

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF DECEMBER 17, 2009

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

## **PUBLIC HEALTH COUNCIL**

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on December 17, 2009, 9:05 a.m., at the Massachusetts 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, Dr. John Cunningham, Dr. Muriel Gillick, Mr. Paul J. Lanzikos, (arrived at approximately 9:30 a.m.), Ms. Lucilia Prates Ramos (arrived at approximately 9:25 a.m.), Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, and Dr. Alan C. Woodward. Absent members were: Dr. Michèle David, Mr. Denis Leary, Dr. Michael Wong, Dr. Barry Zuckerman and 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 that would be heard as listed on the docket.

### **RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF NOVEMBER 18, 2009:**

Mr. Albert Sherman moved approval of the minutes of November 18, 2009. After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Lanzikos and Ms. Prates Ramos not present to vote] to approve the Record of the Public Health Council Meeting of November 18, 2009 as presented.

### **FINAL REGULATION: Request for Final Promulgation of Amendments to 105 CMR 220.000, Immunization of Students Before Admission to School:**

Dr. Susan Lett, Medical Director, Immunization Program, Division of Epidemiology and Immunization presented the final amendments to 105 CMR 220.000 to the Council. She noted that Dr. Larry Madoff, Division Director, summarized the proposed amendments at the June

Public Health Council meeting. She said in part, "...During discussion at that time, the Public Health Council asked DPH staff to seek input on two key issues, an earlier implementation date, and the possible expansion of requirements to include other recommended vaccines. In the public hearing notice, DPH staff requested testimony specifically in response to the proposed amendments, and we asked about the feasibility of a September 2010 implementation date, as opposed to September 2011, which had been originally proposed at the June meeting. We asked folks for input on other childhood vaccines that the Department should consider mandating. This is the results of the testimony...At the September 9, 2009 Public hearing oral testimony was received by two parties who also submitted their testimony in writing. In total, testimony was received by six organizations (The Charles River College Health Association (CRCHA), College Health Association of Administrators and Nurse Directors (CHAAND), Massachusetts Chapter of the American Academy of Pediatrics (MCAAP), Massachusetts School Nurse Organization (MSNO), Massachusetts Academy of Family Physicians (MAFP) and Boston College Health Services and 18 individuals. Testimony was received from two parties in support of a September 2010 implementation date (one vaccine manufacturers and one college health individual). Twenty parties did not support an implementation date of September 2010 and 19 of these recommended an implementation date of September 2011. No testimony was received in support of expanded immunization requirements, beyond those indicated in the proposed changes." Dr. Lett noted that the main reason that the people cited opposition to the earlier implementation date was they need time to implement the changes in their systems and felt it would be a hardship considering all the H1N1 implementation.

Dr. Lett continued, "...Based on the testimony received on amendments to 105 CMR 220.000, DPH staff changed the implementation date outlined in the amendment to September 1, 2011 and did not include any new vaccine requirements beyond those indicated in the proposed amendments. To address concerns raised by the MCAAP, DPH staff has augmented educational materials for providers which will indicate that Tdap is currently preferred over

Td for the 7<sup>th</sup> grade requirement (11-12 year olds). DPH staff has also developed a notice to providers encouraging the use of Tdap, rather than Td, in this population (7<sup>th</sup> grade), as well as in all situations where use of Tdap, rather than Td, is indicated. This notice will be sent to providers across the Commonwealth, including Emergency Departments (EDs). It was noted that individuals receiving emergency treatment which warrants a dose of tetanus containing vaccine may be receiving Td when Tdap would be preferred.”

The final regulations incorporate the following changes from the current regulation:

1. Definitions
  - a. Certificate of Immunization: Language has been revised to also allow nurse practitioners and physician assistants, in addition to physicians, to sign and date the form or letter.
  - b. Certificate of Immunization: Language has been added to clarify that the certificate of immunization must specify the month and year of administration and the type/name of the vaccine(s) administered to the student.
  - c. Preschool: To reflect a name change, the Office of Child Care Services has been updated to the Department of Early Education and Care.
2. Kindergarten Through 12<sup>th</sup> Grade
  - a. Tdap/Td: Beginning September 1, 2011, a single dose of Tdap or Td will be required for students who are seven or more years of age and require additional immunizations to satisfy the DTaP/DTP/DT requirement. Tdap and Td should be given according to the age-appropriate schedule. A single dose of Tdap vaccine will also be required for students attending 7<sup>th</sup> grade if it has been more than five years since the last dose of DTaP, DT or TD. If it has been less than five years since a student

received his/her last dose of DTaP, DT or Td, Tdap will not be required, but may be administered according to the judgment of a physician, nurse practitioner or physician assistant. Beginning on September 1, 2017, the requirement of a single dose of Tdap will apply to all students attending grades 7 through 12.

