

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on November 18, 2009, 9:10 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 (arrived at 9:35 a.m.), Dr. John Cunningham, Dr. Michèle David (arrived at approximately 9:30 a.m.), Dr. Muriel Gillick, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman (arrived at 9:45 a.m.), Dr. Michael Wong, and Dr. Alan C. Woodward. Absent Members were: Mr. Denis Leary and Dr. Barry Zuckerman and there is one vacancy. 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. He noted the docket items and announced that he changed the order in which docket items will be heard. The minutes are written in the order they were heard.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF OCTOBER 21, 2009:

Mr. José Rafael Rivera moved approval of the minutes of October 21, 2009. After consideration, upon motion made and duly seconded, it was voted unanimously [Council Members Ms. Helen Caulton-Harris, Dr. Michèle David, and Mr. Sherman were not present and therefore did not vote on the minutes] to approve the Record of the Public Health Council Meeting of October 21, 2009 as presented.

PRESENTATION: "BETSY LEHMAN CENTER FOR PATIENT SAFETY AND MEDICAL ERROR REDUCTION, REPORT OF THE EXPERT PANEL IN OBSTETRICS"

Ms. Nancy Ridley, Director, Betsy Lehman Center, together with Katherine Flaherty, ScD, Project Director, Expert Panel in Obstetrics

presented the Report of the Expert Panel to the Council. Fredric Frigoletto, MD, Panel Chair, and Bonnie Glass, Panel Vice Chair, RN, MN joined in the discussion and responded to Council questions. Please see the verbatim transcript of the proceedings for full presentation and discussion. Ms. Ridley stated that the death of Betsy Lehman was the shot heard around the world, spearheading a national report on patient safety (1999) that notes that 44,000 to 98,000 Americans die from medical errors each year. Ms. Ridley said in part, "In Massachusetts, the Betsy Lehman Statute was passed in 2001 creating the Center, prioritizing patient safety and naming the Massachusetts Coalition for the Prevention of Medical Errors as the Advisory Board for the Center. The Center works very closely with the Massachusetts Coalition for the Prevention of Medical Errors, the Massachusetts Quality and Cost Council and the consumer group Health Care for All's Consumer Health Quality Council. The Center has released two other reports, one on Bariatrics Weight Loss Surgery and one on Health Care Associated Infections." In closing Ms. Ridley noted that an expert panel is about to be launched in partnership with the Board of Medicine on reconstructive surgery and certain infections that may result from that particular surgery.

Ms. Katherine Flaherty, Project Director, said in part, "...What we were trying to do was to find something that could make a contribution to obstetrical care in Massachusetts, addressing issues like patient safety and medical error reduction. We ended up focusing on labor and delivery, often the focus of malpractice and medical errors and we divided the panel into task groups in these topic areas: Electronic Fetal Monitoring, Induction, Staffing and Communications, and Cesarean Sections." The group developed guidelines for Maternal Hemorrhage and conducted a limited telephone survey to get information on Disparities in Labor and Delivery issues. Ms. Flaherty noted that the panel committed to "reviewing the existing state of the art in quality and safety, including existing and developing best practice approaches, making evidence-based recommendations to improve the care and quality, and identify areas for future research and collaboration."

In regard to Electronic Fetal Monitoring, Ms. Flaherty noted in part, "There is significant evidence that, although fetal monitoring in Labor and Delivery has been the standard of care in the Commonwealth and country for many years, there is not evidence to back its use...There is also some unintended consequences of using EFM that we don't want that is increased operative interventions such as C-Sections as well as liability and increased cost associated with the intervention. She noted that there are national guidelines available and that educational programs must be implemented on the guidelines and processes must be established to ensure implementation in the hospitals."

In addition to recommendations on EFM, Ms. Flaherty noted that "the report recommends that all elective deliveries, including primary and repeat C-sections should not be done prior to 39 weeks in a normal singleton gestational age infant. Under Staff and Communication, the group focused on primarily on ensuring that the Labor and Delivery staff are well rested while caring for women and that the patient's prenatal care information is available in L&D when she arrives, and recommends that pilot projects be done in hospitals to help establish what is adequate sleep, maybe a 16 to 24 hour cut-off for staff and the hand-off of patient care around communication in a very structured an consistent manner is a recommendation."

