

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF MARCH 10, 2010

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

**THE PUBLIC HEALTH COUNCIL OF
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston, MA**

REVISED Docket: Wednesday, March 10, 2010, 9:00 AM

1. ROUTINE ITEMS: No Floor Discussion

- a. Compliance with Massachusetts General Laws, Chapter 30A, §11A ½ **(No Vote)**
- b. Record of the Public Health Council Meeting of February 10, 2010 **(Approved)**

2. REGULATIONS: No Floor Discussion

- a. Request for Final Promulgation of Amendments to 105 CMR 130.000 (Hospital Licensure) Relating to Accreditation and Medical Records **(Approved)**
- b. Request for Emergency Promulgation of Amendments to 105 CMR 100.000 of the Determination of Need Regulations (Regarding Nursing Home Projects) **(Approved)**

3. PRESENTATION: No Vote/Information Only

**“Medical Orders for Life-Sustaining Treatment (MOLST)
Demonstration Project”**

4. PRESENTATION: No Vote/Information Only

“Update on Limited Services Clinics in Massachusetts”

5. PRESENTATION: No Vote/Information Only

“Final Summary of H1N1 Activities”

The Commissioner and the Public Health Council are defined by law as constituting the Department of Public Health. The Council has one regular meeting per month. These meetings are open to public attendance except when the Council meets in Executive Session. The Council’s meetings are not hearings, nor do members of the public have a right to speak or address the Council. The docket will indicate whether or not floor discussions are anticipated. For purposes of fairness since the regular meeting is not a hearing and is not advertised as such, presentations from the floor may require delaying a decision until a subsequent meeting.

Public Health Council

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on March 10, 2010, 9:10 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: John Auerbach, Commissioner, Department of Public Health, Ms. Helen Caulton-Harris, Dr. John Cunningham, Dr. Michèle David, Dr. Muriel R. Gillick, Mr. Paul J. Lanzikos, Mr. Denis Leary, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith B. Rosenthal, Mr. Albert Sherman, Dr. Michael Wong, Dr. Alan C. Woodward; and Dr. Barry S. Zuckerman was absent. There is one vacancy. Also in attendance was Attorney Donna Levin, 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 order of docket items to be heard and that former Public Health Council Member Harold Cox is receiving the Massachusetts Public Health Association's highest award this year, the Revere Award. Last year current Public Health Council Member Helen Caulton-Harris received this prestigious award. All PHC Members are invited to attend.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF FEBRUARY 10, 2010:

Mr. Albert Sherman moved approval of the minutes of February 10, 2010. After consideration upon motion made and duly seconded, it was voted unanimously to approve the **minutes of the Meeting of February 10, 2010** as presented.

FINAL REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) RELATING TO ACCREDITATION AND MEDICAL RECORDS:

Ms. Elizabeth Daake, Director of Policy Development and Planning, Bureau of Health Care Safety and Quality, accompanied by Attorney Lisa Snellings, Deputy General Counsel, presented the Hospital Licensure Regulations to the Council for approval. Ms. Daake said, "At the January 13, 2010 Public Health Council meeting, staff briefed the Council on the two proposed amendments to the Hospital Licensure Regulations. One was additional hospital accrediting organizations approved by CMS and the Commissioner being allowed to work with hospitals in the state for deemed status for Medicare, and a correction to the medical records retention, simply the addition of a phrase." Ms. Daake further noted that a public hearing had been held on February 12, 2010 with public comments closing on February 19th and that one comment was received in support of the proposed amendments by the Massachusetts Hospital Association. Ms. Daake asked that the Council approve the proposed amendments without revision.

There was no Council discussion. Mr. Albert Sherman moved for approval of the regulations. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) RELATING TO ACCREDITATION AND MEDICAL RECORDS** and that a copy of the approved regulations be attached and made a part of this record as **Exhibit No. 14,944**.

REQUEST FOR EMERGENCY PROMULGATION OF AMENDMENTS TO 105 CMR 100.000 OF THE DETERMINATION OF NEED REGULATIONS (REGARDING NURSING HOME PROJECTS:

Chair Auerbach noted for the record that the regulations are being heard as "Emergency" regulations simply because we couldn't get them on the schedule in time to go through the normal regulatory process.

Ms. Joan Gorga, Director, Determination of Need Program, presented the proposed emergency amendment to 105 CMR 100.000,

accompanied by Dr. Alice Bonner, Director, Bureau of Health Care Safety and Quality. Ms. Gorga said in part, "...I am going to be talking about the statewide Long Term Care Bed Need for the year 2015. We are here before you today to request approval of the promulgation of emergency amendments to move the filing date for applications for construction of new nursing home capacity to May 1, 2015. As it stands now, it expires on May 1, 2010. We have prepared some slides which show the trends and discuss the table for statewide need, which was included in your packet. The long-term care bed need moratorium has been extended six times, and here are the dates. The last time new nursing home beds were approved was prior to 1991. DoN's for new beds approved before 1991 have either been implemented or the DoN has expired so there are no beds in the pipeline..."