- b. MMR: Beginning September 1, 2011, two doses of live measles, mumps, and rubella vaccine will be required for students attending kindergarten and 7<sup>th</sup> grade (these doses must be given at least four weeks apart beginning at or after 12 months of age). Beginning on September 1, 2017, this requirement will apply to all students attending grades K through 12.
- c. Varicella: Beginning September 1, 2011, two doses of varicella vaccine will be required for students attending kindergarten and 7<sup>th</sup> grade (these doses must be given at least four weeks apart beginning at or after 12 months of age). Beginning on September 1, 2017, this requirement will apply to all students attending grades K through 12.

### 3. College

- a. MMR: Beginning September 1, 2011, two doses of live measles, mumps and rubella vaccine will be required for all full-time freshmen, and full-time and part-time undergraduate and graduate students in a health science program who may be in contact with patients (these doses must be given at least four weeks apart beginning at or after 12 months of age). Beginning on September 1, 2015, this requirement will apply to all postsecondary students.
- b. Tdap: Beginning on September 1, 2011, a single dose of Tdap will be required for full-time freshmen, and full- and part-time undergraduate and graduate students in a health science program who may be in contact with

patients (these doses must be given at least four weeks apart beginning at or after 12 months of age). Beginning on September 1, 2015, this requirement will apply to all postsecondary students.

- c. Varicella: Beginning on September 1, 2011, two doses of varicella vaccine will be required for full-time freshmen, and all full- and part-time undergraduate and graduate students in a health science program who may be in contact with patients (these two doses must be given at least four weeks apart beginning at or after 12 months of age). Beginning on September 1, 2015, this requirement shall apply to all postsecondary students.
- d. Exceptions: New exceptions added to clarify that the requirements of 105 CMR 220.600 shall not apply where:
  - i. in the case of measles, mumps, and rubella, the student presents laboratory evidence of immunity. Those born in the United States before 1957 can be considered immune to measles, mumps and rubella, with the exception of all full- and part-time students in a health science program who may be in contact with patients.
  - ii. in the case of varicella, the student presents laboratory evidence of immunity; or a statement signed by a physician, nurse practitioner, physician assistant, or designee that the student has a reliable history of chickenpox disease; a self-reported history of disease verified by a physician, nurse practitioner or physician assistant; or was born in the United States before 1980, with the exception of all full- and part-time students in a health science program who may be in contact with patients.

A brief discussion followed, please see verbatim transcript for full discussion. Dr. Lett noted that her unit was developing a web-based immunization registry with federal stimulus funds which would allow

providers to enter the immunization data and schools will be able view it to see that a student has been immunized. Note: for the record, Council Member Lucilia Prates Ramos arrived during the discussion on the regulations at approximately 9:25 a.m.

Mr. Albert Sherman moved approval of the regulations. After consideration, upon motion made and duly seconded, it was voted unanimously [Ms. Prates Ramos abstained; and Mr. Paul Lanzikos not present to vote] to approve the **Final Promulgation of Amendments to 105 CMR 220.000, Immunization of Students Before Admission to School Regulation** as noted above and presented by staff. Staff's memorandum to the Council, dated December 17, 2009 and the approved regulations are attached and made a part of this record as **Exhibit No. 14,940**.

**COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED PROJECT APPLICATION NO. 6-3B39 OF NORTH SHORE MEDICAL CENTER, INC.:**

**Note:** For the record, Council Member Paul Lanzikos arrived at the meeting here, at the start of Ms. Gorga's presentation on North Shore Medical Center at approximately 9:30 a.m.