Ms. Flaherty continued, "...Cesarean Sections are safer now than they ever have been, but there are certainly identified elements and techniques that would further optimize safety and outcome and in the report there is a summary of recommendations to ensure that C-Sections are safe." She said more data is needed to understand why C-Sections rates are high. Ms. Flaherty noted, "In the period from 1997 to 2007, there had been 18 maternal deaths due to maternal hemorrhage and the report recommends clinical guidelines and protocols for recognizing potential maternal hemorrhaging. In regard to disparities, Ms. Flaherty noted that they conducted a preliminary survey of Labor and Delivery units across the state, a combination of tertiary and community hospitals, with physicians, practitioners and nurses in Labor and Delivery to get a sense of the issues they identify in caring for the diverse populations. She noted, "Although there is

great diversity among patients, there is a lot less diversity among the staff.” She said that collaborative training on diversity issues could be helpful, noting the great variability among hospitals around policy and procedures for identifying and addressing diversity issues and great variability in terms of training. The report recommends that a more comprehensive assessment of all the hospitals in the State be done.

In closing, Ms. Flaherty stated in part, “There is a lot of information in this report and some very concrete explicit information. This information will be communicated with all the maternity hospitals and we would encourage the maternity hospital, as well as the professional organizations, like the American College of Obstetricians and Gynecologists, to look at the plans and develop processes through you” [the Lehman Center]. She also noted that for Cesarean Sections, the next step would be to identify best practices by talking to the hospitals and by looking at other states with lower rates to see what they have done that may have contributed to that.

Note: For the record, Council Member Dr. Michèle David arrived at the meeting during Ms. Ridley’s presentation at approximately 9:30 a.m. and Mr. Albert Sherman arrived at the meeting after Ms. Flaherty’s remarks, during Chair Auerbach response to the report at approximately 9:45 a.m.

Dr. Frigoletto addressed the Council, noting that he was honored to be selected to Chair the Panel and that it was an outstanding group to work with. He noted, “I think the report that we put together is going to serve Massachusetts mothers and babies and maybe even mothers and babies in other states.” However, he noted that he was disappointed when the funding was discontinued. The members volunteered their time to complete the research and finish the report. Council Member Michael Wong said he wanted it noted on the record that the Governor’s Office and future Governor’s Offices should not expect this volunteerism as standard practice when this kind of project should be funded.

In response Chair Auerbach said in part, "...I think the report is excellent. I think it points to very practical much needed action steps that should be taken and we at the Department are very happy to receive this as a set of recommendations..." Discussion continued around electronic records being the goal but everyone is not there yet, aligning the recommendations of the report with payment reform efforts of the Mass Health Program and other insurers. Some of the Council Members applauded the diversity survey in the report. It was noted that Brazilian women have C-Section rates of 45%. Dr. Frigoletto noted that many of the women come from countries with a background where the Cesarean rate is 90% and when they arrive here, the tendency away from VBAC may contribute to this high rate. Dr. Smith noted that DPH has an ongoing expert working group "wrestling with trying to understand the phenomenon of C-Sections and that the reason may be non-biologic." Ms. Lucilia Prates Ramos suggested that the hospital Patient Advisory Councils be engaged in looking at diversity and that the Council themselves be representative of the community in their diversity. Please see verbatim transcript for full discussion.

Chair Auerbach noted, "Thank you for this very significant and ground-breaking work in terms of looking at the issue of obstetrics and quality and safety measures and the challenge for both the Department and the Lehman Center...is to take this report's recommendations and come-up with a specific set of concrete actions, short-term actions over the next six to twelve months...We want to make sure we honor this work by taking action to implement the recommendations..."

