

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF MARCH 16, 2011

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**

Updated Docket: Wednesday, March 16, 2011, 9:30 AM*

1. ROUTINE ITEMS: No Floor Discussion

- a. Compliance with Massachusetts General Laws, Chapter 30A **(No Vote)**
- b. Records of the Public Health Council Meetings of January 24, 2011 **(Approved)** and February 9, 2011 **(Approved with minor amendment)**

2. PROPOSED REGULATIONS: No Floor Discussion/Information Only (No Vote)

Informational Briefing on Proposed Amendments to 105 CMR 700.000 (Implementation of the Controlled Substance Act), Concerning Expedited Partner Therapy (EPT) for Chlamydia Infection

3. DETERMINATION OF NEED: CATEGORY 1 APPLICATIONS:

- a. **Project Application No. 1-4938 of Pioneer Valley Surgicenter, LLC** – Transfer of ownership of ambulatory surgery center **(Approved)**
- b. **Project Application No. 1-4939 of MDSINE, LLC** – Transfer of ownership of ambulatory surgery center **(Approved)**

4. PRESENTATION: No Vote/Information Only

“The Patient-Centered Care and Human Mortality Report of the Expert Panel on End of Life Care”

***Time:** Meeting begins ½ hour later than usual

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 (M.G.L.C17, §§ 1, 3) was held on March 16, 2011, 9:30 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, Mr. John Auerbach, Commissioner, Department of Public Health, Dr. John Cunningham, Dr. Michèle David, Dr. Muriel Gillick, Mr. Paul Lanzikos (arrived at 9:45 a.m.) Mr. Denis Leary, Ms. Lucilia Prates Ramos, Dr. Meredith Rosenthal, Mr. Albert Sherman (arrived at 9:37 a.m.) and Dr. Alan Woodward. Absent members were: Ms. Helen Caulton-Harris, Mr. Harold Cox, Mr. José Rafael Rivera, Dr. Michael Wong and Dr. Barry Zuckerman.

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 summarized the agenda of the day.

RECORDS OF THE PUBLIC HEALTH COUNCIL OF JANUARY 24, 2011 AND FEBRUARY 9, 2011:

Dr. Alan Woodward made a motion to approve the minutes of January 24, 2011. After consideration, upon motion made and duly seconded, it was voted (unanimously) [note: Mr. Lanzikos and Mr. Sherman not present to vote] to approve the minutes of January 24, 2011 as presented.

Dr. Alan Woodward made a motion to approve the minutes of February 9, 2011 with an amendment. After consideration, upon motion made and duly seconded, it was voted (unanimously) [note: Mr. Lanzikos and Mr. Sherman not present to vote] to approve the minutes of February 9, 2011 with Dr. Woodward's amendment as follows: On page 16 of the minutes, second paragraph from the bottom, last sentence, it shall now read "that 70% of all their inpatient admissions come through the ED."

**PROPOSED REGULATION: INFORMATIONAL BRIEFING ON
PROPOSED AMENDMENTS TO 105 CMR 700.000:
(IMPLEMENTATION OF THE CONTROLLED SUBSTANCES
ACT), CONCERNING EXPEDITED PARTNER THERAPY (EPT)
FOR CHLAMYDIA INFECTION:**

Mr. Kevin Cranston, Director, Bureau of Infectious Disease, Prevention, Response and Services, together with Dr. Katherine Hsu, Medical Director, Division of STD Prevention & HIV/AIDS Surveillance, and Dr. Grant Carrow, Director, Drug Control Program, presented the proposed amendments to 105 CMR 700.000 to the Council.

Mr. Cranston made introductory remarks. He noted that the Massachusetts Legislature passed Chapter 131, Section 62, of the Acts of 2010, which require the Department to promulgate regulations authorizing certain healthcare providers to prescribe or dispense antibiotics to treat chlamydia infection in the sex partners(s) of infected patients, without an examination of the partner(s). This practice is known as Expedited Partner Therapy (EPT). He said in part, "...Expedited Partner Therapy is a well-established national practice employed in the majority of states and explicitly recommended by the Centers of Disease Control as a method not only for engaging the partners of individuals diagnosed with chlamydia, a very high volume sexually transmitted bacterial infection. We are well on our way to 20,000 cases in 2011 that particularly affects adolescents and young adults. This practice enables the treatment, in an expedited fashion, of the sexual partners of individuals diagnosed with chlamydia in order to first provide treatment to those individuals and to reduce the re-infection of the index case, of the person initially diagnosed with chlamydia and is a powerful tool for the control of this rapidly expanding epidemic. Although the legislation explicitly authorizes physicians to engage in the practice, it does require regulatory change..."