Ms. Joan Gorga, Director, Determination of Need Program, presented the North Shore Medical Center (NSMC) to the Council. She noted at the meeting and in her memorandum to the Council, dated December 17, 2009, "...The applicant is requesting a change to the approved GSF for renovation which consists of two parts (1) due to a minor inaccuracy in the GSF requested in the approved Project for the Davenport Building on the 8<sup>th</sup> floor, the applicant is requesting an additional 213 GSF for a total of 1,139 GSF and (2) on the 5<sup>th</sup> floor of the Davenport Building the applicant would like to use available space for an intermediate care unit. Included in the remaining renovation costs are asbestos removal, the replacement of windows, the need for additional HVAC work and the cost differences between estimates used in the original MCE and the actually bids received for the work. The holder has stated that the primary purpose of the renovations was to address the need for improved medical/surgical

and intensive care facilities and to provide for increased inpatient capability. The intermediate care unit will allow the holder to return to service the 15 out of service beds and the licensed medical/surgical bed capacity will then be 171 beds in service." Ms. Gorga noted that staff recommends additional Community Initiatives of \$524,241 (October 2009 dollars)."

In closing, Ms. Gorga said in part, "Staff has considered whether the requested changes in the GSF and maximum capital expenditure (MCE) were reasonable in light of past decisions and were beyond the holder's control. Consistent with Council's past decisions, staff finds that the increase in the MCE could not have been reasonably foreseen due to the need for evaluation and a decision-making process on the optimal use of the space."

A brief discussion followed, Dr. Muriel Gillick asked for clarification on the level of care provided at the intermediate care unit. Mr. Robert Norton, President and CEO of NSMC informed the Council "The major difference between our acute units and the Intensive care units is in staffing levels, not so much the actual physical facility. We find a series of our patients, are in a mid-stage of their clinical course, in which they don't require intensive care but require more attention than we can provide on our routine care units. This is to prevent unnecessary use of intensive care beds." He noted that other institutions are doing this as well.

Council Member Albert Sherman moved approval of the amendment. After consideration upon motion made and duly seconded it was voted unanimously to approve the amendment Request by **Previously Approved Project No. 6-3B39 of North Shore Medical Center Inc.** for significant change to increase the project's maximum capital expenditure to \$32,529,821 (October 2009 dollars) and gross square footage as noted below:

Construction Costs:

Construction Contract (including bonding contract)	\$26,435,452
Fixed Equipment not in Contract	2,518,195

Architectural & Engineering Costs	2,318,443
Pre-Filing Planning & Development	26,608
Post-Filing Planning & Development	26,608
Other: Asbestos Removal	213,900
Major Movable Equipment	<u>688,124</u>
Total Construction Costs	\$ 32,227,330
Financing Costs	
Costs of Securing Financing	302,491
Total Financing Costs	<u>302,491</u>
Maximum Capital Expenditure	\$ 32,529,821

This amendment is subject to the following conditions:

1. The approved GSF for this project shall be \$55,847 GSF for renovation.
2. North Shore Medical Center, Inc. shall provide an additional \$524,241 in community initiatives based on an increase of \$10,484,815 (October 2009 dollars) in the Maximum Capital Expenditure as described in the request for significant change. The community initiatives will fund programs that address local and regional health priorities in areas of need as assessed by the Office of Healthy Communities. Specific initiatives will be developed collaboratively by the Office of Healthy Communities and North Shore Medical Center, Inc. (within a reasonable time frame not to exceed three months) and may include mini grants, community capacity building, training and evaluation.
3. All other conditions attached to the original and amended approval of this project will remain in effect.

**CATEGORY 1 APPLICATION: PROJECT APPLICATION NO. 4-3B80 OF SOUTH SHORE HOSPITAL, INC.:**

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the South Shore Hospital (SSH) application to the Council. He noted in the staff summary and in his presentation the following information: "...The proposed DoN project involves new

construction of a two-story addition to the existing four-story Emerson Building on South Shore's main campus in South Weymouth to increase the Hospital's adult medical/surgical capacity. Each of the two new floors will house 25 new medical/surgical beds configured in private rooms. In addition, the two existing inpatient units in the Emerson Building will be expanded in a new attached bay and will include 5 additional medical/surgical beds in each unit. There will also be some renovation of the Emerson Building, which will include a new exterior skin for the existing four floors as well as horizontal tie-in points on each floor. When the project is completed in January 2011, it will add 60 new medical/surgical beds and the total number of licensed beds at South Shore Hospital will increase to 445 beds."

