

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF APRIL 13, 2011

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

***Please note the change of location of the meeting, Information is attached.**

**THE PUBLIC HEALTH COUNCIL OF
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

***LOCATION: WILLIAM A. HINTON STATE LABORATORY INSTITUTE AUDITORIUM, 305
SOUTH STREET, JAMAICA PLAIN MA 02130**

UPDATED Docket: Wednesday, April 13, 2011, 9:00 AM

1. ROUTINE ITEMS: No Floor Discussion

- a. Compliance with Massachusetts General Laws, Chapter 30A **(No Vote)**
- b. Record of the Public Health Council Meeting of March 16, 2011 **(Approved)**

2. DETERMINATION OF NEED: CATEGORY 1 APPLICATIONS:

- a. **Project Application No. 2-3B95 of Steward Medical Holdings Subsidiary Two, Inc. for Transfer of Ownership of Nashoba Valley Medical Center** through the sale of its assets to Steward Medical Holdings Subsidiary Two, Inc., a subsidiary of Steward Health Care System LLC, a Delaware limited liability company affiliated with Cerberus Capital Management, L.P. **(Approved with added conditions)**
- b. **Project Application No. 3-3B96 of Steward Medical Holdings Subsidiary One, Inc. for Transfer of Ownership of Merrimack Valley Hospital** in Haverhill, through the sale of its assets to Steward Medical Holdings Subsidiary One, Inc., a subsidiary One, Inc., a subsidiary of Steward Health Care System, LLC, a Delaware limited liability company affiliated with Cerberus Capital Management, L.P. **(Approved with added conditions)**

3. PRESENTATION: No Vote/Information Only

"MOLST: The First Six Month Pilot Project Report, Lessons Learned and Plans for Statewide Expansion"

4. PRESENTATION: No Vote/Information Only

"An Overview of the William A. Hinton State Laboratory"

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 April 13, 2011 at 9:00 a.m., at the William A. Hinton State Laboratory Institute Auditorium, 305 South Street, Jamaica Plain, MA in the Auditorium. Members present were: Chair, John Auerbach, Commissioner, Department of Public Health, Ms. Helen Caulton-Harris, arrived at 9:40 a.m., Mr. Harold Cox, Dr. Muriel Gillick, Mr. Paul Lanzikos, arrived at 9:30 a.m., Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Mr. Albert Sherman, and Dr. Alan Woodward. Absent members were: Dr. John Cunningham, Dr. Michéle David, Mr. Denis Leary, Dr. Meredith Rosenthal, Dr. Michael Wong and Dr. Barry Zuckerman. Also, in attendance was Donna Levin, General Council.

Chair Auerbach summarized the agenda and noted that there were only six members present, therefore, the Council heard the informational presentation first, "An Overview of the William A. Hinton State Laboratory", while they awaited two more members to arrive for a quorum. During Dr. Han's presentation, Council Member Lanzikos arrived at 9:30 a.m. and Ms. Helen Caulton-Harris arrived at 9:40 a.m. at the close of Dr. Han's presentation. A quorum of eight members was now present.

PRESENTATION: NO VOTE/INFORMATION ONLY: "AN OVERVIEW OF THE WILLIAM A. HINTON STATE LABORATORY"

Dr. Linda Han, Acting Director of the William A. Hinton State Laboratory (State Laboratory) made a PowerPoint presentation explaining the various components of the State Laboratory. She said in part, "...A lot of the work that we do takes place behind closed doors and behind the scenes so a lot of people in the Public Health community have very little understanding of what we do on a day-to-day basis..." Dr. Han noted the bureaus located at the State Laboratory building: Bureau of Laboratory Sciences, Bureau of Infectious Diseases, the Environmental Health Food Protection Program and the UMASS newborn screening program. "The State

Laboratory Bureau is divided into three testing divisions: the microbiology division which covers Foodborne Disease, STD, HIV/Hepatitis Reference, Pertussis, Tuberculosis and Biothreat Response; the Molecular Diagnostic and Virology Division which includes Arbovirus surveillance, virus isolation, virus serology, molecular diagnostics and BioWatch; and the Analytical Chemistry Division which includes Environmental Chemistry, Lead, Chemical Threat Response and the Drug Laboratory. In addition, the State Laboratory has a Division of IT, QA, and Central Services which includes: Informatics, Quality assurance, Specimen receiving and Media preparation.