Dr. Katherine Hsu, spoke about the clinical aspects. She noted that EPT is the recommended first line treatment for both patients with known chlamydia infection and their partners, including both adults and adolescents...The standard treatment for chlamydia infection is

one oral dose of 1g of the antibiotic azithromycin. EPT has been shown to be safe and effective in the treatment of sex partners. Two large studies found the use of azithromycin was not associated with adverse events. Most states with long-standing EPT programs also have had no reports of adverse events. Research has also demonstrated that EPT is more effective in reducing persistent and recurrent chlamydia infection than traditional partner notification..."

Dr. Grant Carrow noted the proposed regulatory changes. He said in part, "...These proposed regulations amend 105 CMR 700.000: Implementation of M.G.L. Chapter 94C of the Controlled Substances Act and 105 CMR 721.000: Standards for Prescription Format and Security in Massachusetts...The proposed regulations authorize a physician, physician assistant, nurse practitioner, or nurse midwife to provide EPT for the treatment of chlamydia infection by dispensing or prescribing a Schedule VI controlled substance (i.e., antibiotic) for immediate treatment of the sex partner(s) of a patient diagnosed with chlamydia infection...The provision of EPT is voluntary on the part of clinicians and these regulations do not require companion regulations from the other boards that govern those practitioners noted earlier. However, the Board of Registration in Medicine will issue guidelines to allow prescribing and dispensing for EPT in the absence of an examination of the sex partners(s)..."

He noted and staff's memorandum to the Council, dated March 16, 2011 also explains that the regulations would allow EPT to be provided as follows:

1. the EPT complies with applicable regulations and guidelines of the Boards of Registration (i.e., Medicine, Nursing, Physician Assistants), the Department, and the CDC;
2. in the situation in which a therapeutic agent is dispensed to the patient for a sex partner, the agent is provided in a separate, properly labeled container;
3. in the situation in which the patient is provided with a written prescription for a sex partner, the patient is given a separate

written prescription for the partner, and either the name of the partner or the words "Expedited Partner Therapy," "EPT," or "E.P.T." are noted on the prescription form on the line where the patient's name is otherwise required to be noted;

4. the patient is counseled about EPT and provided with an information sheet for the sex partner about appropriate procedures for taking the medication, possible allergic reactions, and avoiding future infection.

Dr. Carrow further noted that the regulations require the EPT to conform to guidelines of the Department. These guidelines are entitled CLINICAL ADVISORY: UTILIZING EXPEDITED PARTNER THERAPY (EPT) FOR CHLAMYDIA INFECTION IN MASSACHUSETTS. Copies of the guidelines were distributed to the Council attached to the memorandum as Attachment B. The advisory explains the legislative and regulatory changes and provides clinicians with three options for providing EPT, depending on the clinical setting and the circumstances of the patient...The options for a physician, physician assistant, nurse practitioner, or nurse midwife providing EPT are as follows:

1. the clinician provides a written prescription for a named sex partner of the infected patient;
2. the clinician provides a written prescription using, in place of the partner's name, "EPT,; E.P.T., " or "Expedited Partner Therapy", which the partner can have filled at any Massachusetts pharmacy; or
3. the clinician dispenses the medication directly, one dose to be taken immediately by the patient, and an additional dose or doses to be delivered by the patient to the sex partners (s). A separate, properly labeled container is to be used for the dose(s) for each sex partner.

Dr. Hsu added that the written prescription or medication dispensed by the clinician for each partner will be accompanied by a partner information sheet. This information explains why a partner is getting medication and how to take it, describes symptoms, and encourages

partners to contact a clinical provider for follow-up care. The information sheet was attached to the staff memorandum as Attachment C.

Mr. Cranston made closing remarks and noted that a public hearing will be held in April of 2011, after the public hearing and public comment period, the regulations will return to the Public Health Council for a final vote.