Some of Ms. Gorga's slides showed (1) statewide need for nursing home beds for the year 2015 and the population rates used to project the need, (2) The utilization rate (nursing home residents in each of three age groups per thousand population and (3) bed need calculated based on a 95% occupancy, the present rate is 89%. Ms. Gorga noted, "...The active bed supply plus the beds out of service (closed but not de-licensed and can be returned to service by the licensee) minus the bed need of 39,639 equals a surplus of 10,772 beds. The last time staff calculated this; there was a surplus of about 4,700 beds. The surplus has grown. Ms. Gorga further noted that the average bed census for 2009 was 43,417 filled nursing home beds out of a total of 48,754. There were 5,337 empty nursing home beds in 2009.

Ms. Gorga noted that national data shows nursing home utilization rates declining and noted in part, "...Since the last new beds were approved in 1991, the long term care industry has experienced dramatic changes. The development of assisted living facilities and other alternatives have reduced the demand for lower acuity services and thousands of beds have closed. Age specific utilization rates have declined. Our projections continue to show a surplus of beds through 2015. If there is a need for additional beds before 2015, then the Department will revisit the projections, there are several

mechanisms to address the need. First, staff could return to the Council and change the filing date to accommodate the change or second, return out of service beds to service (over 1,500 beds out of service) or thirdly nursing homes could use the one-time increase of twelve beds permitted under the DoN regulations."

In conclusion she said, "The extension of the filing date means that the Department will not accept applications for new nursing home beds until May 1, 2015. Applications for renovation and replacement of nursing homes will continue to be accepted by the Department on any business day. I ask that you approve this request for promulgation of the emergency regulations to 105 CMR 100.000 of the Determination of Need Regulations."

Dr. Alice Bonner noted briefly, "We certainly believe that this is a good policy to extend the moratorium. There are opportunities for nursing homes to come back to us if there are specific specialty needs that all of a sudden are determined." Dr. Bonner noted that the Mass Senior Care Association and Mass Aging are comfortable with this.

Discussion followed by the Council, please see verbatim transcript for full discussion. During discussion, Council Member Dr. Meredith Rosenthal stated, "It seems that statewide supply is more than adequate, but I was wondering if there were any geographic disparities since, clearly, being close to family would be important to some people." Ms. Gorga replied "that the state is divided into about 36 geographic areas so that people could be close to their loved ones in a nursing home because they visit much more frequently that they would with a hospital, where the average length of stay is so short. However, there are some areas in the state where there is a vast surplus of nursing home beds and other areas such as down on Cape Cod where the surplus is not as large but still the nursing homes there have not asked for increases in beds, they can use the 12-bed add-on if needed."

Council Member Mr. Paul Lanzikos noted for the record that as designee of the Secretary of Elder Affairs, he endorses this

moratorium. He noted the context of elder care services in Massachusetts and noted some of the programs being utilized in Massachusetts right now: the Olmstead Plan to provide alternatives to nursing facility placement; community-based programs such as The PACE Program, Senior Care Organizations, the Choices Program, a Medicare waiver program allowing nursing home eligible folks to stay in the community. He noted the Governor is coming out with a campaign on March 24th called "Embrace Your Future" with a lot of information on how to plan for this. Mr. Lanzikos noted that the populations in nursing homes have changed from a long-term care based population, staying for years to three distinct populations (1) short-stay rehabilitative care, (2) longer medical or neurological stays and (3) folks with dementia. In closing he stated, "I would hope the next time the Council revisits this moratorium, it could really be the harbinger of a total overhaul of the way, as a matter of public policy, we are approaching this sector."

Dr. Alan Woodward made the motion to approve the emergency regulations. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Request for **Emergency Promulgation of Amendments to 105 CMR 100.000 of the Determination of Need Regulations (Regarding Nursing Home Projects)**. A copy of the approved emergency amendments is attached and made a part of this record as **Exhibit Number 14, 945**. As approved, the amendment **extends the moratorium on nursing home beds from May 1, 2010 to May 1, 2015.** The extension of the filing date means that the Department will not accept any applications for new nursing home beds until 2015. In addition there is a **technical correction to definition of "expenditure minimum"** that clarifies that the \$25 million for outpatient projects that was added by c.305 of the Acts of 2008 is adjusted annually in accordance with section 25B ½ of chapter 111 of the Massachusetts General Laws.