NO VOTE/INFORMATION ONLY

PRESENTATION OF GIFTS TO NANCY RIDLEY UPON HER RETIREMENT FROM THE DEPARTMENT OF PUBLIC HEALTH

Chair Auerbach noted that Ms. Ridley was retiring after 32 years of service to the Department of Public Health. He noted many of her contributions to the Department. He said in part, "On behalf of the Department and the Public Health Council, thank you for your

enormous and significant service to the Commonwealth and for the major changes you have made in terms of the way that health care operates within Massachusetts. It has affected millions of people's lives." Chair Auerbach noted further that the Board and Leadership of the Betsy Lehman Center have voted to create a new annual award that will be called the Nancy Ridley Award for Excellence in Quality and Safety and that it will be awarded each year by the Betsy Lehman Center. Council Member Albert Sherman also made kind remarks about Ms. Ridley and her accomplishments. He presented her with gifts, including a silver Paul Revere Bowl. Ms. Ridley responded in part that her accomplishments came about because she "had the pleasure of working with, selecting, and inheriting extremely competent staff, and having the support staff here at DPH like Donna Levin and her staff of lawyers and Carol Weisberg and her financial staff in the budget office..."

PRESENTATION: "SMOKING CESSATION AS A HEALTH-CARE COST CONTAINMENT STRATEGY: PRELIMINARY FINDINGS"

Lois Keithly, PhD, Director, Massachusetts Tobacco Cessation and Prevention Program, accompanied by Thomas Land, PhD, Director, Surveillance and Evaluation, Massachusetts Tobacco Cessation and Prevention Program, presented preliminary findings of their study to the Council. She noted in part, "We are addressing the importance of smoking cessation because smoking remains the leading cause of preventable death and disease in Massachusetts. Approximately eight thousand smokers die each year in Massachusetts, due to smoking attributable illnesses, and especially for this presentation, smoking causes 4.3 billion dollars in excess health care costs in Massachusetts every year...While case studies exist on individual health insurance benefits, our results demonstrate that use of cessation resources on a population-wide basis can lead to significant health improvements in one year or less. Dr. Keithly said in order to decrease smoking prevalence, we should motivate more smokers to make more frequent quit attempts, encourage smokers to use evidence based methods when making a quit attempt and reduce high rates of relapse after cessation. She said further that we should create an environment that fosters quitting smoking by

changing social norms, having smoke-free environments, healthcare provider interventions with smokers and taxing tobacco products.

MTCP partnered with MassHealth to design their smoking cessation benefit. There was much discussion about the MassHealth Cessation Benefit which was mandated in the 2006 Health Care Reform Legislation. It mandated a smoking cessation benefit for all Medicaid recipients, access to all FDA-approved medications including nicotine replacement therapy, such as the patch or gum, Chantix or Bupropion. It also provided up to sixteen face-to-face counseling sessions with a low co-payment of one to three dollars. There were no barriers to treatment and the Pharmacotherapy Benefit was not linked to counseling. It was noted that 40% of all MassHealth smokers are using the benefit, 75,810 people (from July 2006 to May of 2009). Of those, ninety-nine percent used the medications and one percent used the counseling. Over 33,000 MassHealth smokers quit, a 26% drop in smoking prevalence. Ms. Ayesha Cammaerts, Chief of Staff, MassHealth Program, clarified information for the Council from the floor. Please see verbatim transcript for full presentation and discussion.

Dr. Thomas Land discussed the medical claims data and the changes that occurred in that data after the implementation of the MassHealth Cessation program. He focused on the results of three diagnostic categories, adult asthma, heart attack, and complications during pregnancy. Dr. Land said in part, "...Despite the complexity of using Medicaid claims data, the general analytic model we used is fairly straightforward. Simply put, we looked at the number of adverse outcomes in the year before and individual used the Tobacco Cessation Benefit, and after and individual used the Tobacco Cessation Benefit. We used this model for evaluating inpatient, heart attack, and Emergency Department asthma claims. Due to eligibility guidelines, a different model was used for looking at claims related to complications during pregnancy...We will start with adult asthma. Here we compared the number of individuals who had Emergency Department visits for a primary diagnosis of asthma in the year before and year after using the Tobacco Cessation Benefit. This population included members who were enrolled in MassHealth,

excluding those on managed care, and who began using the MassHealth Tobacco Cessation Benefit in the first year after it was implemented. Our analysis found that the likelihood of an individual having an Emergency Department claim with a primary asthma diagnosis declined by seventeen percent in the year following initiation of tobacco cessation treatment. This difference was significant at the .05 level. This analysis focused only on Emergency Department claims. Similar patterns were found for clinic visits and laboratory claims. Nonetheless, further investigation is required to refine the estimate of the effective tobacco cessation benefit in reducing asthma claims in the Emergency Department and elsewhere.”