Discussion followed by the Council. Please see the verbatim transcript for full discussion. Mr. Cranston responded to concerns of Dr. David and Mr. Sherman regarding a possible allergy being assessed on the expedited partner, "We would certainly prefer that allergy be assessed...it is not necessarily common or universal practice to do so. That is why the delivery of the patient information sheet is through the index case. So, the first engagement is between the prescriber and the individual concretely diagnosed with chlamydia. At that point, it is really the health care provider's role to explain the importance of taking the medication and completing that treatment, as well as engaging their sexual partner in the treatment. The partner is part of that information delivery system. This is the nature of Expedited Partner Therapy..." Mr. Sherman further inquired about young adolescents worried about being anonymous. Mr. Cranston noted that young adolescents have the alternative of going to school-based clinics and family planning clinics where the medication can be dispensed directly to them in order to avoid the challenges of cost and co-pays or the use of parent's insurance. They would not have to go to the pharmacy.

Discussion continued, "...Dr. Woodward noted that Dr. Alfred DeMaria, Jr., Medical Director for the Bureau of Infectious Disease Prevention, Response and Services made a presentation on EPT to the Committee on Public Health at Mass Medical Society (MMS) two weeks ago. He said, there was broad-based support for this in the medical community but that the issue of liability to physicians was a concern that needs to be addressed. He said further that the Public Health Committee of MMS strongly supports this. Mr. Cranston said the legal issues would have to be explored with DPH legal counsel.

Dr. Gillick added in part, "...I think we all need to bear in mind what the alternative is and that even with some loopholes, the proposal is a great deal better than the current reality and that studies demonstrate that this is a sound approach..." Dr. Hsu added that..." it is a judgment call on the part the physician regarding EPT and that the Department does not espouse it as the gold standard of clinical care that is broadly applied to every chlamydia patient but rather DPH still hopes that the patient information sheet will encourage more people to come in for clinical care..."

NO VOTE/INFORMATION ONLY

DETERMINATION OF NEED PROGRAM: CATEGORY 1 APPLICATIONS:

PROJECT APPLICATION NO. 1-4938 OF PIONEER VALLEY SURGICENTER, LLC – TRANSFER OF OWNERSHIP OF AMBULATORY SURGERY CENTER

PROJECT APPLICATION NO. 1-4939 OF MDSINE, LLC – TRANSFER OF OWNERSHIP OF AMBULATORY SURGERY CENTER

Chair Auerbach noted that both transfer of ownership applications Pioneer Valley Surgicenter, LLC and MDSINE, LLC are being acquired by the same Tennessee Company AmSurg Holdings, Inc. Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented both applications to the Council.

Mr. Page presented the information on **Pioneer Valley Surgicenter LLC**. as follows:

"The application has been filed to transfer ownership and seek original licensure of Pioneer Valley Surgicenter, LLC, a physician-owned Massachusetts limited liability company and multi-specialty ambulatory surgery center located at 3550 Main Street, Suite 103 in Springfield, MA."

“Pioneer reports that it has operated the 10,730 square foot free-standing ambulatory surgery center at this site since June 2003. The Center has two operating suites and four procedure rooms. The change of ownership will be effected by a transaction whereby Pioneer will first merge into a Tennessee limited liability company, also called Pioneer Valley Surgicenter LLC. Following the merger, AmSurg Holdings, Inc. (AmSurg), a Tennessee corporation will purchase sixty-five percent of the ownership interests of LLC. When the transaction is completed, AmSurg will own sixty-five percent of LLC and former physician owners of Pioneer will own thirty-five percent; and LLC will be the new owner/operator of the Pioneer ambulatory surgery center.”

“Pioneer reports that it and AmSurg are forming LLC to own and operate the Center because they believe that, by combining the Pioneer physicians’ clinical and operational expertise and AmSurg’s resources, management experience and operational experience, they can better ensure that the communities surrounding the Center will have available to them high quality ambulatory surgical care for many years to come.”

“The Center is certified by the Accreditation Association for Ambulatory Health Care and Medicare. Staff notes that, as of September 30, 2010, AmSurg Holdings, Inc. owned a majority interest in 206 ambulatory surgery centers, including West Bridgewater Endoscopy ASC, LLC (West Bridgewater, MA) and Boston Out-Patient Surgical Suites (Waltham, MA). No capital expenditure is associated with this transfer of ownership and it will remain at its current site...”

“Based upon a review of the application as submitted and clarification of issues by the Applicant, staff finds that the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. Staff also finds that the Applicant satisfies the standards under 105 CMR 100.602. of the DoN Regulations...”