After a 30-day notice to the legislature as required by §25F of M.G.L. c.111, the Department will file the amendments with the Secretary of the Commonwealth for emergency promulgation. Emergency amendments take effect when filed and remain in effect for three

months. During that three-month period, the Department must comply with all hearing and notice requirements of M.G.L. c.30A. A public hearing will be held on April 12, 2010 in the Public Health Council Room, following that public comment period, the regulations will return to the Council for a final vote. Following the final action by the Public Health Council, the Department will be able to final regulatory documents with the Secretary of the Commonwealth before the expiration of the three-month period and thereby make permanent changes to 105 CMR 100.000.

PRESENTATION: "MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST) DEMONSTRATION PROJECT" BY Ms. Andy Epstein, RN, Senior Advisor, Massachusetts Department of Public Health and Ms. Jena B. Adams, MPH, MOLST Project Director, UMass Medical School, Commonwealth Medicine

Ms. Epstein made introductory remarks. She noted, "that the Health Care Quality and Cost Council, which falls under the Executive Office of Health and Human Services (EOHHS) recommended that DPH implement a process of communicating patient's wishes for care at the end of life similar to the nationwide effort....And in addition, in April of 2008, the Legislature enacted Chapter 305 of the Acts of 2008, in which DPH was mandated to implement the MOLST in one region of the Commonwealth, test its successes and provide recommendations for establishment of a statewide program. Worcester was chosen for the pilot project..."

Ms. Jena Adams addressed the Council. Some excerpts from her Powerpoint presentation follow. Please see the verbatim transcript for the full presentation. She noted that she manages the day to day oversight of the MOLST Demonstration Program and that they have a broad-based steering committee chaired by Ms. Andy Epstein, Mass. Department of Public Health and Ms. Ruth Palumbo of the Executive Office of Elder Affairs. Ms. Adams explained MOLST, "...it is a process for discussing and documenting, and communicating very sick patients' end of life care wishes across health care settings. It is a process that results in the completion of a standardized form that has a certain set of medical treatments often used at the end of life

on patients, along with their physicians, nurse practitioners or physician assistant, after discussing their goals for care and their values, and their medical condition and prognosis. Then, if they choose to complete the form, which is voluntary, they will be able to make choices about certain treatments that might be expected to be offered to them at some point. It is a form that can be used with patients of any age and it is a portable document intended to travel with the patient across health care settings.”

She continued, “the first task was to create a form that would be specific to Massachusetts (attached and made a part of this record as **Exhibit No. 14,946**). The Legislation also required that the program include education and outreach to health care professionals, consumers, patients, families and care-givers and include an evaluation component to test the success of the demonstration program and make recommendations for a statewide expansion that may begin as early as next year, 2011...In terms of education and outreach for health professionals, we have developed three training modules, Powerpoint presentations that will eventually be available as interactive modules on the MOLST web site. We established a guidance document, an eight page document to accompany the form with specific instructions about how to use this process and this form with patients. We developed sample policies that various organizations can use to implement MOLST, one for an acute care setting, one for the skilled nursing facility setting to be adapted per institution. We created a video with Dr. Susan Block and one of her nurses from Dana Farber as actors to demonstrate an effective conversation about advanced care planning and how that may lead to a conversation about MOLST...We have already started training providers at all levels in all of the local demonstration sites. We also have a Consumer Education and Outreach Work Group and developed the goals, and figured out what kinds of materials might be needed by patients and their families. We conducted five focus groups in Worcester and a couple of other groups, one that represented people with a lot of different kinds of disabilities to receive their feedback about the program. We developed this consumer educational video which we will show shortly and developed frequently asked questions and material on understanding

MOLST and everything is being translated into Spanish, Vietnamese and Portuguese.”

“In terms of the evaluation component”, continued Ms. Adams, “This is a demonstration program and the evaluation needed to be a process evaluation. What everybody is interested in is outcome data. Are patients’ wishes really adhered to if they successfully complete this process with their clinicians and complete a MOLST form? But, because of the numbers in the demonstration and the need for more time to collect that kind of data, we are focusing right now on the process primarily on how the success will really be measured by how well we can make this program understood and available and put into different kinds of health care organizations and systems throughout the Commonwealth.”

Ms. Adams noted that they are on the path to make this statewide and that DPH’s Office of Emergency Medical Services has been supportive of this demonstration project from the onset and EMTs throughout the Commonwealth will honor these MOLST forms and are receiving training....Our main purpose for the demonstration is doing it well and tailoring it specifically for use here in Massachusetts, and then gathering our lessons learned so that, when we get ready to expand, we will have very solid suggestions and recommendations for how other organizations around the State will be able to implement.”