The staff summary notes and during the discussion with the Council, the applicant noted that the additional medical/surgical beds are to accommodate the Hospital's steadily increasing inpatient volume over the past five fiscal years. Please see the verbatim transcript for full discussion. "South Shore's requested major capital expenditure (MCE) is \$54,030,000 (July 2009 dollars), which exceeded the capital cost threshold of \$15,327,687 (October 2008 dollars) in place at the time of filing. The applicant meets the requirements of the DoN Review factors including health planning, operational objectives, standards compliance, reasonableness of expenditures and costs, financial feasibility, relative merit, environmental impact, and community health service initiatives. Within these review factors is the requirement that the applicant demonstrate that the project will not duplicate existing services. The applicant illustrated that its overall utilization of most of its inpatient and outpatient services has increased steadily for fiscal years 2004 through 2008; inpatient occupancy grew by 12.5% and patients days by 10.8% during the period, while patient discharges and emergency visits grew at a 6% rate. South Shore further reported that the significant growth experienced in inpatient admissions and discharges in recent years, has severely taxed its existing adult inpatient medical/surgical capacity. To address this growth, South Shore has introduced a number of measures to manage patient flow and create capacity. These include adding staff to open 100% of the existing medical/surgical capacity, as well as increased hospitalist staffing. As

a result, average inpatient lengths of stay have been reduced to just over four days and the hospital has focused on discharging patients prior to noontime to create capacity at the busiest times of the day. However, South Shore reports that these measures have not been able to remedy the underlying problem of insufficient inpatient capacity to meet the current and expected demand. Staff notes that the Hospital's adult medical/surgical occupancy rate exceeded 85% in FY 2008 and is above 95% through the first seven months of FY 2009. These rates do not include the spike in demand due to seasonal variation that the Hospital experiences in February and March of each year. Further, South Shore reports that a consequence of the increased inpatient demand without a corresponding increase in bed capacity is the 'boarding' of patients in the emergency department and post anesthesia care unit awaiting the availability of beds. South Shore reports that this has resulted in longer wait times for patients in the emergency department (ED) as treatment bays in the ED are occupied by patients who might ordinarily be immediately transferred to an available inpatient bed when admitted."

Mr. Page note in conclusion, "...Staff finds that the proposed new construction and renovation at South Shore to add 60 adult medical/surgical beds is necessary to accommodate the Hospital's current substantially increased inpatient service volume, as well as its projected volume....As the data shows, South Shore is now the inpatient provider for nearly a third of the population in its service area for adult medical/surgical services. More significantly, the Hospital is currently above 95% occupancy with regard to the average daily census in its adult medical/surgical bed units (for first seven months of 2009), and this has created operational problems related to the normal turnover in daily discharges and bed availability, which have also been exacerbated by annual seasonal variation in admissions. Given these reasons, as well as the expected population growth in the Hospital's service area, especially among the older age cohorts, staff recommends approval of the proposed new medical/surgical beds."

Mr. Page stated further that “staff asked the applicant to revise the original MCE and operating costs to reflect the 20% equity contribution, as well as show renovation costs in the MCE that were miscategorized as new construction costs in the application, and reflects changes in the incremental operating costs based on the revised MCE of \$52,030,000, which is \$2,000,000 less than the original. He further noted that the new construction cost of \$578.98/GSF is less than the Marshall & Swift allowable cost/GSF for new construction of \$594.43/GSF and therefore staff finds it reasonable. The requested renovation costs of \$92.76/GSF are less than the DoN standard of 60% of the Marshall & Swift allowable cost/GSF for new construction of \$356.66/GSF and therefore recommend approval of the renovation costs.”

It was noted that the applicant agreed to provide a total of \$2,600,000 (July 2009 dollars) over five years to fund community health service initiatives directed to primary and preventive health programs and the promotion of community-level policy change to benefit vulnerable populations with a focus on at least one of the following Department statewide priorities: (1) eliminating racial and ethnic health disparities and their social determinants; (2) promoting wellness in the home, workplace, school and community, and (3) preventing and managing chronic disease. Funding by South Shore for these initiatives shall begin in the twelfth month following the date of DoN approval by the Public Health Council.