Dr. Han continued, "...We are regulated and inspected by everybody that I can think of. The Federal Government has a CLIA, which is the Clinical Laboratory Improvement Act. They come by and they oversee our laboratory quality. They were here in December for our once a year inspection, which we passed with no deficiencies. We were happy for about a week and then the College of American Pathologists (CAP) showed up to do their inspection of our blood laboratory...The CDC's Agent and Toxin Program are coming in two weeks. They oversee our handling, testing, and storage of agents such as anthrax and botulism. FDA comes in and inspects our Dairy Laboratory every two years and we meet requirements for a lot of other acronyms. The Animal Care and Use Committee visit us and OSHA visit us. We spent a lot of time on Fire safety and Biosecurity...We have programs for certain unconventional vaccinations, botulism, anthrax, small pox and medical surveillance programs for handling exposures in the laboratory or handling onset symptoms that could be consistent with exposures...We have FBI clearance for a lot of our select agent laboratories. We have a grade A security system with fingerprint monitors...There is an inventory system where we have to keep track of every specimen for the Select Agent Program that we have on-site and we will count them every month and make sure they are all there...Maintaining partnerships with other agencies is critical. We are always in communication with our partners in terms of testing practices and policies. We need to update them on specimen submission requirements and work under

them on outbreak response, and changes in testing interpretation.”

Dr. Han stated further, “We spend a lot of time working on investments in our Informatix system, in terms of development, maintenance and adaption. Informatix is a critical part of our whole laboratory operation. It is in charge of provider service; providers can log into their electronic system and access their test results remotely. It is needed for our disease reporting and surveillance capacity so we can transmit all of our results electronically to the Bureau of Infectious Diseases and to the CDC, as well. We need it for laboratory quality control so that the report lot numbers and dates of testing, times of testing, technician names. It synthesizes all of the data so that we can analyze it to perform laboratory practices and policies, and when a system is as robust as this one we currently have, it gives us a lot of flexibility and power to handle outbreak response and other public health emergencies. We spend a lot of time thinking about implementing and developing new testing technologies and practices but we still need to retain old methods so that we can do surveillance for drug resistance acquisition etc...We also need to continually adapt so that we can respond to emerging diseases...”

Dr. Han spoke about the testing activities. She noted how they were able to respond very quickly to the H1N1 virus in 2009 because of the fact that they had already upgraded their facilities and had already established partnerships with the CDC and had staff already familiar with the procedures. In two weeks they went from doing zero testing of influenza up to 658 tests per week. The State Laboratory collects and tests mosquitos each summer season for Eastern Equine Encephalitis Virus and West Nile Virus to identify trends that might indicate that human disease may be likely and then interventions can occur to protect the public health. She noted that the State Laboratory is part of the National Laboratory Responses Network founded in 1999 by CDC, the Association of Public Health Laboratories and the FBI. It is a network of over 200 chemical biological Laboratories in the country, all using similar protocols and operational plans. The structure is at the top, the National Laboratories like the CDC that does the definitive characterization,

Our State Laboratory is at the middle level, a reference laboratory that does confirmatory testing and then at the bottom is the sentinel laboratories which are located in the acute care hospitals which do all the initial testing and screening and ruling out. The State Laboratory works with all the sentinel Laboratories to make sure that they are trained and that they know what the procedures are..."