Discussion followed by the Council. Ms. Epstein noted that the pilot is limited to two hospitals, Fallon Primary Care, all of the Emergency Medical Services and five nursing homes and the VNA Care Hospice. She noted that it is a controlled pilot and expected to start in April of 2010. She noted further that a lot of the preparation work is getting the institutions to understand that they have to honor this. The Department issued a circular letter through Alice Bonner, Director, Bureau of Health Care Safety and Quality. She said they touched base with many organizations about this who received it enthusiastically such as the Mass. Medical Society and the Boards of Registration and Medicine. Ms. Adams reiterated that the pilot will begin on April 1st and that the evaluation will be in place through

December of 2010 to collect the lessons learned and quality improvement throughout the year will occur and a report will be prepared with what they have learned with recommendations about statewide expansion by the end of the year. She noted that this MOLST is standard of care and there is nothing to stop other organizations and institutions from outside the demonstration from starting to do this and are making materials available throughout the Commonwealth.

Council Member Dr. Muriel Gillick, a geriatrician, made comments on the MOLST Demonstration Project, stating that it is an exciting approach and that the video didn't make it clear as it is on the form that a surrogate can complete the MOLST form with the patient's preferences which is important especially for those with cognitive impairment. Secondly, she stated, "that the process is really critical because we have good evidence that legalistic advanced care planning documents are not the best way to go....we don't want the MOLST form to be just another piece of paper, we truly want it to reflect a discussion which goes over the person's underlying condition, the individual's prognosis and what the likely projectory of that person's illness is..."

Dr. Alan Woodward suggested that a wristband be used instead of just a form because the form if it is left home or is folded up in someone's wallet or purse is not going to be seen by emergency personnel, "something like a Med Alert band that states please check my wallet. I am in this program." It was noted that duplicate copies of the forms are acceptable. Dr. Woodward said further, "If we don't get the logistics right, the program is not going as effective as its potential which is great and very useful." He said the video should be distributed so the general public is aware and allows them to initiate this discussion with their physician. "I think end of life and futile care and not conforming to people's wishes is a real problem. It is something that we haven't done optimally and this will move us a lot closer if it is well done..."

Council Member José Rafael Rivera noted that the MOLST form requests gender at the top. What does a transgender individual do,

if they are presenting differently at the time and the form says the opposite? Council Member Paul Lanzikos concurred. Staff will consider that issue. Ms. Adams noted that the form is considered valid by EMTs and First Responders as long as sections D and E are completely signed and legible. Council Member Mr. Albert Sherman suggested that information on the pilot be sent to the State Fire Marshall because the fire engine usually arrives at the scene about 18 minutes before the ambulance arrives. Ms. Adams noted they have specific training for both fire and police departments. Mr. Lanzikos noted that the video shown had music for drama but it may make it difficult for people with auditory disabilities to hear, so he further recommended in the future that persons with all kinds of disabilities should be considered when making videos.

During the discussion Chair Auerbach noted that he sees MOLST implementation as being a cultural change in the landscape and that there is not a single step that will insure that it becomes universally utilized but rather "the struggle is to figure out how to get as close as possible in the absence of it just being a law or regulation..." He said they would look to the expert panel for a set of specific recommendations in order to implement this statewide. "It may involve regulations and the consideration of mandated training by various boards of registration and consideration of funding for trainings and education and working with consumer groups. Each of these steps would require different steps, some of it funding, some of it regulatory and some of it relying on professional organizations...The challenge will be having a very clear plan and the staff in place to implement it."

Council Member Dr. Michael Wong noted that physicians like him are aware of MOLST and POLST from the medical journals and have been for at least a year. He said further that he agreed with Dr. Woodward that a wristband would be useful because forms are always misplaced. In response, Ms. Adams noted that the state of Oregon launched a statewide registry of the MOLST forms and that seems to be where a lot of states are heading toward the statewide registry, some states have pink stickers on window panes or a wallet card. Staff will continue to think about the best way to approach

this. Dr. Gillick made a suggestion that the Bureau of Health Care Safety and Quality consider giving long term care facilities some kind of modest incentive to fill-out the MOLST forms because a lot of the residents do not want to be hospitalized.

In closing discussion on MOLST, Dr. Auerbach stated, "I think the spirit of Mr. Lanzikos' request and other Council Members' comments would be that the Council would like to be actively involved in supporting and promoting the objectives of the MOLST program. I think that may be relevant as you are prepared to actively think about going beyond the Demonstration Project to the statewide project. I suspect that will be the case before the completion of the evaluation period in December. I would request that you work with us around coming back before the Council in five or six months and at that time, come with a set of action steps or recommendations for how to move from the Demonstration Project to the statewide project and include in that some thought about actions that are actually within the scope of activities that the Council oversees, including the one that Dr. Gillick was just mentioning, given that the Council is actively involved in approving applications and guiding the work of the regulatory process."