Mr. Page presented the information on **MDSINE LLC.** as follows:

“The application has been filed to transfer ownership and original licensure of MDSINE, LLC d/b/a Spine Institute of New England (MDSINE), a physician-owned Massachusetts limited liability company and multi-specialty surgery center located at 55 George Road in Springfield, MA. MDSINE reports that it has operated the 9,000 square foot freestanding ambulatory surgery center at the above site since 2007. The Center has four operating suites and one procedure room...”

“The change of ownership will be effected by a transaction whereby MDSINE will first merge into a Tennessee limited liability company, also called MDSINE LLC. Following the merger, AmSurg Holdings, Inc. (AmSurg), a Tennessee corporation, will purchase 55% of the ownership interests of MDSINE LLC. When the transaction is completed, AmSurg will own 55% of MDSINE LLC and former physician owners of MDSINE will own forty-five percent; and MDSINE LLC will be the new owner/operator of the MDSINE ambulatory surgery center. ”

“MDSINE reports that it and AmSurg are forming LLC to own and operate the Center because they believe that, by combining the MDSINE physicians’ clinical and operational expertise and AmSurg’s resources, management experience and operational experience, they can better ensure that the communities surrounding the Center will have available to them high quality ambulatory surgical care for many years to come.”

“The Center is certified by the Accreditation Association for Ambulatory Health Care and Medicare. As of September 30, 2010, AmSurg Holdings, Inc. owned a majority interest in 206 ambulatory surgery centers, including West Bridgewater Endoscopy ASC, LLC (West Bridgewater, MA) and Boston Out-Patient Surgical Suites (Waltham, MA). No capital expenditure is associated with this transfer of ownership and it will remain at its current site...”

“Based upon a review of the application as submitted and clarification of issues by the Applicant, staff finds that the application satisfies the

requirements for the Alternate Process for Change of Ownership found in the DoN Regulation 105 CMR 100.600 et seq. Staff also finds that the Applicant satisfies the standards under 105 CMR 100.602. of the DoN Regulations.”

A brief discussed followed by the Council. Please see the verbatim transcript for the discussion.

Dr. Muriel Gillick made the motion to approve **Project Application No. 1-4938 of Pioneer Valley Surgicenter, LLC**. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Request by Pioneer Valley Surgicenter, LLC for transfer of ownership of the ambulatory surgery center as noted in the staff summary. The reason for this approval is that the application satisfies the standards applied under the Alternate Process for Change of Ownership, as listed at 105 CMR 100.602 of the Determination of Need Regulations. Please see the staff summary which is attached and made a part of this record as **Exhibit No. 14,972** for the standards of the DoN Regulations.

Dr. Muriel Gillick made the motion to approve **Project Application No. 1-4939 of MDSINE, LLC**. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Request by **MDSINE, LLC** for transfer of ownership of the ambulatory surgery center as noted in the staff summary. The reason for this approval is that the application satisfies the standards applied under the Alternate Process for Change of Ownership, as listed at 105 CMR 100.602 of the Determination of Need Regulations. Please see the staff summary which is attached and made a part of this record as **Exhibit No. 14,973** for the standards of the DoN Regulations.

PRESENTATION: NO VOTE/INFORMATION ONLY:

“The Patient-Centered Care and Human Mortality Report of the Expert Panel on End of Life Care”

Chair Auerbach introduced the presenters from the Expert Panel on End of Life Care, Andy Epstein, Special Assistant to the Commissioner of Public Health; Dr. Lachlan Forrow, Panel Chair of the Expert Panel and Director of Ethics Support Service and Director, Palliative Care Consultation Service, Mr. James Conway, Vice-Chair for the Expert Panel and Senior Fellow, Institute for Health Care Improvement and Member of the Cost and Quality Care Council. Other Expert panel members present were: Dr. Ruth Palombo, Executive Office of Elder Affairs; and Dr. Muriel Gillick, Member of the Public Health Council and Staff Physician, Harvard Vanguard Medical Associates; Clinical Professor of Ambulatory Care and Prevention, Boston.

Ms. Andy Epstein made introductory remarks. Dr. Lachlan noted first for the record that, although this report came from the Health Care Quality Cost Council, it did not come as a cost issue but as a quality issue. Excerpts from the presentation follow. Please see the verbatim transcript of the proceedings for the full presentation and discussion.

