FREAS:

So it's important to get patients that are eligible to be dual eligible on to Medicare so that you could cover their Part B expenses on Medicare. But there is still eventually going to be -- there's still going to be Medicaid patients with respect to long-term care.

So whether or not -- frankly, it's a social work responsibility --

MR. CAREY:

Right.

MR. FREAS:

-- to do that work. How much of a difference it would make, I would not care to speculate.

MR. CAREY:

It's mostly Medicare Part B, billing for the doctor visits, if they go out for doctor visits. Other than that, past the first 90 days there's a very narrow window that you would bill Medicare again. They would have to be in a facility for a couple of months and not receiving skilled need while living in the nursing home, require to go back out to a hospital for more than three days, come back in, then you might get another 90 days. But Medicare is just designed for short-term 90 days, that's all it.

MS. KENNEDY:

We frequently send them out. They go out quite frequently and when they come back sometimes they are weaker, and they could need physical therapy, additional physical therapy if they have not had it.

MR. FREAS:

But that's a Part B billing.

MS. KENNEDY:

But that's a Part B. We also don't do any supplemental with D.

MR. CAREY:

We have a couple of Part D enrolled, yeah. And we're doing the billing too.

LEG. BROWNING:

No, it's just like Chris. When Chris came in, it automatically went to Medicaid. Why couldn't they go ahead and apply for Medicare for him when he first came in?

MR. FREAS:

He's got to be disabled for two years. And he was overseas, remember. If they never applied for him before -- I mean, I know who you're talking about.

LEG. BROWNING:

Right.

MR. FREAS:

But if they never applied for him and he was covered by private insurance --

LEG. BROWNING:

Well, the National Health Care System took care of him.

MR. FREAS:

Well, if England picked up -- Great Britain took part of the tab, that's very nice of them.

LEG. BROWNING:

They did.

MR. FREAS:

But now he's back here and eventually he'll be -- you know, assuming --

LEG. KENNEDY:

There's a way to do this.

MR. FREAS:

He should end up as a dual eligible at some point, let me put it that way. He should.

LEG. KENNEDY:

The way to do this without a social worker necessarily have to eyeball every patient case history, is actually through DSS. Because DCAP is the unit that takes the Medicaid recipients who are SSD eligible and racks them up and does the SSD ap, which they then get denied on and then they file for the hearing. And the parameters are he's got to be disabled from the performance of substantial gainful activity for 12 months at a minimum, and you have to have had on the books earnings for five of the last ten years.

MR. FREAS:

Yeah.

LEG. KENNEDY:

So it really is limited -- you know, it's not everybody across the board.

MR. FREAS:

No, no, no.

LEG. KENNEDY:

If nobody ever works on the books, they're never going to be eligible for SSD.

MR. FREAS:

I would think that that would be another issue with some of the patients at Foley who were wheelchair bound or had other disabilities, that they were not --

LEG. KENNEDY:

Right.

MR. FREAS:

They weren't working.

LEG. KENNEDY:

And never had on the books employment.

MR. FREAS:

Right. So you never become dual eligible unless you have -- the other way is if you are HIV positive.

LEG. KENNEDY:

HIV positive, blind or a disabled child, you can actually go on a parent, but even that it's very limited. So -- but, you know, I'll talk to Greg Blass. Maybe if we had a list of all the patients that are current Medicaid recipients and Social Services just did a shake against past earnings history or something like that, that would be easy enough to see how many out of -- there's got to be 160, 170, 180 in the facility that are Medicaid recipients would fall into the category of, yeah, they had on the books earnings within the last five years or so. And then they may, in fact, actually be -- and they're not currently SSD recipients, could possibly be. And then if we get that category, I'll go sit there. I'll go sit there with a social worker and go through it. I'm telling you, you bang it out in a half an hour. It's that easy, it's that simple, it's not rocket science.

MS. KENNEDY:

We do it in the office all the time. We do it in the office all the time, fill out the aps.

LEG. KENNEDY:

Yeah, it's not that hard.

MR. CAREY:

Social workers are actively enrolling people in SSI, they're actually actively doing it.

LEG. KENNEDY:

Remember, there's two programs, and you know it. I mean, there's the SSI which is the Federal equivalent of our local welfare or Medicaid, but then there's the SSD which is insurance, just like Traveler's or Hartford or anybody else, and the premiums are what we pay out of our paycheck every two weeks. That's the one that actually allows for -- and it used to be, I don't know if it's still this way, but it used to be, with the SSI, the Medicaid that somebody would be entitled to, how to reduce local share. There's only a 10% contribution on a local share for Medicaid

or an SSI recipient. That's another reason why DCAP was so effective, because it shifted.

MR. FREAS:

Because it shifted the cost over. I think that's still the case, I would have to check with Diane.

LEG. KENNEDY:

Yeah, that's very significant. Compare and contrast, 10% and 25%. That's a big delta.

MR. CAREY:

I'll work on it.

LEG. KENNEDY:

Okay.

COMMISSIONER TOMARKEN:

Any other business?

MS. KENNEDY:

I have a question. We were there the other day and I asked someone why there weren't a lot of patients in physical therapy, and they said, "Oh, what used to go down is not going down anymore." Why is that? Aside from the fact they said if they don't want to get out of bed they don't have to go. What other reason; is it the reduction of the floor or --

MR. CAREY:

Right now the primary reason is the fifth floor short-term rehab that we -- a couple of months ago we were full at 24, now we probably have nine or ten; that's the primary reason. The short-term rehab people are coming down every day for an hour as opposed to other rehab throughout the building would not be that high.