NO VOTE/INFORMATION ONLY

Update: HAITI EARTHQUAKE:

Chair Auerbach stated, "I just wanted to acknowledge the work that Dr. David has done recently. She recently returned from a week in Haiti where she was actively involved in providing medical care..." He noted that they spoke about her addressing the Council at a future meeting on her experiences in Haiti. Dr. Michéle David spoke briefly, "...Our approach both here in Massachusetts and in Haiti has been to sort of look at the aftermath of the earthquake and its effect on the Haitian population, both here in Massachusetts and also because we have been receiving patients directly from Haiti, who come here for care, as well as how we can best help our country. Here in Massachusetts, we have a lot of community agencies, and there has been a task force created of those agencies, including a Mental

Health Task Force of all the Haitian professionals to try and address this, and some of the things we are seeing is that people who have lost family members, from none to up to the whole family, the most horrendous we have heard about is 26 members of the whole family died and we are getting children who are totally traumatized and the adults are traumatized and so the combination just doesn't work well together. When I was in Haiti, what I saw this past week was that there is still a lot of huge medical needs, and part of it stemmed from a very good effort that happened immediately after the earthquake, some of the care that were delivered, because it was in field condition, dirty fields, a lot of the surgeries have created great problems three weeks later. In terms of infection rate and stuff that has to be done to correct doing OR in dirty fields. Another thing we are seeing is a traumatized population. Our group of six saw from 200 to 275 people a day and there is a huge amount of depression and stress. People describe it as their minds are empty. They don't know how to cope. There is also a huge epidemic of asthma from all the dust from the earthquake. So, there is still going to be ongoing needs happening in Haiti."

NO VOTE/INFORMATION ONLY

PRESENTATION: "UPDATE ON LIMITED SERVICES CLINICS IN MASSACHUSETTS", By Andrew Sussman, President, MinuteClinic

Chair Auerbach gave some background information, "Council Members may remember that we began discussing the issue of the idea of a Limited Service Clinic model early in the tenure of this particular Council. In fact, the discussion began in August of 2007, and it resulted in the final passage of Limited Service Clinic amendments to the clinical Regulations in January of 2008; and, at that time, the Council Members asked us to closely monitor the progress in terms of the establishment of Limited Service Clinics in the State, looking at utilization of those clinics, looking at quality issues, looking at other information that might have helped to inform us about the value of that option and so we wanted to do today's presentation with that in mind." Chair Auerbach noted that at the

present time, there is only one company operating Limited Service Clinics in Massachusetts and that is MinuteClinic. He said further, "However, there are discussions with both retail facilities and community health centers and hospitals around the possibility of opening additional Limited Service Clinics and I do think we will be seeing, over the coming year, some additional models that do get added, beyond the ones that are currently operated by Minute Clinic."

Mr. Andrew Sussman, President of Minute Clinic and former Executive Vice-President and Chief Operating Officer at UMass Memorial Medical Center and is on the faculty of the University of Massachusetts Medical School, addressed the Council. Excerpts from his presentation follow. Please see the verbatim transcript for the entire discussion. Dr. Sussman noted, "...We opened 18 clinic sites in Massachusetts and this is part of a larger national network of over 500 clinics. MinuteClinic has now cared for over six million patients across the country. We accept almost every type of insurance, including Medicare, MassHealth, Network Health, and all of the commercial insurance products in Massachusetts and since opening in September 2008, have cared for over 47 thousand patients for acute care visits....The clinic hours for MinuteClinic are as follows: open seven days a week and we see patients without appointment. We have hours in the morning, mid-day and in the evenings...We are open on major holidays as well."

He noted that a patient satisfaction survey of over 9,000 patients showed on a scale of 1 to 10, with ten being the best possible experience, a patient satisfaction rating of 9.13. And with the question of whether patients would refer them to a family member or friend, the patient rating was 9.29. He noted further that their clinic model is a nurse practitioner model with Board Certified Family Nurse Practitioners providing the care in convenient locations inside CVS pharmacies. We provide a limited scope of services. Our prices are posted and we try to be quite transparent about costs. A typical sick visit at MinuteClinic is \$62.00. We have an electronic medical record that we keep track of all of the care in...We promptly communicate with primary care physicians after seeing a patient and with the

patient's permission, we send a copy of all the records to the primary care physician. We also give a printout of the visit record to the patient to take with them. MinuteClinic has telephonic interpreter services available at all of its sites for patients who English may not be their first language and we can provide prescriptions at the pharmacy of a patient's choice. We e-prescribe all of our prescriptions, but we can send them to any pharmacy, or print them out on paper if the patient prefers that."

Dr. Sussman noted that they are accredited by the Joint Commission and that the Department of Public Health reviewed their clinical guidelines and as part of their application to become a MassHealth provider, their guidelines were reviewed by them as well.