Mr. Conway spoke about his work as an Executive at Dana Farber Institute; he realized there, "the importance of a good death, the importance of the family feeling that we were with them at the time of death." He noted the principles applied by the Expert Panel which included (1) the work is about the patient and the people around them (2) It was inclusive of the patients that they were seeking to serve and the community (3) built on work already being done in the Commonwealth (4) It is evidence-based (5) It is action-oriented. He said, "A report is just a report until we move it into action orientation...It is very specific tasks that have to be accomplished by a specific date in order to meet the requirements of actionable..."

Excerpts from Dr. Lachlan Forrow presentation follow:

"This is the only issue in health care, the only one, in which every single member of the Commonwealth has a stake. Every one of us is mortal. Everyone we know and love is mortal. Everyone in the Commonwealth has a stake. That is not true of any other issue in health care. We are all in this together..."

"It is an urgent issue that cannot wait. No matter how hard it is to talk about, it cannot wait. As our report states, every day in the Commonwealth, roughly 150 people die...So, for most people, yesterday and today were normal days but, for 150 people yesterday, 150 people today, it was the last day of their life, and they died. If only three or four people cared deeply about that person, that means that at least 500 people in the Commonwealth woke-up today having lost someone they loved and for a whole lot of those people, that last phase of that loved one's life was not the way they would have wanted. There was pain, there was suffering, there was fear, and their was sometimes treatment that was given in a different way than the patient would have wanted if they really understood their choices."

"...Despite the impression that was created in the national debate, that we differ passionately about what to do, every single person, every single organization in the Commonwealth that we consulted, agrees on what we need to do, and I mean everyone. The people who identify themselves as Right to Die, the people who identify themselves as Right to Life, the people who think we spend too much on end-of-life care, the people who think we don't spend enough on end-of-life care, every single person agrees...They all agree on three things: (1) from the time any of us is diagnosed that our illness or condition is predictably fatal, I, in a sensitive, compassionate way, need to be told and I need to be informed of the whole full range of medically accepted ways in which I could be cared for, the full range, life prolonging options, options that keep me at home as much as possible or any blend in between. I need to be informed. (2) I need to be asked if I have preferences among those options and if I have preferences, those need to be documented and those need to be available anywhere I might have to have a decision made about my care; and (3) those preferences have to be respected, not some of the time, all of the time, and the only person that might disagree with that is someone who thinks I should be taken care of the way they think I should – un-American."

Dr. Forrow described his father's experience of dying and how his father lucked out in getting the kind of care he wanted. He said, "We

can't have a health care system where you have to be lucky. We need a health care system that ensures we are cared for the way we want."

"Ultimately, we are going to have the health care system the People of the Commonwealth demand and insist on so they addressed a letter to the people of the Commonwealth. He said they have universal agreement on five principles: (1) the life of every person in the Commonwealth is of incalculable value through the very end of life (2) medical decisions require informed consent of the patient or surrogate and always need to be anchored in the patient's own values and preferences (3) Our individual values, priorities, and preferences are hugely variable (4) care for patients always has to be individualized. We have to know what the individual understands and wants and (5) an ethical health care system that insures this happens."

"The vast majorities of people want to die at home but most are not at home when they die."

"...A common misperception for hospice and palliative care is that it is about helping people die. Yes, that's the last part of it, but every hospice worker I have ever known believes that what they are doing is helping people live, helping people live the way they want to, as fully as possible, every single day that they are alive...Everybody in Hospice knows, if you only start to provide that kind of approach in the last days of life, you can't possibly accomplish what people want and need, which is help in becoming comfortable, help in stopping being scared, and then support of your family so that you can have some quality time. Quality doesn't mean what I think is quality. Quality means what you think is quality, and that doesn't happen well if it is just the last days."

"Only 17% of people surveyed by AARP said they had even spoken to their doctor about their preferences...Forty-five percent of surveyed residents of nursing homes say they are in persistent pain..."

"A strong national consensus on end-of-life standards already exists, led by many people from the Commonwealth..."

“There is a myth that, oh I have to choose between hospice or comfort-oriented care, and life-prolonging care. My Dad didn’t want that choice. He wanted life-prolonging care up until the time it is not working, and then he wanted comfort. He wanted both and actually both simultaneously, not one after the other.”