Dr. Land continued, “The results for heart attack follow. The population and data exclusion for this analysis are identical to those for asthma with one exception. The hospital inpatient protocols require that AMI patients receive medications for quitting smoking while in the hospital. The analysis excluded those receiving their first treatment within a 15th day buffer period after the AMI event. After applying this restriction, we found that the likelihood of an individual having an inpatient claim for an AMI declined by 38% in the year following initiation of tobacco cessation treatment, excluding those who had initiated their treatment within the 15 days after admission. This difference was marginally significant. P equals .06. Further investigation that includes MCO claims, is required to refine the estimate of the effect of the Tobacco Cessation Benefit in reducing AMI inpatient claims.”

Dr. Land noted that in regards to pregnancy, some women were not eligible for MassHealth prior to their pregnancy and therefore would not have claims a year before using the benefit so a different model was used for assessing the effects of the Tobacco Cessation Benefit with respect to pregnancy complications. He said, “We examined the population rate of pregnancy complications over a four year period, FY 2005 and FY2006 versus FY 2007 and FY 2008. We compared the pre-benefit period to the post-benefit period without regard for when and individual began using the benefit. The population included women 18 to 44 years of age, who used the Tobacco Cessation

Benefit in the first two years after it was implemented. We found that the rate of pregnancy complications for preterm labor, ectopic pregnancy and hemorrhaging during pregnancy declined by seventeen percent during the two year period following implementation of the benefit. This difference was significant at the .01 level. Since these periods correspond to time before and the time after the Tobacco Cessation Benefit was implemented, further investigation is required to refine the estimate of the effect of the use of the Tobacco Cessation Benefit in reducing pregnancy complications.”

Chair Auerbach noted that there are insurance benefit discussions that occur around demonstration of short-term improvement in health and short term savings because insurers are not concerned about preventing lung cancer since it occurs once the person is on Medicare and they wouldn't see the savings. Discussion followed; please see the verbatim transcript for full discussion.

NO VOTE/INFORMATION ONLY
PRESENTATION: “H1N1 VIRUS UPDATE”

Lauren Smith, M.D., MPH, Medical Director, Massachusetts Department of Public Health updated the Council on the Department's activities regarding the H1N1 vaccine distribution. Dr. Smith noted initial target groups to receive the vaccine: pregnant women, the household contacts of infants, health care workers, emergency services personnel, young children and young adults and high risk in this age group who have underlying medical conditions that make them at risk. She said, “Initially, with our shipments that have been going to clinical providers, we have been focusing on pregnant women, the health care providers and young children.” She noted that the Department received over a million doses of H1N1 vaccine and by the end of the month hopes to receive 1.5 million doses and 3 ½ million doses by the end of January. Dr. Smith said congratulations should go to the State Laboratory personnel who work every day to make sure the vaccine gets distributed to providers and local boards of health right away. Dr. Smith noted that the Department receives hundreds of phone calls a day

regarding the vaccine, continues to update the DPH website and continues to distribute updated booklets in many languages. The Department continues with guidance to the schools and local boards of health.

Discussion followed by the Council. Chair Auerbach noted that the federal distribution of the vaccine “seems to be a fair process that has insufficient quantity of vaccine, at this point, to meet the demand, and so, every week, we feel the impact of the public’s desire for greater vaccine than we are able to provide.”

NO VOTE/INFORMATION ONLY

FINAL REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE), 105 CMR 140.000 (LICENSURE OF CLINICS) AND 105 CMR 150.000 (LICENSURE OF LONG TERM CARE FACILITIES) – RELATING TO INFLUENZA VACCINATION OF PERSONNEL:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 700.000 (IMPLEMENTATION OF THE CONTROLLED SUBSTANCES ACT) – AUTHORIZING ADMINISTRATION OF VACCINES BY DESIGNATED HEALTH CARE PROFESSIONALS:

Alice Bonner, PhD, RN, Director, Bureau of Health Care Safety and Quality, accompanied by Deputy General Counsels Attorney Lisa Snellings and Howard Saxner, presented the regulations relating to influenza vaccination of personnel, and in addition, regulations authorizing administration of vaccines by designated health care professionals to the Council.