In terms of oversight, Dr. Sussman said, "Every MinuteClinic location has a designated responsible Massachusetts collaborating physician, who is Board Certified in Family Medicine. Each nurse practitioner has a collaborating Physician Agreement with those physicians, and they are immediately available telephonically if there are questions about a particular patient or situation and all of our physicians are practicing in Massachusetts and are Board Certified in Family Medicine". He further noted that about 10.8% percent of the patients' MinuteClinics sees are referred to higher levels of care, either to their primary care physician, or to an urgent care, or emergency department. Every MinuteClinic maintains a list of area hospitals, urgent care centers as well as a list of primary care providers who are accepting new patients including community health centers. MinuteClinic provides support to their nurse practitioners by providing 40 hours of continuing education time, funding 1500 dollars of courses and through staff meetings and email information on important clinical developments.

Other information he provided: a patient cannot be seen more than three times a year at MinuteClinic for the same symptom or condition because they should see a higher level of care like their primary care physician. MinuteClinic can view a patient's record electronically and know how many times they have visited any MinuteClinic nationwide. In 2009, about 30% of the Massachusetts patients identified having a

primary care physician compared to the national average of about 40%.

Dr. Sussman stated in part, "I think the important thing here is that we really see MinuteClinic not as the primary home for a patient. We are not a patient's medical home, but we do think we have an important role to play in collaborating with their medical home, in providing a site of access for care, and then passing that information on to their primary care physician... Let me conclude by saying, firstly, how much we appreciate all the collaboration we have had with the Department of Public Health, in establishing Limited Service Clinics and how proud we are of the care we are providing to the people of Massachusetts, evidence-based high quality care that has been accessible and affordable, and we hope to continue this relationship going forward..."

Discussion followed by the Council. Please see verbatim transcript for full discussion. Dr. Michael Wong asked, "Has there been any decreases in unnecessary ER visits in the communities in which the MinuteClinics are located?" Chair Auerbach responded that the Division of Health Care Financing and Policy may have the emergency room utilization data "so we may look at where the utilization of a Minute Clinic has been the highest and the neighboring emergency departments to see whether the numbers are robust enough to be measurable but we can investigate that." In response to questions by Dr. Meredith Rosenthal, Dr. Sussman responded in part, that about 90% of their patients use insurance and about 10% pay cash and that the "patients come in with common diagnoses such as pharyngitis, ear infections, sinus infections, those sorts of things." Dr. Sussman also noted that MinuteClinic gave 17,000 vaccinations in Massachusetts for H1N1 for 2010 so far.

Discussion continued and Dr. Alan Woodward express his concern about MinuteClinics data which states that 30% of its Massachusetts patients say they have no primary physician compared with 40% nationally and further that he hopes they have a ceiling on overall visits by a patient, not just on one diagnosis because "this says the patient is not getting integrated care." Chair Auerbach noted that

data gathered since Health Care Reform, telephone data and other mechanisms consistently indicate that a much larger percentage of Massachusetts residents have primary care providers (in excess of 70%). So, that data would suggest that either your clinics are serving a disproportionate and subpopulation, or a subpopulation with a disproportionately high percentage of patients who don't have a doctor. Therefore, they are seeking primary care from the Minute Clinics, or people aren't saying the truth..." Dr. Sussman responded to these concerns by stating in part, "...I think the important thing is, we are seeing patients who would otherwise largely be detached from our medical system, and we really see an important role for us to help reattach people and make sure they get the care they need and follow-up."

Chair Auerbach asked "of the 43,000 patients in 2009, do you know how many separate and distinct unduplicated patients that represented?" Dr. Sussman didn't have the specific number for Massachusetts but said nationally the data shows that two-thirds of the patients are new patients (having one visit) and he suspects that most of the patients in Massachusetts are new patients having just opened here but he would provide more precise data on that in a follow-up to the Council. Chair Auerbach said, the larger question that Dr. Woodward is getting to is, "are there people who regularly use MinuteClinic as their medical home..." Ms. Caulton-Harris asked about MinuteClinics impact on community health centers. Dr. Sussman said they are talking to the community health centers and that MinuteClinic is "interested in collaboration with the community health centers to take care of patients in the way that is most effective for them." Dr. Sussman indicated that they planned on opening a couple more clinics in the coming year or so.