MS. KENNEDY:

Our first tour, that place was jammed pack, and then two days ago it was like three patients. So, it's a big difference.

MR. CAREY:

Yeah, we're having a little lul, a summer time lul with short-term rehab.

MR. FREAS:

And you said that's typical, the other day?

MR. CAREY:

For the summer, to have a reduction in the summer? Yeah.

MR. FREAS:

There's no occupational therapists on staff currently?

MS. KENNEDY:

Occupational therapists.

MR. CAREY:

We have one part-time OT.

MR. FREAS:
Contract?

MR. CAREY:
No, we have more than one contract, but we have --

MS. KENNEDY:
No.

MR. CAREY:
Yeah, we have one OT, one PT and one transport, that's three.

MS. REEVES:
Who's the PT?

MR. CAREY:
Hold on a second, I have it right here. One PT -- oh, I'm sorry, you're right. You're absolutely right. We have one PT, one PT assistant and one transporter. We don't have an OT, you're right. The OT is contracted, yeah.

MR. FREAS:
Okay.

COMMISSIONER TOMARKEN:
Any other issues, questions, discussion?

Okay, let's set our next meeting. Do you want to meet in July?

LEG. KENNEDY:
You know what? Listen, you guys are working on the survey, that's probably, you know, the more important thing.

MS. KENNEDY:
We might have to meet depending on what happens four weeks from now, four to six weeks when decisions are made. Anybody read Newsday?

MR. FREAS:
When is your survey?

MS. REEVES:
When they show up.

MR. FREAS:
When do you expect it? I would be disappointed if you didn't have that wired. When are they showing up, or when do you think they're showing up?

MR. CAREY:
Last year they came August 2nd. The last ten facilities they surveyed, eight out of the ten they were two weeks early, which puts us at the second week in July, the third week in July.

MR. FREAS:
After the fourth, the third week of the month.

MR. CAREY:

The last eight out of ten they were there two weeks early. They mixed it up a little bit, but that's their average week, early. So it could be tomorrow, it could be back on August 2nd again. But this year I have been looking at every single facility they're in, I get the e-mail every week, they're right on target. They're not jumbling around at all. I would say the second week or the third week of July.

MR. FREAS:

Do they give you notice or they just show up?

MS. REEVES:

No, they just show up.

MR. CAREY:

They just show up. Certain times they try to show up at off hours like at 6 AM, one time they showed up over the weekend. But for the overwhelming majority of the time, one morning at eight thirty in the morning we'll see a few people standing in front of the building, a half hour later we'll see six people standing in front of the building.

COMMISSIONER TOMARKEN:

July 25th which is a Wednesday?

MR. PEARSALL:

That's fine.

LEG. KENNEDY:

Okay.

COMMISSIONER TOMARKEN:

At 10.

LEG. KENNEDY:

Sure.

MR. PEARSALL:

Yes.

MR. FREAS:

Is that committee week?

MR. PEARSALL:

Yeah, that's committee week.

COMMISSIONER TOMARKEN:

The week before?

MR. PEARSALL:

The week before is fine.

COMMISSIONER TOMARKEN:

The 18th?

MR. PEARSALL:

Committee week, the only day the auditorium is available is on Friday.

COMMISSIONER TOMARKEN:

Oh. Do you want to do that?

MR. PEARSALL:

Friday is alright with me. At 10 o'clock in the morning?

COMMISSIONER TOMARKEN:

Ten.

MR. PEARSALL:

Ten o'clock.

COMMISSIONER TOMARKEN:

July 27th, 10 AM, here. Okay. Motion.

MR. PEARSALL:

Kevin, I just want to thank you and your staff for the reception you have given Easter Seal people for the last couple of visits they have been here. We really appreciate it.

MR. CAREY:

No problem. Housekeeping did a good job.

LEG. KENNEDY:

They did. I have to tell you, every time we go in that place, boy, it looks clean, presents well.

MR. PEARSALL:

Whether we have visitors or not.

LEG. KENNEDY:

The residents look good.

MS. KENNEDY:

And the staff is always working, which is nice.

LEG. KENNEDY:

Yeah. No, they have absolutely positively, they're standard course.

MR. CAREY:

Thank you. Thank the staff.

MS. REEVES:

You thank the staff.

MR. CAREY:

I will.

LEG. KENNEDY:

You did a great job with the BBQ, too. That was a bit of a challenge. But you pulled it off, you made a good decision to have it inside, but nevertheless, the

residents got to have their summer BBQ and it was a good thing.

MR. CAREY:

Yeah, disappointing, but fun.

MS. KENNEDY:

You saved their health, they weren't out in 100 degree temperature, so that was a good thing.

MR. CAREY:

No. But with a warning, to get everybody in, we would have took them out while everybody else was being warned to bring them in, and that wouldn't have went over big.

LEG. KENNEDY:

No. The other thing that was nice was the day that we were there, I was thrilled to see our outfit from across the street at the facility, cutting grass and trimming; that was great. Get them more often.

MS. KENNEDY:

It was great.

LEG. KENNEDY:

Absolutely.

MS. KENNEDY:

They were noted. They were noted, and not in an offensive way.

MS. REEVES:

(Inaudible).

COMMISSIONER TOMARKEN:

Motion to adjourn.

MR. PEARSALL:

Motion to adjourn, Doctor.

COMMISSIONER TOMARKEN:

We're adjourned.

*(*The meeting was adjourned at 2:53 PM*)*