Dr. Bonner noted in part, “...As the Commissioner noted, you saw these regulations previously at the Public Health Council of August 12, 2009 meeting and approved emergency promulgation of those amendments...The goal is to make seasonal and novel or pandemic influenza vaccination readily available to all personnel, so that we can

increase vaccination rates, reduce the incidence of illness among health care workers, reduce transmission, protect patients and maintain the infrastructure needed to care for patients.”

Staff’s memorandum dated November 18, 2009 to the Council noted further, “On September 9, 2009, the Council approved a revised version of the amendments to 105 CMR 700.000 in order to include medical students and nursing students in the group of potential vaccinators. The emergency regulations were filed and became effective on September 14, 2009 and currently are in effect. A Commissioner’s Order and accompanying guidelines implementing the emergency regulations were issued by the Department on September 14, 2009.”

Dr. Bonner noted that public hearings had been held on October 9 and November 6, 2009, in which six parties submitted testimony. Dr. Bonner briefed the Council on the public comments. A summary of the public comments and staff’s response are attached to staff’s memorandum to the Council, dated November 18, 2009, as Attachment C. She said further in part, “...As a result of comments made by The Massachusetts Hospital Association (MHA) the Department made the following two changes to the final regulations (1) clarified the definition of employee to more clearly specify the categories of individuals covered by the regulation as follows: “Personnel means an individual or individuals employed by or affiliated with a health facility, hospital, clinic or long term care facility, whether directly, by contract with another entity, or as an independent contractor, paid or unpaid, including but not limited to employees, members of the medical staff, contract employees or staff, students, and volunteers who either work at or come to the licensed facility site, whether or not such individual(s) provide direct patient care”. And (2), staff revised the language of 105 CMR 130.325(H) to delete the requirement that documentation of vaccination status or declination be kept in a personnel file and instead requires the facility to maintain the required written documentation in such a manner that it is easily retrievable by the facility. The Department has provided sub-regulatory guidance on the other issues raised by MHA as follows:

- Electronic signatures are acceptable for declination if their use is part of the hospital's standard practice.
- Verbal declinations of vaccine are not acceptable.
- The required term of retention for declination forms will be addressed in guidelines and is not included in the regulations.
- Providers may accept a general statement from a contractor regarding the vaccination status of the contractor's employees, as long as the contractor maintains written documentation of their employees' vaccination status that can be produced upon request.

In regard to 105 CMR 700.000, Dr. Bonner stated in part, "...The goal of these regulations and amendments is to provide the Commissioner with the authority to increase the number of health care professionals who can administer vaccines in the event that we have a flu season where we need to vaccinate a lot of people in a short period of time and we don't have adequate personnel existing. The regulations expand the number of health care professionals who can administer the vaccine for a pandemic, novel or seasonal influenza virus when the Commissioner determines there are insufficient health care professionals available for timely administration. The regulations require a Commissioner's Order to be issued in order to enhance the pool of vaccinators. Additional vaccinators include dentists, paramedics and pharmacists, or medical or nursing students enrolled in an accredited program. Vaccinator training supervision and compliance with protocols are being developed and there has to be an order, a prescription of a practitioner order authorized to prescribe the vaccine. This amendment was addressed at the public hearings of October 9 and November 6th."

Dr. Bonner noted that comments inquired about why Physician Assistant, dental and pharmacy students were not included in the pool of vaccinators. She noted that though this was a good suggestion, no change has been made at this time because staff feels there would be adequate workforce with the way the regulations are currently written. And further medical assistants

are not included because they do not fall under any state licensure certification standards. Staff recommends that a technical correction be made to 105 CMR 700.004 (B) (7) changing as follows "(7) A health care professional duly licensed ~~and~~ or certified by the Department...." This correction is necessary to conform with section 700.004 (B)(7) to section 700.003(H).

Staff's memorandum to the Council, dated November 18, 2009 explains in conclusion, "The emergency regulations as initially adopted by the PHC were effective upon filing with the Secretary of the Commonwealth on September 14, 2009. In response to public comments, staff now requests PHC approval of revisions to the emergency amendments. Following PHC approval, the Department will file the revised amendments with the Secretary of the Commonwealth for publication in the Massachusetts Register. Based on its publication schedule, the revised emergency amendments will be published and therefore have an effective date of December 11, 2009."