During discussion, Council Member José Rafael Rivera suggested that the following phrase “and existing community data” be added to the Interpreter Services condition No. 8, on Attachment 3 of the staff summary. Mr. Richard Aubut, President/CEO of South Shore Hospital agreed to this change to the condition. Chair Auerbach asked the applicant what the reason is for the patient occupancy rates to have raised from the 70s to the 90s in just a few years. Mr. Aubut replied in part, “...Our goal has been to increase the number of programs we provide to our community and to allow patients to get care close to home. We added a brand new Cardiovascular Center about five years ago, so instead of traveling to Boston, they come to South Shore Hospital for cardiac care. The number one reason, beyond

maternity for admission to SSH is for cardiac events. Over the last year, we added the only Level II American College of Surgeons Trauma Program south of Boston...Our ambulance traffic has increased from about 45 ambulances a day to on average, more than 65. That added additional volume to the hospital." He noted further that they are working on a Cancer Center and orthopedics. "We have increased our marketshare in elective and emergency orthopedic surgery, especially secondary, on the emergency side, due to the Trauma Center. All those programs cumulatively have allowed us to continue to grow volume on the Adult Medical/Surgical Division. In addition, the population is aging, and patients are seeking to receive care close to home, avoid traveling into Boston and we have created the right clinical platform that patients are responding to. It is multi-factorial and has taken time to build, but we are responding to that growth in program development."

In response to questions by Dr. Alan Woodward, Mr. Aubut noted that they increased their discharges before noon from 20% to about 40% and added more case management on weekends, providing good discharge planning on weekends and finding the right placement like home care. They have their own home care division and are working with post-acute providers to have weekends discharges. Dr. Woodward applauded South Shore Hospital's efforts, particularly discharging patients before noon, a major efficiency measure, recommended by The "Statewide Boarding and Patient Flow Task Force", which he co-chairs with Commissioner Auerbach.

Council Member Sherman moved approval of the staff recommendation on South Shore Hospital. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-3B80 of South Shore Hospital**, based on staff findings, with a revised maximum capital expenditure of \$52,030,000 (July 2009 dollars) and revised first year incremental operating costs of \$16,302,000 (July 2009 dollars). This approval provides for new construction of a two-story addition to the existing four-story Emerson Building on South Shore's main campus in South Weymouth to increase the Hospital's adult medical/surgical capacity. Each of the two new floors will house 25 new

medical/surgical beds configured in private rooms. The two existing inpatient units in the Emerson Building will be expanded in a new attached bay and will include 5 additional medical/surgical beds in each unit. There will also be some renovation of the Emerson Building, which will include a new exterior skin for the existing four floors as well as horizontal tie-in points on each floor. Once completed, the project will add a total of 60 new medical/surgical beds at the Hospital. This Determination is subject to conditions, please see the staff summary and its attachments for the conditions which is attached and made a part of this record as **Exhibit No. 14,941.**

**PROJECT APPLICATION No. 4-3B81 OF TUFTS MEDICAL CENTER, INC.:**

Ms. Joan Gorga, Director, Determination of Need Program, made introductory remarks regarding ECMO. She noted, "ECMO or Extracorporeal Membrane Oxygenation was added to the list of innovative services and new technologies in 1989. We [the Council] approved three applications: Children's Hospital, Mass. General Hospital, and New England Medical Center for ECMO. NEMC [now Tufts Medical Center, Inc.] did not implement their application and they are in today, asking for an ECMO unit. In 1992, when we reviewed the applications, it was clear to us that this was an institutionally-based need and we treated it as such. We also set a rate for a cost for each patient treated by ECMO and since these costs were the same across all three programs, we felt that it was immaterial that there were three programs because the cost would be the same and the labor intensity, which is probably the reason this was put on the list, was not as important because that labor would be doing other things. Those respiratory therapists would be doing other things in the hospital between ECMO cases. So, therefore we treated it as an institutional need, not a statewide need."

Ms. Gorga said further, "It is interesting that ELSO, the national group has reduced the minimum volume required for maintenance of an ECMO unit. When we did it back in 1992, it was twelve. It is now seven." Ms. Gorga noted that ECMO "has been shown to be effective

in the treatment of H1N1 in the U.K. and in the Southern Hemisphere, where they just experienced their winter and for that reason, we fast-tracked this by a couple of months in order to get this before you before the heavy winter flu season.”