He noted a study, the Massachusetts General Hospital study in the New England Journal of Medicine found that one group, randomized palliative focused on quality of life comfort at the same time that the patient received regular lung cancer care, chemotherapy etc. and the patients had less anxiety, less worry and were less depressed and the patients lived longer, on average living three months longer than those receiving just regular care at MGH.”

“It is not true that increasing quality in any area of medical care needs to mean increasing costs – for instance spending more time at home instead of the hospital should be less expensive.”

He noted the six recommendations of the report: (please see the actual report and/or the verbatim transcript for more detail)

1. Inform and Empower Residents of Massachusetts
2. Support a Health Care System that Ensures High-Quality, Patient-Centered Care
3. Ensure a knowledgeable, Competent, and Compassionate Workforce
4. Create Financing Structures That Promote Patient-Centered Care
5. Create a Responsible Entity to Ensure Excellence and Accountability
6. Employ Quality Indicators and Performance Measurement

The Executive Summary of the report states, “Implementing these recommendations will require the united efforts of health care professionals and organizations, community and business leaders,

and the general public – exactly the collaborative approach that has been so successful in the first phase of health care reform in the Commonwealth, achieving near-universal insurance coverage.”

In regards to the sixth recommendation, Dr. Forrow stated, “...The reason why progress in every state in the country and nationally has not yet happened the way it has to is because, unlike any other important issue in health care, we actually are not keeping track of how well we are doing, and making sure that we do better all the time. We care about mammograms. We track mammograms and you get them or not. We care about colonoscopies. We track those. We care about diabetes control. We track that. We don’t even try to track how well people are being informed, are their wishes, if they have preferences, documented? Are those available when they are needed, and are they respected?...”

In conclusion, he said, “...We have to say this is about patients not politics. We have to collaborate and cooperate. We have to stop using language that polarizes. We are all in this together. And then, as much as the Panel believes we have the right vision, we have the right blueprint and road map, Thomas Edison has been quoted as saying, ‘A vision without execution is a hallucination.’ If we look back six months, a year, two, three years, and things have not changed because we didn’t do what was recommended, then I think every one of us, not just the Public Health Council, every one of us, every organization, every faith community, AARP, all of us will have failed not just other people. We have failed ourselves because we all want the same things in our health care system, and we want them today.”

Discussion followed by the Council, please see the verbatim transcript for the full discussion. Dr. Michèle David said in part, “...As an active primary physician, most of my practice now in clinical medicine, this issue is very core to my practice. I used to be a practicing Intensivist, and the reason I switched to Primary Care is that I couldn’t bear the ways in that last six months of life...I keep up with the literature, I know about all the different options. I do not have time to discuss it with my patients. I just

do not, period. So, unless there is change, it doesn't matter what this recommendation says, it will not happen. It really has to change and I am telling you, I care deeply about this issue...My practice is mostly dealing with patients with low health literacy. Those materials are of no use to them. I always have to simplify and redo...It doesn't help the people who have English as a second language. All of these things will not help the physician in the field unless these things are done also."

Dr. Forrow responded, "I wanted to touch on your latter comment about how we deal and operate effectively when there's low literacy or other challenges. We have this exceptional pilot going on in Massachusetts, the MOLST Project in Worcester...I think one of the gifts that are going to guide this work, and your work, will be those resources that are coming out of Worcester as part of the MOLST Initiative. There is light at the end of that challenge and it is pretty exciting." He noted that the material in Worcester is being developed in at least 10 different languages and for all literacy populations. Chair Auerbach noted that the Public Health Council will hear an update on the MOLST Pilot at the next meeting of the Council. Mr. Albert Sherman noted that the material in Worcester is translated into 16 different languages. He made suggestions on how best to approach the Legislature with the issue. He said in part, "...I find it inhuman that we haven't resolved this issue but again, it is very complicated and it can be resolved and what you need is somebody with enormous credibility with the House Speaker and the Senate President..." He said Chair Auerbach and Council Members Mr. Lanzikos and Dr. Woodward are very creditable people and that the Mass Medical Society is the most organized people to promote an issue like this.