Council Member Paul Lanzikos asked staff for a report back on the number of additional personnel that were actually used as a result of the amendments to 105 CMR 700.000 allowing for additional vaccinators. Chair Auerbach noted that some of the local health officers/boards in organizing their H1N1 and seasonal flu clinics are taken advantage of the extra personnel, however, the Department does not presently have a set way of gathering the information but he would look into how they may be able to gather it.

Dr. Alan Woodward made the motion to approve the **Final Promulgation of Amendments to 105 CMR 130.000 (Hospital Licensure), 105 CMR 140.000 (Licensure of Clinics) and 105 CMR 150.000 (Licensure of Long Term Care Facilities) – Relating to Influenza Vaccination of Personnel**. After consideration, upon motion made and duly seconded, it was voted unanimously to approve said regulations as presented with the additional phrase, "directly, by contract with another entity, or as an independent contractor," to 105 CMR

130.325 (A) (1); 105 CMR 140.150 (A) (1); and 105 CMR 150.002 (D)(8) (a) 1..

Dr. Michael Wong made the motion to approve the **Final Promulgation of Amendments to 105 CMR 700.000 (Implementation of the Controlled Substances Act) – Authorizing Administration of Vaccines by Designated Health Care Professionals** as presented. After consideration, upon motion made and duly seconded, it was voted unanimously to approve said regulations with the additional technical change noted above to remove the word “and” from 105 CMR 700.004 (B)(7).

PRESENTATION: “SCHOOL HEALTH EDUCATION AND SEXUAL RISK AMONG YOUTH”

For the record, Council Members Gillick and Rosenthal left the meeting during this presentation at approximately 11:40 a.m.

Mr. Kevin Cranston, Director, Bureau of Infectious Disease Prevention, Response, and Services made introductory remarks. He stated in part, “...In an era of uncertain resource base for our existing prevention and intervention services, it is all the more necessary to employ our existing evidence-based interventions. We are happy to draw your attention again to data that review a multi-year association between receiving sexuality education in school and using age education as a proxy measure for that, as reported by students, in the Youth Risk Behavior Survey, and the association between receiving that education and improved sexual health outcomes. It is a well established association. We are also here to present some disturbing trends around the relative availability of school health education, and our anticipation of the possible effect on those positive outcomes. As we draw your attention to these trends, we also want to acknowledge that, at previous presentations to the Council about the Youth Risk Behavior Survey, you made very specific requests for breakouts by race/ethnicity and other demographics, and those are included in the report, and we are pleased to anticipate the 2009 data, and

we will be happy to return to report on the YRBS for 2009 when that is fully analyzed..."

Dr. Carol Goodenow, Director of Coordinated School Health, Massachusetts Department of Elementary and Secondary Education addressed the Council, "I am going to be going over some data from May of 2008 and some new information. Basically, what do we know currently about the sexual risk behavior of Massachusetts adolescents, specifically public high school students, some data that we have about evidence of what may be associated with lower rates of risk behavior and an overview of what Massachusetts public schools are currently doing with regard to sexuality education and HIV/STD pregnancy prevention. I am drawing on two data sources, the 2007 Youth Risk Behavior Survey, which is a sample of 59 public high schools, representative of the State, and the second data set is the 2008 School Health Profiles. It is a survey developed by the Centers for Disease Control and we send it out to representative samples of middle and high school principals and lead health education teachers."

Dr. Goodenow continued, "...In the last ten years, there have been no statistically significant changes in the sexual risk behavior of Massachusetts adolescents, and a bit of wobbling from one year to the next, but none of those are significant, and this is at a time when there have been significant improvements in a great many areas, substance use, violence behavior has all gone down but sexual risk behavior remains remarkably unchanged. We hoped that condom use was significant and it was for a bit in 2005 but then it dropped back down again....In analyzing data for 2007, in addition to asking about sexual risk behavior, we asked students whether or not they have received HIV/AIDS prevention education in school. Simple yes or no answer....Students who say that they have received HIV/AIDS prevention education in school consistently exhibit lower rates of sexual risk behavior than those who say no; lower rates of intercourse before the age of thirteen, lower rates of four or more lifetime sexual partners, lower rates of any STD diagnosis or any pregnancy. This happens year after

year." Dr. Goodenow noted another question from the YRBS, "Have you ever been taught in school, how to use a condom?" Students that answered yes are significantly more likely to use a condom the last time they had sexual intercourse. They are less likely to have an STD and less likely to report any pregnancy. She noted that The American Journal of Public Health have published recent articles reporting very similar results.