Mr. Bernard Plovnick, Consulting Analyst, Determination of Need Program, presented the Tufts Medical Center’s request for an Extracorporeal Membrane Oxygenation Service (ECMO) to the Council. He noted in part, “ECMO is an extremely low volume, high risk, costly, labor intensive procedure, most often administered as a last resort to selective patients, mostly pediatric, with failing respiratory systems, and with a fifty percent or greater, risk of mortality. The ECMO machine functions as a temporary replacement for a critically ill patient’s lungs and heart, continuously pumping blood from the vein through a membrane oxygenator that imitates the gas exchange process of the lungs, and back through one of the patient’s arteries. ECMO is administered in the ICU at the patient bedside, and requires a constant one-to-one or one-to-two staff to patient ratio for a period of up to two to three weeks. Tufts expects to provide seven ECMO procedures per year, one more than the minimum standard recommended for ECMO Centers by the Extracorporeal Life Support Organization, an international consortium of health care professionals and scientists, ELSO for short....”

Mr. Plovnick noted further that staff’s finding of need was based upon the reasonableness of evidence submitted by the applicant in support of its projected volume and that it was unlikely that establishment of the proposed ECMO service would have an adverse impact upon existing ECMO services in the Boston area. This request requires no construction and has an estimated capital expenditure of \$184,000 (August 2009 dollars). The applicant has agreed to contribute \$75,000 to fund community health initiatives in Boston neighborhoods (\$15,000 annually for five years).

In closing, Mr. Plovnick stated, “...I would like to offer an observation. ...I asked myself the question, whether the Department needs to continue to regulate this particular service because it seems as though hospitals, very few hospitals actually could qualify or be

interested in providing this service, and it doesn't appear to be a service that would be over utilized. It is one done of a last resort to the patients who meet certain criteria."

Discussion followed by the Council, please see the verbatim transcript of the proceedings for full discussion. Dr. Gillick asked about the mortality rate of the procedure when compared to treatment with conventional ventilator therapy. Dr. Rashed Durgham, Chief of Pediatric Critical Care, Floating Hospital for Children at Tufts Medical Center and Medical Director of ECMO replied in part that there is over a 70% respiratory illness survival rate usually without any lung disease for the patient. It was noted that without ECMO, Tufts has to transfer critically ill children to other facilities.

Council Member José Rafael Rivera asked that patient and existing community data be included in the interpreter condition #8. Chair Auerbach asked DoN staff to include Mr. Rivera's language for condition #8 in all future interpreter conditions. Ms. Gorga said she would speak to the Office of Health Equity about it. During discussion it was noted that two machines are required for an ECMO service, one for back-up and there are about six machines in the state currently. In response to Mr. Lanzikos' follow-up question regarding Mr. Plovnick's suggestion that the ECMO services probably don't need to be regulated Ms. Gorga responded that would require a change to the DoN Bulletin of Innovative Services and New Technology, the list of DoN regulated services which, is usually updated in the fall. Any proposed changes would be brought to a public hearing and a public comment period is held and the new proposed list is required to be approved by the Public Health Council. Ms. Gorga suggested that staff discuss it and then bring back a recommendation to the Council.

Council Member Albert Sherman moved approval of the ECMO application. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-3B81 of Tufts Medical Center, Inc.** for establishment of an Extracorporeal Membrane Oxygenation (ECMO) service with a maximum capital expenditure of \$184,000 (August

2009 dollars) and estimated first year incremental operating costs of \$340,057 (August 2009 dollars). This Determination is subject to conditions, please see the staff summary and its attachments for the conditions which is attached and made a part of this record as **Exhibit No. 14,942.**

**PRESENTATION: "H1N1 UPDATE", BY DR. LAUREN SMITH, MEDICAL DIRECTOR, DEPARTMENT OF PUBLIC HEALTH:**

Dr. Lauren Smith, Medical Director, Department of Public Health presented an update to the Council on the Department's distribution of the H1N1 vaccine.

Dr. Smith noted in part that we are now experiencing a lull in the number of H1N1 cases occurring and she said, "there is no way of knowing whether or not we will see a third wave of illness due to H1N1. We do know that we will see flu due to regular seasonal flu starting shortly." She noted that the Department has received over two million doses of H1N1 vaccine as of December 15<sup>th</sup> and expects to receive 3.4 million doses by the middle of January. It was noted that people should still receive the H1N1 and seasonal flu shots because we have a long flu season here which, runs through April. Dr. Smith emphasized that the live attenuated vaccine is safe, all the vaccine is safe. Dr. Woodward mentioned that the H1N1 flu epidemic of 1917/1918 went around several times before it became highly virulent.