Dr. Han talked about their foodborne surveillance Laboratories and noted that in addition to performing conventional, old fashioned serotyping methods, the State Laboratory also does molecular subtyping, a powerful method. For instance she said, if four people have e-coli, you can digest the DNA, run it out on a gel to resolve the DNA. If the four samples have matching patterns, it means they are infected with the same strain. Testing results can be shared by computer, so laboratories from all over the country and internationally submit their information to the CDC and Massachusetts as the Northeast Regional Reference site can access the information and compare patterns of isolates and look for matches so pretty immediately the State Laboratory staff can identify whether there is an outbreak going on..."

Ms. Julianne Nassif, Director of the Division of Analytical Chemistry William A. Hinton State Laboratory Institute, also made a PowerPoint Presentation. Some excerpts from her presentation follow: "...We have four laboratories, our Chemical Threat testing laboratories where we look at exposures to chemical agents. We also have a Childhood Lead Screening Laboratory, where we test approximately 40% of all children in Massachusetts, which is just over about 95 thousand tests per year so that we can identify children with elevated blood levels so that they get the specialized medical treatment that they need and it will trigger a variety of educational and social and environmental services for those children to identify their exposure and to help remediate them...We do forensic drug testing here at the State Laboratory in Jamaica Plain and we also have a laboratory in Amherst, on the campus of the University of Massachusetts. We test illicit drug samples, confiscations that police officers bring to the State Laboratory. We identify them and in some cases quantify them. Those analyses are used in criminal prosecution of cases. Our

analysts are called upon to testify....We do quite a bit of human bio-monitoring, testing individuals who live near known sources of contamination or where there might be a cluster of disease that have a chemical origin.”

She noted that as part of the National Laboratory Response Network, as a level one Laboratory, they are a research capacity laboratory for CDC and the rest of the nation...”One thing that we do as part of that is we do outreach to hospitals and the medical community around the signs and symptoms of chemical exposures. We talk to them about who to contact, what our capabilities are, and give them our contact information, and we do that on a regional basis several times a year. We developed this poster for hospitals. We asked them to post it prominently in their Emergency Departments, and the most important bit of information down there in the corner is our 24/7 contact information, as well as the number for the Poison Control Center where they can get some toxicological advice.”

Ms. Nassif spoke about testing private wells in central Massachusetts for suspected arsenic due to the large amount of granite that runs through the middle of Massachusetts and upwards into New Hampshire. The State Laboratory performed urine samples on the people involved. In addition, she told the story of a New Bedford fisherman, who while fishing off Long Island, pulled up a torpedo-shaped metal canister, which is not an uncommon occurrence. Their practice is, they pick up the torpedo and they toss it back overboard and they continue to work. The fisherman had a burning sensation and several hours later he had a very large blister. She said, “So based, on his clinical presentation and his reporting of the event, we immediately suspected it was one of two compounds that we had the ability to test for. There are a number of notifications that needed to be made, including our Emergency Preparedness Director; we had support from the CDC, from their medical toxicologist. We contacted our FBI Weapons of Mass Destruction Coordinator. Another fisherman, the second patient, thought he might be exposed so we tested him too. We tested for metabolites of sulfur mustard. The first patient was positive for sulfur mustard, the second patient was not. This data was not used only for his personal medical treatment

but also for the cleanup of that particular ship and the determination of what we were going to do with the over four thousand pounds of clams on that ship. We worked closely with our Food Protection Bureau here to ensure that the clams were embargoed and did not make it to market. Ultimately, the clams were transported to hazardous waste incinerators in Arkansas and Texas about two weeks after the initial incident. We tested subsequent samples from the first patient until he eliminated the sulfur mustard metabolite."

In closing, Ms. Nassif stated, "...I just wanted to give you a quick overview of the types of chemical testing that we do here at the State Laboratory. We do it for surveillance purposes, in support of regulations, in support of identifying individuals who need specialized medical treatment, and we do a little bit of research into the development of new methods and technologies..."

Chair Auerbach said, "Thank you very much Julie and Linda, and just extraordinary activities and your really wonderful high quality work that goes on here and we really are so grateful for your leadership and for the work of your colleagues as well."