During the discussion Dr. Sussman spoke of the MinuteClinics value in light of the primary care provider shortage. Dr. Michael Wong asked, "Is there any incentive or anything that can be done, either by this Council or by the Department of Public Health, in conjunction with any of the other registries, to try to entice medical students and residents to actually go into primary care?" Chair Auerbach responded by noting that Chapter 305 of the Acts of 2008, included

specific financial incentives to try to entice students to go into primary care practice within Massachusetts (funds have been lost due to the 9C cuts) and created a Medical Providers Council to monitor where the physician shortages exist and that is ongoing. He further noted that he has been working with Dr. Alice Bonner to see how the Board of Medicine may monitor shortages and think of creative ways to encourage physicians in training to consider primary care. He said the Department and other organizations such as the Massachusetts Medical Society recognize that this area needs more work.

NO VOTE/INFORMATION ONLY

PRESENTATION, "FINAL SUMMARY OF H1N1 ACTIVITIES":

Dr. Lauren Smith, Medical Director, Department of Public Health, accompanied by Ms. Donna Lazorik, RN, MS, Adult Immunization Coordinator, Bureau of Infectious Disease, Massachusetts Department of Public Health presented the update on H1N1 to the Council. Some excerpts from the Powerpoint presentation follow please see the verbatim transcript for the full discussion.

Dr. Smith made introductory remarks and said in part, "...I am going to take a little bit of time to tell you about some racial and ethnic disparities that were identified in both the experience of illness, as well as the receipt of vaccine and some of the steps we took to deal with that....This was primarily an issue of younger people, especially those under 18 years of age, which is different [than the seasonal flu]." Looking at the data, Dr. Smith noted that the slide shows that as of March 4, 2010, we are substantially lower [less cases of flu] than what we would normally be experiencing during regular seasonal flu.

Ms. Donna Lazorik stated, "Since October 1, when we received our first allocation of H1N1 vaccine, we distributed in Massachusetts 3.7 million doses. One and half million doses have gone to public sites, including boards of health, community health centers, public hospitals, and correctional facilities and 2.1 million have gone to private sites, including ... to obstetricians, which is really amazing

when you think that previously obstetricians very rarely administered vaccines.” Dr. Smith added, “That is a win for the State and the outreach that we have done because of the increased risk that pregnant women had in having severe complications... and kudos to the Obstetricians’ (OBs) for really stepping-up and changing their practice because this is not something that they would have ordinarily done.”

Ms. Lazorik said further, “We hope to build on that for the seasonal flu vaccination. In order to get the vaccination distributed, we developed a web-based system for provider registration. All providers that wanted to receive H1N1 vaccine could register with us, and we also used the system for allowing the providers to request additional doses of vaccine, and then to report back doses administered. We registered 4500 provider sites and 1500 of those sites are new to the DPH vaccine program. There are now 1500 sites with the ability to administer vaccine. We have contact information from them, and we hope to continue to partner with them going forward, with other vaccination efforts...”

Ms. Lazorik noted for the doses reported back to them so far, 51% have gone to children eighteen and younger, 27% to younger adults; and then 21% to those 50 years old and older. Staff revealed a map showing all the Massachusetts cities/towns that held at least one school-based H1N1 clinic, almost all of the 351 communities in Massachusetts. “This is a major effort that was undertaken, and involved an immense amount of training and partnership and Kudos to the School Health folks for doing a tremendous job”, stated Dr. Smith.

Ms. Lazorik noted, “The Public Health Council promulgated emergency regulations to permit certain health care providers to administer vaccine, including pharmacists, dentists, paramedics, nursing and medical students and they required special protocol and training, the Department was very involved in that training. We held 31 regional four hour training and practice sessions with 600 participants and there was a special Paramedic Train the Trainer project to enable paramedics to vaccinate each other, and we also

worked with the Northeastern University School Health Institute to provide additional training for public health nurses and school nurses, to make sure that everybody was really up to speed with administering vaccines to children and the proper handling of vaccines, and the documentation, and over 460 school health and public health nurses attended the training, and then an additional 542 nurses attended refresher courses that we held and the School Health Institute has an on-line refresher course that was taken advantage of by a number of nurses, as well. We worked with the Massachusetts Medical Society to put the training on-line and offer CMEs to physicians and credited for over 300 completed modules which, have been awarded so far, including some physicians from out of state."

Data from the Behavioral Risk Factor Surveillance Survey (January 2010) and the National 2009 H1N1 Flu Survey combined by the CDC show 55% of Massachusetts residents, children six months to 17 years of age, received a seasonal flu vaccine, compared to 51% in New England and 40% in the United States and then for H1N1 57% received the H1N1 vaccine compared to 52% in New England and 33% in the United States. For adults 18 years and older it was 59% for Massachusetts seasonal flu, 51% for New England and 36% for the United States. And for H1N1, adults 18 years and older 28% in Massachusetts, 25% in New England, and 15% for the United States.