**NO VOTE/INFORMATION ONLY**

**PRESENTATION: "HEALTH PROFILE OF MASSACHUSETTS ADULTS BY DISABILITY STATUS", by Anita Albright, Director, Healthy Aging and Disability Unit, and Monika Mitra, PhD., Senior Epidemiologist, Healthy Aging and Disability Unit**

Chair Auerbach, Commissioner of the Department of Public Health made introductory remarks. He stated in part, "that the issue of health equity has been a priority of the Department of Public Health with particular emphasis on the issue of racial and ethnic disparities,

based upon data which indicated that inequity and a greater burden of illness and premature death exists among People of Color within the State and what we wanted to do was to determine whether there were other populations within Massachusetts who also had such a disproportionate burden of illness and premature death and you will be hearing today about the outstanding work done within this unit which demonstrates that adulthood disabilities in fact do bear a much greater burden of illness, unrelated to their underlying primary disability itself but rather other illnesses that become associated with that disability...This is important work for us to understand. It is important for us to recognize that we, in fact, have many populations in the State that have double and triple disproportionate impact of a variety of different conditions in their lives, which make them at greater risk..."

Ms. Anita Albright, Director, Healthy Aging and Disability Unit, DPH gave a brief overview of the unit, "This unit, the Health and Disability Unit, has been funded by the CDC since 1989, to look at building state capacity to better address the needs of people, the health care needs of people with disabilities....At the national level, both the surveillance and some of the policies and systems changes that we have been able to facilitate, have gotten national recognition. We are very pleased to be able to do this work."

Dr. Monika Mitra, Senior Epidemiologist, Healthy Aging and Disability Unit made a Powerpoint presentation. Some excerpts from her presentation follow below; please see the verbatim transcript for the full presentation.

"The Commonwealth of Massachusetts, as well as health care entities across the State have made great strides in recognizing health disparities among people from different racial and ethnic groups and are working together to eliminate them and just as the eradication of racial and ethnic minorities have been made a priority, we also feel like similar efforts need to be made for people with disabilities...and while there is a lot to do, we are really in the forefront, nationally, and especially, particularly in terms of integrating disability into all of our Public Health efforts."

Dr. Mitra's presentation highlighted the health disparities that are faced by persons with disabilities in the Commonwealth, in several areas of public health: health care access, tobacco use, chronic conditions, sexual violence, and overall health status. She said, "We believe that these data can be useful in informing a public health agenda for persons with disabilities...It is critical that people with disabilities are included in every aspect of public health efforts."

This study was done with data from the Massachusetts BRFSS, the Behavioral Risk Factor Surveillance System with aggregated data of three years. Four recommended CDC screener questions have been asked since 1998: (1) Are you limited in anyway in activities because of your impairment or health problem? (2) Do you use any special equipment, or help from others to get around? (3) Do you have trouble learning, remembering, or concentrating because of an impairment or health problem? (4) Do you have a physical, mental, emotional or communication-related disability of any kind? If one answers yes, the length of the disabling condition is asked, it has to be for at least one year, in order to exclude people with temporary disabilities. She noted that there is not one consistent measure of disability – it varies from state to state and on the national level. Dr. Mitra noted further that the disability research field as well as advocacy is concentrated on functioning because two people can have the same disease causing disability but have very different levels of functioning and people could have a different diagnosis but the same functioning. Some of the statistics from her presentation follow:

- About 21% of adults report having a disability (about 1 million adults) and 6% reported needing help with routine or personal care activities.
- Disability is strongly related to age. Fifteen percent of persons 18 to 44 reported disability compared to 32% of those over 65 years of age.

- There is no difference in the prevalence of disability by sex. However, 4% of males report needing help compared to 8% of females report needing help.
- Persons in the other race/ethnicity group, which includes Asians, were less likely to report having a disability. No statistically significant differences were found in the prevalence of disability among other groups. However, people of Hispanic ethnicity are more likely to be in the needs help group.
- Adults with disabilities were less likely to have access to oral health care, 67% compared to 81% of adults without disabilities and more likely to have lost six or more teeth due to gum disease or tooth decay, than people without disabilities.
- Persons with disabilities were 1.6 times more likely to smoke compared to those without disabilities. Sixty-one percent of smokers with disabilities tried to make a quit attempt in the past year, compared to 57% of those without disabilities. Forty-seven percent of those with disabilities used the MassHealth Tobacco Cessation benefit.
- People with disabilities are less likely to engage in physical activity.
- One in three adults with disabilities are obese compared to 19% of adults without disabilities.
- Adults with disabilities are almost three times as likely to report having a chronic condition, compared to those without disabilities. Twenty-seven percent of adults with disabilities report having asthma compared to 7% of those without disabilities. One in four adults with disabilities who need help report having diabetes, compared to four percent of people without disabilities.
- Seventeen percent of men with disabilities report lifetime sexual violence, compared to 4% of men without disabilities. One in three women with disabilities, who report needing help, report lifetime

sexual violence, compared to 13% of women without disabilities.

