

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, July 8, 2009, 9:00 a.m., at the Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen Caulton-Harris, Mr. Harold Cox, Dr. John Cunningham, Dr. Michèle David, Dr. Muriel Gillick, Mr. Denis Leary, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, Dr. Michael Wong, Dr. Alan C. Woodward, and Dr. Barry Zuckerman. Mr. Paul J. Lanzikos and Ms. Lucilia Prates Ramos were absent. Also in attendance was Attorney Donna Levin, DPH General Counsel.

Chair Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF MAY 13, 2009:

A record of the Public Health Council Meeting of May 13, 2009 was presented to the Public Health Council for approval. Mr. Albert Sherman moved approval. After consideration, upon motion made and duly seconded, it was voted unanimously [Dr. Michèle David not present to vote; Ms. Prates Ramos and Mr. Lanzikos absent] to approve the May 13, 2009 minutes of the Public Health Council as presented.

REGULATION:

REQUEST FOR APPROVAL FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 445.000: MINIMUM STANDARDS FOR BATHING BEACHES (STATE SANITARY CODE, CHAPTER VII):

Ms. Suzanne Condon, Director, Bureau of Environmental Health, presented the amendments on Bathing Beaches to the Council for approval. She was accompanied by Mr. Michael Celona, Environmental Analyst, Bureau of Environmental Health. Staff's memorandum, dated July 8, 2009, to the Council states, "The proposed amendments update the requirements for the operation of public and semi-public bathing beaches in the Commonwealth..." Ms. Condon stated, "The purpose of these amendments is to safeguard public health and provide minimum sanitation standards to protect bathing waters from contamination from sludge deposits and solid refuse; floating solid, grease or sum wastes; oil, hazardous material, and heavy metals; and bacteria at our public and semi-public beaches in the Commonwealth. The proposed amendments would empower local health enforcement abilities, improve information for beach visitors, clarify language and strengthen requirements for beach operators to report to boards of health in a timely fashion...." Public hearings had been held on March 19, 2009 in Boston and on March 20, 2009 in Worcester. The public comment period closed on March 27, 2009. No oral or written testimony was presented at either hearing. Written testimony was received from two board of health agents (from Athol and Brewster) and one local health association (Mass. Health Officers Association).

Ms. Condon noted that in response to written comments, the Department is proposing to delay the implementation date until the 2010 beach season for two of the requirements in the final regulations: the requirement to issue permits to operate a beach, as described in 105 CMR 445.300, and the requirement to install permanent signs at the entrance to each beach, as described in 105 CMR 445.020. Ms. Condon noted that the delay in the implementation date will allow local health officials sufficient time to prepare for next year's beach season.

After consideration, upon motion made and duly seconded, it was voted unanimously [Dr. David not present to vote; Ms. Prates Ramos and Mr. Lanzikos absent] to approve Final Promulgation of Amendments to 105 CMR 445.000: Minimum Standards for Bathing Beaches (State Sanitary Code, Chapter VII). A copy of the approved

regulations is attached and made a part of this Record as Exhibit No. 14, 929.

STAFF PRESENTATION: "REPORT ON THE ANNUAL STATUS OF BEACH WATER QUALITY IN MASSACHUSETTS", BY SUZANNE CONDON, DIRECTOR, AND MICHAEL CELONA, ENVIRONMENTAL ANALYST, BUREAU OF ENVIRONMENTAL HEALTH:

For the record, Dr. Michèle David arrived here during Ms. Condon's presentation at approximately 9:20 a.m.

Ms. Condon presented the annual report to the Council. She said in part, "...In 2000, the Massachusetts legislature passed an Act Relative to Minimum Standards for Public Bathing Waters, often referred to as the Massachusetts Beaches Act. The Act mandated that the Department publish an annual report analyzing statewide bacteria testing results. The first Annual Report was published in 2001. The report being released today summarizes beach monitoring and testing data from Massachusetts public and semi-public marine and freshwater bathing beaches in the 2008 season."

Ms Condon presented some of the highlights from the report: "We received data from 99% of the communities with bathing beaches open for the 2008 season. There are 1,066 public and semi-public marine and freshwater beaches in 215 communities across the Commonwealth. A total of 15,470 marine and freshwater water samples were received for the 2008 report. Approximately ½ of beaches in Massachusetts are marine beaches (528 out of 1066). These public and semi-public beaches are located in 60 coastal communities. Sixty-eight percent of the marine beaches had no exceedances during the 2008 beach season and 5.7% of all bacterial water quality samples exceeded the marine standard. The historical average is 4.5%. Bacterial exceedances are closely tied to rain events and the rainfall was 4.29" above normal during the 2008 beach season. Ninety-nine percent of marine beaches were tested at least as required by the State Sanitary Code (usually weekly)."