NO VOTE/INFORMATION ONLY

DETERMINATION OF NEED: CATEGORY 1 APPLICATIONS

PROJECT APPLICATION NO. 2-3B95 OF STEWARD MEDICAL HOLDINGS SUBSIDIARY TWO, INC. for Transfer of Ownership of Nashoba Valley Medical Center

PROJECT APPLICATION NO. 3-3B96 OF STEWARD MEDICAL HOLDINGS SUBSIDIARY ONE, INC. for Transfer of Ownership of Merrimack Valley Hospital in Haverhill

Ms. Joan Gorga, Director, Determination of Need Program, explained the difference between the two Steward applications being presented and the Steward applications approved by the Public Health Council in October of 2010. She explained that in October, the applicant was a not-for-profit entity (Caritas Christi Health Care) transferring to a

for-profit entity (Steward). The Attorney General's Office was involved because of Caritas being a public charity, and Attorney David Spackman of the Attorney General's Office addressed the Council at the October meeting speaking about the AG's role and their conditions of approval. This transfer today is a for-profit entity (Essent Healthcare, Inc.) transferring to a for-profit entity (Steward Health Care Systems) and so no public funds are involved and the Attorney General's office is not involved. Ms. Gorga further explained that staff is limited to the requirements of the DoN Regulations that has four standards for approval of a transfer of Ownership and if the applicants meet these standards they are recommended for approval which is the case for these two applications. If the community chooses to become involved like they did in this Merrimack Valley application, staff incorporates the agreement/conditions into the staff recommendation. She noted that public hearings were held and that the community of Haverhill became involved and came to an agreement with the applicant on application 3-3B96 and that the agreement has been made a part of the application with its nine (9) conditions.

Mr. Jere Page, Senior Program Analyst, Determination of Need program, presented the Steward Medical Holdings Subsidiary One, Inc. request to the Council to acquire through transfer of ownership the **Merrimack Valley Hospital in Haverhill** located at 140 Lincoln Avenue, Haverhill, MA. He said in part, "...Steward has indicated that the proposed transaction will provide resources necessary to assure that the Hospital and the community-based Steward Health Care System of which it is a part functions as a financially-sustainable, lower-cost, high-quality, community-based provider of hospital and other health services. Merrimack Valley Hospital is a 124-bed acute care hospital with a service area including the Merrimack Valley and southern New Hampshire. Essent Healthcare is the current licensee of the Hospital, and the proposed licensee will be Merrimack Valley Hospital, A Steward Family Hospital, Inc. The applicant does not anticipate any immediate changes in services, and there is no capital expenditures contemplated in association with this transfer and there are no prior DoN conditions of

approval connected with the Hospital that would require the new owner to continue funding any community benefits.”

Staff found that the applicant satisfies the standards applied under 105 CMR 100.600 for the Alternate Process for Change of Ownership and 105 CMR 100.602 standards, noted in the staff summary. The Suitability Review Program of the Division of Health Care Quality determined that the applicant met the requirements for suitability for a hospital license set forth in 105 CMR 130.104

Mr. Page noted that a public hearing was requested by the Interested Party formed by the Mayor of Haverhill and held on January 19, 2011 at Haverhill High School. The hearing was attended by approximately 125 people, 46 of whom testified. In addition, 149 letters were received on the proposed transfer by the DoN Office. He noted, “Those testifying or submitting written comments included senior management of Steward and Merrimack Valley Hospital, as well as physicians, nurses and other employees of the Hospital, trustees of the Hospital, local citizens, elected public officials including the Mayor of Haverhill, Haverhill City Councilors, and members of the General Court. In addition, representatives of business, union, medical and other professional organizations in the Merrimack Valley Hospital service area also presented comments. Those organizations include the Greater Haverhill Chamber of Commerce, Pentucket Bank, Holy Family Hospital, Northern Essex Community College, Massachusetts Nurses Association, Teamsters Local 25, Massachusetts AFL-CIO, 1199 SEIU, Area Trades Council, New England Regional Council of Carpenters, Trinity EMS, Haverhill YMCA, Community Action, Inc., Bethany Community Services, East Coast Trauma Intervention Program, and the Merrimack Valley Regional Transit Authority.” Mr. Page indicated that the overwhelming majority of the comments expressed strong support of the transfer to Steward. Only one commenter was opposed on anti-trust grounds. Anti-trust matters are evaluated by the Office of the Attorney General.