Mr. Conway responded to Mr. Sherman's question of how the impressive Expert Panel was chosen: "The conversation began moving with the Quality and Cost Council, but it was actually the Legislature and the Governor, by act, which set-up the expectation that a committee convene under the leadership of the Secretary of Elder Affairs and the Secretary of Health and Human Services. We then began a process with the people you see sitting here and

others such as Kim Dominique, a Vice-Chair of the Expert Panel, who has since moved west, to get names, which we then ran them back to the various constituencies to make sure that we were meeting the expectations of the Governor and the Legislators, as we moved this group forward.”

Dr. Alan Woodward, an emergency care physician, noted in part, “...If we are going to have rational end-of-life care, we need to have a rational discussion and that is the tone you have set here, which is so critically important. I was involved in the roll-out of the Comfort Care Program. It was the first step of what we could accomplish.” He spoke about the MOLST pilot and how he looks forward to the update next month and said, “It is a huge piece of the overall equation. Just having a form that is recognized and that everyone can use for a format for discussion and then provide to all health care providers...I would just encourage and endorse you and whatever you think the Public Health Council can do to support your efforts and carry this forward...We don’t want to lose your drive, your momentum. We want to support you in any way we can. We want to commend you for your efforts to date, and I think it is just extraordinary what you have done...As you point out, this is critical for every single one of us, and our family members, and our loved ones, and our neighbors and there is no more important discussion to be having at this point other than the cost of health care but this is an access issue. This is a quality issue. This is an issue that is an essential pillar of the infrastructure of a good health care system. I give you all my support and I hope you will get that from the entire Council.”

Mr. Paul Lanzikos added in part, “...In looking at the written report, and scanning it, it is very clear in its message. I am very pleased to see your recommendation on its dissemination, not only within the current ranks of professionals in whatever involvement they have in providing care and service, but also to people in training. I think that is where we are going to have the most effect over time, while that is necessary, I don’t think it is sufficient. I would strongly encourage that this be disseminated to all the boards and advisory councils that are involved with the

various care providing organizations in the Commonwealth, specifically, the patient and family councils and copies be sent to each hospital and ask that it be put on their agenda not for presentation only but for discussion..." Mr. Lanzikos said he plans on doing this with his board, being the Executive Director of an organization that provides home and community-based services to thousands of frail elders on the North Shore. Mr. Lanzikos further suggested that the Expert Panel put their presentation on a video tape because just reading the report won't do it justice, their sense of compassion and caring is very potent in their presentation.

Dr. Muriel Gillick, Council Member and Palliative Care expert made closing remarks, noting that the room was almost empty. "...I had a small epiphany during the presentation which was that, usually when the room is packed; it is because there are stakeholders who have a strong financial interest in the outcomes of the deliberations or the implementation of the report. Even though you persuasively say, this affects us all as individuals, I can't help but feel that there is a perception on the part of the big players, the hospitals, the group practices, the health plans, that they have little financial stake in the implementation of this report. As we move forward and enter the regulatory phase of this, I would argue for penalties...I tend to favor positive incentives as a way of influencing behavior but I would encourage the Department of Public Health and us, as a Council, when we need to act upon proposed regulations, to think about what needs to be done in order for this to actually be translated into reality."

Chair Auerbach responded, "...Clearly, you have received very positive feedback from the Council Members...I think the question is, where do we go with this and what are the concrete action steps? ..."I would ask Andy and Ruth to perhaps be our guide in terms of some of the specific concrete action steps that maybe can be carved up and assigned to different organizations and agencies. I would be happy to work with you, as with DPH, to determine what particular component of the various recommendation are best addressed by the Council's specific

authority and we oversee the regulations for hospitals and other health facilities – that is one example of where we do have some authority and can think about what those regulatory components, regulatory opportunities might be, along with penalties...We can easily follow-up on Mr. Lanzikos' direction to send copies of the report to hospital leaders as well as to the patient and family councils." Mr. Lanzikos asked Ruth Palombo, Executive Office of Elder Affairs, to recommend to the Secretary that the report be disseminated to the local Councils on Aging and the other home and community-based agencies under the auspices of the Secretary of Elder Affairs. "...Asking them not only to receive it but to engage in the discussion at the board and staff levels," said Mr. Lanzikos. It was noted that the report is available on the Cost and Quality Council web site and will be available on the DPH web site also.