Ms. Condon continued, "The remaining 538 beaches are freshwater beaches and are located in 182 Massachusetts communities. Seventy-five percent of these beaches had no exceedances during the 2008 season. There were 325 bacterial exceedances at freshwater beaches reported in 2008. This means 4.1% of all bacterial water quality samples exceeded the freshwater standard. The historical average is 4.3%. Ninety-eight percent of freshwater beaches were tested within the frequency required by the State Sanitary Code."

In closing, Ms. Condon explained further, "The Department conducted five trainings in the spring of 2009 for local health officials discussing quality assurance measures. Additional sanitary surveys will be conducted to further the goals of the Tiered Monitoring Plan in 2009...The tiered Monitoring Plan's goal is to direct sampling resources to the beaches where they are needed most (i.e., provide additional sampling events at beaches with high risk of bacterial exceedances and fewer sampling events at beaches with low risk of bacterial exceedances)." Ms. Condon noted that her bureau will continue to collaborate with the local boards of health on this and she said "the local boards of health deserve credit for having stepped up to the plate to keep our beaches safe for the public..."

A brief discussion followed and it was noted that after bacteria builds up due to large amounts of rain, it usually clears up quickly in about 24 to 48 hours of the weather clearing.

NO VOTE/INFORMATION ONLY

PRESENTATION: RECOGNITION OF PAUL DREYER ON HIS RETIREMENT:

Chair Auerbach and the Public Health Council commended Dr. Paul Dreyer on his many accomplishments and contributions he made to the Department of Public Health. He retires after 33 years with the Department. His accomplishments included: Developing the first Nursing Home Report card, the primary stroke service system, the elimination of ambulance diversion, and the transparent cardiac

surgery system. Dr. Paul Dreyer said, "I want to thank you all for your kind words. It occurs to me that one of the best sources of enrichment in one's career is to have a respect among colleagues, and I feel that I had that, and with that, I want to thank you all."

DETERMINATION OF NEED CATEGORY 1 APPLICATIONS:

PROJECT APPLICATION NO. 4-3B73 OF BOSTON MEDICAL CENTER – PROVIDE PANCREAS TRANSPLANTATION SERVICES AT BOSTON MEDICAL CENTER:

It was voted for the record that Drs. Michéle David and Barry Zuckerman recused themselves from discussion and voting.

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the Boston Medical Center application to the Council. Staff's summary to the Council, dated July 8, 2009 states in part, "Boston Medical Center (BMC) has filed a Determination of Need (DoN) to provide pancreas transplantation services at its East Newton campus location in Boston as part of the United Network for Organ Sharing (UNOS) Region 1 Regional Pancreas Oversight Committee...BMC has identified a significant need to establish a pancreas transplantation service to complement its existing kidney transplant services. Once BMC receives DoN Approval for the proposed pancreas service, it must then receive UNOS approval. Given this, BMC expects to begin the pancreas service in FY2011, approximately 8-10 months after the anticipated UNOS approval... BMC (as University Hospital) was previously granted a three-year temporary DoN approval (Project No. 4-3814) to establish a pancreas transplant program in 1992 as part of the New England Pancreas Consortium, and in 1997, after the merger between Boston University Medical Center and Boston City Hospital, BMC received permanent approval (Project No. 4-3926) to proceed with the program. BMC was unable to implement this approval as the surgeon trained to perform pancreas transplants at the time relocated and the authorization period for the DoN approval expired...BMC anticipates performing six pancreas-kidney transplants and two pancreas alone transplants in FY2011, the first full year of operation of its proposed

transplant program, and four pancreas-kidney transplants and one pancreas alone transplant in FY 2012, the second full year of operation...Staff found the applicant's conclusion of need reasonable based on the success of BMC's existing kidney transplant program, the potential transplant volume in Massachusetts when compared with 2010 population-based estimates, the current Region 1 waiting list, as-well as the estimated number of pancreas available for transplant in Region 1. In addition, as a condition of approval, BMC will provide Medicaid access and free care as required and will not reduce Medicaid intensive services to non-transplant patients."