- Thirty-five percent of persons with disabilities report fair to poor health compared to 6% of those without disabilities.
- Twelve percent of adults with disabilities report contemplated suicide in the last 12 months, compared to 2% of adults without disabilities.

Dr. Mitra noted that similar analysis done for middle and high school youth in Massachusetts found similar and significant differences in risk behaviors, violence, bullying, mental health status, and other health indicators between youth with and without disabilities. The most disturbing and staggering finds for youth is in the domain of violence, bullying, family violence, mental and suicide ideation.

In conclusion, Dr. Mitra stated, "Overall, these data indicate that it is critical to include people with disabilities in all Public Health programs. The access to health care and health promotion services should be increased and also monitored. In addition, standard disability indicators should be included in all administrative survey data to monitor the progress we are making for this vulnerable population..."

A brief discussion followed, please see verbatim transcript for full discussion. Council Member Paul Lanzikos noted that training takes money which is a good investment because it pays off in the long run with decreased ER visits, inpatient hospital stays and decreased use of professional health services. Council Member Helen Caulton-Harris asked if the data was available geographically for city or town. Dr. Mitra noted that the BRFSS is a random sampling by telephone and folks indicate their city or town so there is a possibility of doing a regional analysis and by city/town. In terms of doing sub-state analysis for health disparities, she will look into it but there would have to be enough numbers for it to be statistically significant information.

Note: Council Member Albert Sherman left the meeting during Ms. Mitra's presentation and Ms. Meredith Rosenthal followed, leaving at approximately 10:50 a.m.

## **NO VOTE/INFORMATION ONLY**

### **FOLLOW-UP ACTION STEPS:**

- Have Office of Health Equity add Mr. Rivera's added phrase to the DoN interpreter condition #8 – add the words, "and existing community data" to that condition (Auerbach to Gorga)
- ECMO – does it need to remain on the DoN Bulletin of Innovative Services and New Technologies List (needs staff discussion)
- Maybe do some analysis with the hospitals on their need for procedures or technologies that would have been useful to them in their treatment of H1N1 (Auerbach)
- Possibility of doing a regional analysis and by city/town for the disability data. In terms of doing sub-state analysis for health disparities staff will look into it. (Caulton-Harris asked Dr. Mitra for data)

Chair Auerbach said in part, "The policy implications of the report, as we have learned with our work around racial and ethnic disparities, sometimes when we design programs that are general population programs across the spectrum of many different things, cancer, heart disease, diabetes, etc. The general population campaigns may reach the majority populations, and completely exclude reaching certain sub-populations....One of the lessons of the work that you have done is that, when we look at a particular categorical illness, let's say diabetes, if we are seeing a much higher rate of diabetes among people with disabilities, then our campaigns really need to be customized for that population of people with disabilities, and what it means for them in terms of

either preventing or controlling their diabetes in order to be most effective, and that, you might guess, takes some rethinking of the way that we do our work, and deciding that maybe we don't have to reach everyone. Maybe we will try to reach the particular targeted populations that are at greatest risk and we are, increasingly I think, coming to this awareness with people with disabilities."

Mr. Lanzikos suggested that in terms of reaching people with disabilities, focus should include those with cognitively challenged capacity. Ms. Prates Ramos noted that cultural competency wasn't mentioned in the presentation and further noted the lack of access for people with disabilities in oral health due to offices not having the equipment to accommodate those with disabilities. Mr. Albright agreed and it said it was a "very serious issue" and elaborated on the fact that "we are better at getting folks into buildings but once in their, people with disabilities cannot get on an exam table, into a dental hygienist chair, cannot be weighed which can affect their medications...It is an area, certainly within our state and nationally, which needs to have more focus paid to it."

## **NO VOTE/INFORMATION ONLY**

The meeting adjourned at approximately 11:00 a.m.

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John Auerbach, Chair

LMH