In closing Ms. Lazorik said, "...I wanted to thank the Council for your support in passing these emergency regulations, both for increasing the number of vaccinators, and also helping to promote vaccination of health care workers. Vaccination still continues. Although transmission of H1N1 continues at a very low rate in Massachusetts and around the country, it still continues, and we expect to see transmission into the summer; and we are not going to be able to motivate the public to go out and seek vaccine at clinics, we would like to continue to try to put vaccine in their paths for the next few months."

Regarding schools, Dr. Smith noted, "We had 38 school closings and six closings of other types of facilities compared to six in the fall

despite that we had three times as much illness. Some of that had to do with the tolerance that people had but also there was a substantial amount of work done at the Department in collaboration with the school nurses and the school superintendents to put in place really rigorous guidelines to make sure schools were prepared to deal with the significant upsurge in illness that they had..."

Regarding racial and ethnic disparities [slides put together by Dr. Alfred DeMaria] Dr. Smith said in part, "... This data through the beginning of February and it shows the rates per hundred thousand populations by race/ethnicity, of laboratory-confirmed H1N1, and what you can see is that there is a substantial difference by race/ethnicity in those rates, for Black and Hispanic residents being substantially higher than their White counterparts. If you look at similar rates in hospitalization by age group, again this is by rate, the younger children have by far the highest rate of hospitalization and there are multiple reasons for that; (a) they had the most illnesses but, physiologically, there's also reasons that younger children would be more likely to be hospitalized when they become significantly ill with influenza. There were hospitalizations in these older groups but it was really predominantly among the younger age groups."

She continued, "If you look at race and age at the same time, what stands out substantially here are the quite high rates of hospitalization of Latino and Black young children, whose rates far exceed that of their counterparts in other racial groups and those in other age groups as well. The death rates associated with H1N1 by race and ethnicity and is per thousand. We were very fortunate in Massachusetts relative to other states. Obviously, every death is a loss, but our total number of deaths due to H1N1 was relatively small given our population compared to some other states in the country. These numbers are small so the rates are unstable but what you can see is that the death rates are substantially different by race/ethnicity."

Dr. Smith stated further, "This slide shows the estimated rate of H1N1 per thousand live births of pregnant women and there are racial differences there...Identified confirmed cases and hospitalized

cases shows a substantial increase in both cases and hospitalization percentages among Latino women.”

In closing she said, “This is preliminary data. We need to dive into it more and sort of think about what does this reflect in terms of patterns of care seeking and delivery of services for these women. Luckily, we didn’t have a significant number of bad outcomes with pregnant women. I think 81,000 pregnant women vaccinated was an amazing thing. We have about 80,000 births per year in Massachusetts and we have gotten a big cohort of pregnant women vaccinated...We expanded communication campaigns that were specifically targeted to Communities of Color. We had been doing that throughout in terms of some of our outreach efforts, but we had specifically three new PSAs that were done...reaching out to specific minority communities and in addition to that there was a quarter of a million dollars of funding that was identified for health disparities that we already had contracts with to use their channels to reach out to their constituents...Lastly, I would say we also continue to look for alternative sites and additional sites for vaccination including youth centers and others, to try to make sure that the vaccine is getting out to all our constituents.”

Discussion followed by the Council, please see verbatim transcript for the full discussion. Council Member Dr. David suggested that in the PSAs there needs to be rationale for patients to get a vaccination this late in the season. As an internist, she has seen a high rate of refusal, having received the vaccine late in the season. Dr. Alan wondered about the reasons for the disparities. Ms. Lazorik responded in part, “...I think the sample size is really small and in fact, we see that every year with seasonal flu vaccine. It is all over the place, even though our overall rate is consistent within it, that the rates by race and ethnicity really vary from year to year and I really do think that is because the sample size is so small. It is just hard to get a handle on it.”

NO VOTE/INFORMATION ONLY

FOLLOW-UP/ACTION STEPS:

- Council would like to be actively involved in supporting and promoting the objectives of the MOLST program. Staff should come back to the PHC in five/six months with a set of actions steps or recommendations for how to move from the demonstration project to the statewide project, include in that, actions within the scope of activities that the Council oversees like approving applications and guiding the work of the regulatory process (include Dr. Gillick's suggestion on page 14 of these minutes) (Auerbach to Epstein, Adams)
- Have Council Member Dr. Michèle David address a future PHC meeting on her experiences in Haiti (Auerbach to David)
- Check with the Division of Health Care Financing and Policy for emergency room utilization data to try to figure out if there has been any decreases in the ERs due to MinuteClinics being available (see page 19 of these minutes) (Wong, Auerbach)

Chair Auerbach asked, of the 43,000 patients MinuteClinic saw in 2009, how many are separate and distinct unduplicated patients? Dr. Sussman said he would report back to the Council with this information.

The meeting adjourned at approximately 11:50 a.m.

John Auerbach, Chair

LMH