Discussion followed by the Council. Dr. Matthew Nuhn, Chief of Transplant Surgery, Boston Medical Center, joined DoN staff to answer questions by the Council.

During discussion, the Council Members raised questions such as: Why have the number of transplants gone down dramatically in the region in the last few years? (Dr. Woodward) It was noted that staffing, philosophy and the exporting of organs out of the region may be the reasons. Why can't the applicant refer patients to other hospitals for the pancreas transplants? (Dr. Gillick) Staff replied that they do not see this as duplication of services because the resources are already in place.

Ms. Caulton-Harris asked for a summary of what BMC was trying to do with this DoN. Dr. Nuhn responded that "the most important thing here is that we, at BMC, want to provide complete care for the diabetic patient, which we cannot currently do, and we want to provide transplant services to our patients, that we can technically do, and that the institution can provide at no additional cost, and in a safe manner, and we have of course been reviewed by CMS favorable to do such."

Dean Cox asked in part, "...If our work is to consider whether or not there is adequate need in our community to actually provide this service, part of what I am hearing is that we have individuals who need this specific level of care, who are going outside of our region..." Ms. Gorga noted that if you have a successful kidney program, then the guidelines state that you can go ahead and

perform pancreas transplants. If you can perform liver transplants, kidney transplants and heart transplants then you can do another transplant because a lot of the procedures are the same. For example, the training of the nursing staff is already in place..." Mr. Sherman inquired about age limits for organ transplants. Ms. Gorga noted that when the first transplant programs had been set-up, there were age specific qualifications for transplants (the same for all institutions). Dr. Nuhn said the age limits are largely based upon the transplant community's understanding and the clinical data that shows who does well. All institutions would have about the same age requirements but there is no national standard. Dr. Nuhn said further, "I think the most important factor, the data is clear that people who meet criteria for pancreas transplant do well. People who meet criteria for pancreas and renal transplant combined do better than patients who receive renal transplant alone with insulin therapy for their diabetes. We know this is very clear and well accepted within the transplant community. There is an advantage to do kidney/pancreas transplant combined in patients that meet criteria."

In summary, Chair Auerbach said in part, "I think we are struggling with the larger issues of cost and quality, and distribution of resources, and I think that is coming out in this discussion and will continue to come out in other discussions..."

Mr. Albert Sherman made the motion to approve the request as recommended by staff. After consideration, upon motion made and duly seconded, it was voted unanimously [Drs. David and Zuckerman recused; Dr. Gillick abstained; Mr. Lanzikos and Ms. Prates Ramos were absent.] to approve **Project Application No. 4-3B73 of Boston Medical Center, Boston** with conditions and with no capital expenditure and estimated first year incremental operating costs of \$363,000 (February 2009 dollars). This approval provides for Pancreas Transplantation Services at Boston Medical Center. The staff summary containing the reasons for staff's recommendation and the conditions of approval is attached and made a part of this record as **Exhibit Number 14,930**.

For the record, Mr. Sherman noted his concern about age-limits on receiving transplants. Chair Auerbach suggested to DoN staff "that perhaps we explore this issue when we look at transplant applications in the future with particular attention to the question of how are age limits derived and are they justifiable?"

PROJECT APPLICATION NO. 3-3B76 OF SAINTS MEDICAL CENTER, TRANSFER OF OWNERSHIP FROM SISTERS OF CHARITY OF OTTAWA TO COVENANT HEALTH SYSTEMS, INC.:

Mr. Jere Page, Senior Program Analyst, Determination of Need, presented the Saints Medical Center transfer of ownership application to the Council. He stated, "Saints Medical Center in Lowell is seeking a transfer of ownership and original licensure of the Medical Center resulting from a change of control at the membership level of Saints parent company, Saints Health Systems, Inc. from the Provincial Superior and Provincial Counselors of the Saint Joseph Province of the Sisters of Charity of Ottawa to Covenant Health Systems, Inc. of Lexington, Massachusetts." He noted that Saints satisfies the five standards for transfer of ownership under the DoN regulations; that a public hearing was held in Lowell on June 18, 2009; 61 people attended, 12 spoke. All testimony and written comments received supported the proposed acquisition by Covenant.