Chair Auerbach added, "I do think that Dr. David's comments about ensuring that the impact of the report affect all populations, especially those that are most vulnerable and perhaps least connected to the health care system really does require some additional attention on all of our parts. So Andy and Ruth, I might ask if you can think about how to best address some of those concerns. I have heard the Council Members clearly are interested not simply with the posting of the report, but also thinking about other innovative ways to make this available. Maybe we can arrange a video taping and YouTube posting and we have a blog site as well. Chair Auerbach noted that the discussion will continue next month with the MOLST update. We will leave it with Andy and Ruth to think about those particular action steps, perhaps follow-up with some of the Council Members on their individual thoughts."

Chair Auerbach stated that everyone should come back for to a future meeting of the Council to discuss what action steps have been taken and where we are on making progress because that is what is needed. Mr. Conway added that the funding opportunities associated with this and identifying resources that will allow them to do this is also needed. Dr. Woodward said in part, relative to Dr. David's comments, "The first implementation phase is the discussion with the

physician. It is not the hospitals...You have to have a mechanism to support payment of physicians to sit down, this is a half hour discussion to go through the MOLST program...I think we have to make sure that is important to everybody and that the insurers understand the importance of this discussion.”

Dr. Forrow stated, “Dr. David wants and knows how to do this and does not practice in a health care system that allows her to, and a health care system is not going to allow or support her in doing that unless it has incentives, there are so many pressures on the health care system, unless there are incentives, which means rewards if you do it well and penalties if you do it badly. Those are crucial to happen as fast as possible...” He said he would like to come back to the Council in September to kick-off celebrate the progress everyone has made and figure out what is next to do.

Chair Auerbach made a final note on reimbursement, stating in part, “...I think the whole notion about the current system with its fee-for-service reimbursement...and the attention that is being paid to payment reform, and the notion of accountable care organizations and within that structure, creating expectations of quality measures that must be met in order to meet the payment incentives that are part of the added payments...I think we have to think concretely, what are the specific measures with regard to the systems in place, the access to palliative care and hospice care. Are those in place in the Accountable Care Organization? We need to have a concrete proposal to bring to the table as those discussions proceed...If we are designing what the new systems will look like, we might as well think about this in a very specific way.”

NO VOTE/INFORMATION ONLY – A copy of the “The Patient-Centered Care and Human Mortality Report of the Expert Panel on End of Life Care” is attached and made a part of this record as Exhibit No. 14, 974.

FOLLOW-UP ACTION STEPS:

- Disseminate report "**The Patient-Centered Care and Human Mortality Report of the Expert Panel on End of Life Care**" (the report) to all boards and advisory councils (various care providing organizations) and specifically the Patient and Family Councils and each hospital and ask them to put it on their agenda for discussion not just presentation (Lanzikos)
- Put the report presentation on video so the panel's compassion and caring is evident to everyone (Lanzikos)
- Upon drafting regulations, add penalties (Gillick) and rewards (Forrow)
- Andy and Ruth come up with actions steps needed for implementation (Auerbach) and think about how to present the report information to vulnerable populations (Auerbach to Epstein, Palombo)
- Everyone come back to discuss action steps taken and where to go from there (Auerbach)
- Send copies of the report to Councils on Aging and other home and community based organizations under EOEA (Lanzikos to Ruth)
- DPH arrange video-taping, YouTube posting, and DPH blog posting (Auerbach)
- Funding resources need to be explored (Conway)
- Need a mechanism to support payment of physicians (speak to insurers) etc. (Woodward)
- September suggested as a follow-up meeting date to discuss the report (Forrow)

- Have a concrete proposal to incorporate report in the design of the new health care system (Auerbach)

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

- Docket of the meeting
- Copy of the meeting notices to A&F and Secretary of the Commonwealth
- Draft minutes of the Public Health Council for the meetings of January 24, 2011 and February 9, 2011
- Informational briefing memorandum and proposed new draft regulations on 105 CMR 700.000 (Implementation of the Controlled Substance Act), Concerning Expedited Partner Therapy (EPT) for Chlamydia Infection and a copy of PowerPoint slides
- Determination of Need (DoN) summary to the Council on Project Application No. 1-4938 of Pioneer Valley Surgicenter, LLC
- DoN summary to the Council on Project Application No. 1-4939 of MDSINE, LLC
- Copy of the report entitled, "The Patient-Centered Care and Human Mortality Report of the Expert Panel on End of Life Care"

The meeting adjourned at 11:40 a.m.

John Auerbach, Chair

LMH