Dr. Goodenow stated further, "What do we know about what goes on in Massachusetts Public Schools with regard to HIV/STD/pregnancy prevention and sexuality education, and shifting to school level data, this is information that we got from middle and high school principals and health teachers. In Massachusetts is delivered through a health education course and once in a while by a school nurse. Massachusetts is a local control state. There are no state requirements for health education. There is a stipulation of lists, of things that should be taught in health education if it occurs, but there is no stipulation that it occurs, and sex education is not in that list. Sexuality education and health education are completely issues of local control in Massachusetts. We have a set of general guidelines approved by the Board of Education that outline what should be covered at different grade levels...They are good guidelines but they are not requirements or regulations."

Dr. Goodenow noted that Health Education is being cut out or reduced in many districts due to the pressure of MCAS budget restraints. In 2002 about 90% of schools had health education but at that time, funding from the Tobacco Tax Funding of 25 million dollars a year, the Health Protection Fund that went to the schools to support health-related programming was put into the state general revenue fund instead...We have seen for the first time in 2007, a significant decrease in self-reporting of receiving AIDS education in school. From the school health profiles, she said, "We learned that in high school, 11% of high schools don't have any sexuality education at all...but the majority is discussing the benefits of abstinence and some include the benefits of condoms and other kinds of contraception. In middles schools,

38% discuss abstinence but do not mention anything about condoms or birth control, and 31% that follow the old Board of Education recommendations that abstinence and condoms/contraception be discussed.

In closing, Dr. Goodenow said, "At this point, we don't really know much about the quality or extent of what is being discussed but the picture of a declining rate of students who say that they have ever received AIDS education in school, is somewhat troubling at this point..."

Mr. Kevin Cranston noted that at a time when "our own available resources are compromised we rely on what is essentially the foundational approach to anticipating and addressing adolescent sexual risk behavior and sexual risk outcomes through where they are mandated to be, which is in middle school and most of high school. If we are not able to maintain that core level of education, it only puts greater pressure on public health resources and medical resources down the road..."

Discussion followed by the Council, please see the verbatim transcript of the proceedings for full discussion. Some of the items mentioned during discussion was a recommendation by Mr. Rafael Rivera that a social norming campaign may be useful in the schools for sexuality education for it has been successful for substance abuse; and Chair Auerbach asked if the data was available broken down by socio-economic indicators. Dr. Goodenow said they had the data but need the resources to get the data analysis done. Mr. Cranston suggested that perhaps DPH could help with the analysis. Chair Auerbach said he recommended that "because they know in the areas that are related to the risk behaviors, there are health care disparities, and some of those disparities may be related to access to health education or other resources in those communities and I think if we had a clearer sense of that, it might give us the ability to maybe focus more attention on action steps that would reduce the disparities." Mr. Paul Lanzikos suggested that Ms. Goodenow's report be given to the legislature and local school committees. It

was noted that Dr. Lauren Smith, Medical Director to the Department of Public Health will be presenting some of this data to the Massachusetts Association of School Committees and the Massachusetts Association of School Superintendents.

NO VOTE/INFORMATION ONLY

FOLLOW-UP ACTION STEPS:

- (1) Have Hospital Patient Advisory Councils look at diversity issues and (2) the PACs membership should be representative of the diversity in the community(Prates Ramos)
- Come-up with actions in next six to twelve months, to honor work of Ob Expert Panel Report by implementation (Auerbach)
- Staff report back to Council with information on how many additional personnel were used to administer the vaccine as a result of the new amendments to 105 CMR 700.000. (Lanzikos to Auerbach)
- Invite Helen Caulton-Harris to perhaps do a presentation on the Springfield experience on sex education in the schools the next time the Department of Elementary and Secondary Surveys are presented. (Auerbach to Caulton-Harris)
- DPH Assist Department of Elementary and Secondary Education to break down their survey data by social economic/diversity factors (Auerbach to Cranston)

The meeting adjourned at 12:00 p.m.

John Auerbach, Chair

LMH