Mr. Albert Sherman moved approval. After consideration upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 3-3B76 of Saints Medical Center for Transfer of Ownership from Sisters of Charity of Ottawa to Covenant Health Systems, Inc., Lexington with a condition.** The staff summary containing the reasons for staff's recommendation and the condition which pertains to the provision of interpreter services is attached and made a part of this record as **Exhibit No. 14, 931.**

STAFF PRESENTATION: "STRATEGIC PLAN FOR ASTHMA IN MASSACHUSETTS: 2009-2014", BY JEAN ZOTTER, JD, DIRECTOR, AND CARRIE HUISINGH, EPIDEMIOLOGIST, ASTHMA PREVENTION AND CONTROL PROGRAM:

Attorney Jean Zotter presented the Strategic Plan for Asthma to the Council, accompanied by Ms. Carrie Huisingh, Epidemiologist. Attorney Zotter said in part, "...The primary point that we want to convey today is that we have new data that asthma is largely uncontrolled in Massachusetts. Asthma is a chronic condition of the airways. Uncontrolled asthma can lead to poor quality of life, disability and, in some cases, death. However, with proper management, most people with asthma can lead full and active lives. The reason that we are presenting today is that the cost of asthma, especially the cost of this poorly controlled asthma, is great. In 2003, the Centers for Disease Control estimated that asthma resulted nationally in 12.8 million missed school days, and nearly 10.1 million missed work days. National estimates from the American Lung Association place the total direct and indirect costs of asthma at 19.7 billion. This cost includes 14.7 billion direct cost and 5 billion indirect costs. We don't have direct and indirect costs for Massachusetts but we know how much was charged for hospital care. In Massachusetts, the total charges for acute care hospital use for asthma were approximately 136 million dollars in 2006. Public insurance was the primary source of payment for 53% of these visits. The cost of asthma underscores the need for effective interventions, and a strong public health approach. The Department of Public Health is taking the first steps in controlling asthma, and we will share some of those highlights with you today."

She spoke of the office becoming a reality under the leadership of Commissioner Auerbach, who aggressively pursued federal funding from the CDC which allowed them to hire 2 ½ staff and create the Asthma Disparities Initiative in which they have funded five regions where asthma hospitalizations rates are above the national average (Boston, Brockton, Fall River, New Bedford, and Springfield). The

office has no state funding. They coordinated the development of two documents, The Burden of Asthma in Massachusetts, and in partnership with The Massachusetts Asthma Advocacy Partnership developed The Strategic Plan for Asthma. They are aggressively seeking more federal grants to expand their program.

Ms. Carrie Huisingsh, Epidemiologist for the program, addressed the Council. She said in part, "The Burden of Asthma in Massachusetts Document (April 2009) was prepared with input from multiple programs at DPH in Health Promotion, Research and Evaluation, and Environmental Health. It is a significant update from the previously published burden document in 2007. The current report includes data from eleven data sources, and is organized into six sections: Prevalence of Asthma among Adults and Children, Factors Associated with Asthma Management, Work Related Asthma, Hospital Treatment and Deaths, and Healthy People 2010 Objectives. I will be presenting the findings from the report." Some statistics she presented are taken from the BRFSS and Asthma Call-back Survey:

- From 2000 to 2007, the Prevalence of Lifetime and Current asthma among adults increased in both Massachusetts and the U.S. The prevalence of current asthma increased 16.5 percent in Massachusetts and 13.7 percent in the U.S. For each year examined, the prevalence of Lifetime and Current asthma among adults was higher in Massachusetts than in the U.S.
- From 2000 to 2007, the prevalence of asthma increased 44% among adults ages 65 and older, and almost 20% among adult females.
- Three years of combined data from the BRFSS show that in Massachusetts, the prevalence of current asthma remains higher among females, individuals with lower incomes, household incomes, smokers, and individuals with a disability.
- The prevalence of current asthma among Massachusetts adults was similar across race/ethnicity subgroups. Findings in Massachusetts on this point are inconsistent with the U.S.

National studies which have found differences by race/ethnicity.

- Results from a new data source called the Asthma Call-back Survey show that exposures in the workplace may be important contributing factors to asthma among adults. Work-related asthma has been shown to be more severe, and can be prevented. Among adults with current asthma, 40% reported that their asthma was caused or made worse by exposures at either current or previous jobs.
- Starting in 2005, Massachusetts started collecting data on asthma prevalence among children. The three year average annual prevalence of current asthma among Mass children is 10.3%. There are no national estimates; however, we know that current asthma is similar among other New England states.
- About half of children with current asthma reporting having activity limitations because of their asthma in the past year. About four out of ten has an asthma attack in the past year. Four out of ten experienced symptoms of asthma at least one in the past month. About one out of six reported having sleep disruption because of their asthma in the past month, and about one in six reported using an inhaled short-acting beta agonist or rescue medication, one or more times per day.
- On an average day in Massachusetts, between 2005 and 2006, there were 102 Emergency Department visits, 25 hospital admissions, and eight observation stays due to asthma (does not include unscheduled office visits or urgent care visits). This data is from the Statewide Acute Care Hospital Discharge database from the Division of Health Care Finance and Policy.
- The rate of observation stays due to asthma decreased 35% from 2000 to 2005.
- From 2000 to 2006, the rates of hospitalization due to asthma were highest among children ages zero to four years, and adults ages 65 and older. This pattern in age-specific rates is

similar to national findings.

- With the age group of adults 65 and older, the rate increased 49.4% from 2000 to 2006, and the state plan includes activities to better understand the burden of asthma among priority populations such as older adults.
- Hospitalizations due to asthma by race/ethnicity, from 2000 through 2006. Over time, the rates are consistently higher among Blacks and Hispanics, compared to Whites. In 2006, the rate among Blacks was 3.1 times higher compared with Whites; the rate among Hispanics was 2.7 times higher compared with Whites.

Attorney Zotter added, "The goal of the plan is to improve the quality of life of all Massachusetts residents with asthma, and to reduce disparities in asthma outcomes by race, ethnicity, age, gender, and geographic location. This is also the mission of our program. The framework for the plan is a socioecological model. The model recognizes that public health must address the multiple levels of health improvement, not just individual behavior, or clinical treatment, but also the social and environmental factors that affect health outcomes. Asthma benefits from this approach as there is no one solution to improving asthma outcomes. Instead, a coordinated approach that focuses on multiple fronts is needed."

Attorney Zotter noted further, "Research by the Asthma Regional Council has found that health insurers in Massachusetts do not consistently cover asthma education or case management. Some only cover one visit, some cover asthma education or not all. Others require it to be provided by a nurse. Some only cover telephonic education...And for people with poorly controlled asthma, cost is a barrier to care. Daily controller medications are important for very poorly controlled asthma, to keep their asthma in control. However, those medications are often the most costly to patients. Many insurers place controller medications on their Tier 3 drug formularies. Tier 3 medications have the biggest co-

pay. These co-pays in this tier can range from twenty to fifty dollars per medication.”

Discussion followed by the Council Members around the issue of how we get all the insurers to pay for asthma preventative care and education. Staff said they will be working collectively with the asthma programs across New England and the Asthma Regional Council to develop consensus strategies working with stakeholder groups such as insurers, purchasers of insurance (employers and clinicians).

Chair Auerbach stated in part, “...10% of our children have asthma in the state. This is a major chronic disease, where we really need to be focusing more attention, and clearly, the fact that you don’t get any state money is an indication that more needs to be done in terms of raising the consciousness of our partners in government....I am appreciative that the recommendations for actions are practical applications that are doable, even in challenging economic times like now, and not simply a wish list that we can’t move ahead on is admirable...”

The Council noted staff should contact the State Connector; and the largest health insurer in the state – Blue Cross Blue Shield about providing better coverage for controller medications for asthma patients. Attorney Zotter noted that the Department has introduced legislation that would mandate coverage of asthma education. Chair Auerbach noted, “...The most compelling information to an insurer is an indication that the provision of a particular service will result in decreased costs to them.” It was noted that Medicaid provides a barrier to asthma medication by requiring prior approval. There were suggestions that a report card be put out on providers showing what they cover and do not cover; and perhaps using positive accolades for those providers providing optimum care for their patients would encourage better coverage. Attorney Zotter responded that if they receive the CDC grant they applied for they would like to do an assessment of what providers provide coverage for drugs and education of asthma.

NO VOTE/INFORMATION ONLY

Follow-up Action Steps:

- DoN staff perhaps explore how age limits are derived when they look at transplant applications in the future with particular attention to the question of “how are age limits derived and are they justifiable?” (Auerbach to Joan Gorga on behalf of Sherman)

The meeting adjourned at 11:15 a.m.

John Auerbach, Chair

LMH