Mr. Page noted that on January 19, 2011, the Mayor of Haverhill and Steward Health Care System, LLC (Steward) signed an agreement

that will require Steward to commit to conditions. These include a commitment by Steward to maintain inpatient, outpatient and emergency room services at the Hospital for a period of five years from the date of the closing, a commitment to make a minimum \$10 million capital investment in the Hospital, and a commitment to cooperate with the City and Blue Cross Blue Shield of Massachusetts, to add a new tiered network group health insurance plan option for the City's employees to encourage city employees to use Steward inpatient and outpatient facilities at MVH and Holy Family Hospital. The agreement further commits Steward to provide health education, screening, immunization and other preventive medicine programs in the community, to use commercially reasonable best efforts to continue to offer substantially all of the health care services now provided by the hospital, and to conduct a vigorous public relations and marketing effort to promote MVH both as an independent hospital and as part of the Steward/Caritas System. At the request of the City of Haverhill, staff has incorporated these commitments by Steward as conditions of approval of the proposed transfer." Staff's brief of the public comments is attached to the staff summary and made a part of this record. See Exhibit below.

Staff's summary further noted that Steward has committed to make the full resources of its system available to the Hospital's patients and staff, including the following:

- 1) Deployment of electronic medical record systems for physicians
- 2) Implementation of an advanced clinical and physician order entry systems at the Hospital
- 3) Creation of a community-based regional health information organization
- 4) Deployment of a fully-integrated patient portal
- 5) Enhancement of the Hospital's case and care management programs
- 6) Implementation of disease management programs

State Senator Steven Baddour addressed the Council on both Steward applications. He said in part, "...The viability of the hospital. The capital provided by this transaction will provide much needed

upgrades at both of these facilities and the terms of the deal require Steward to maintain all of the current clinical programs at each facility, but it is more than just that. By joining Steward, both Merrimack Valley and Nashoba will receive all of the benefits of joining a strong, local community hospital system. The expertise and experience of the Steward Leadership team will be a valuable resource to the leadership of both hospitals. Steward's investment in technology will modernize both facilities and give them a competitive advantage. Most importantly, Steward is building a strong local system to operate to succeed in the new health care environment. As part of Steward, both facilities will share in that success and maintain their long term viability...This sale is the best thing for the hospitals, for the patients, the employees and the communities they serve. I ask that the Council approve the sale so we will have a strong, revitalized Merrimack Valley Hospital and Nashoba Valley Medical Center, providing quality care, job opportunities, tax revenue and economic growth for Haverhill and for the years to come..."

Mayor James J. Fiorentini addressed the Council on the Merrimack Valley Hospital application and submitted a letter of support which is attached and made a part of this record. He said in part, "...On my behalf and on behalf of the City of Haverhill, I would urge you to support this application along with the conditions that were sent to you previously. These conditions include, but are not limited to, a five year commitment to extend the services of an acute care hospital at the current Haverhill location with inpatient and outpatient services and an emergency room. This application from Steward represents a \$10 million commitment to invest in Haverhill at the hospital. This application as conditioned will increase the availability of physicians and leading health care professionals, health networks, screenings, community immunizations, transportation, health education and preventive medicine in the community. It will also prove beneficial for addressing the health care needs of our city employees. We believe that the purchase of the Merrimack Valley Hospital by Steward will be the best way of keeping this hospital in the community and ensuring that the critical health care services provided by Merrimack Valley Hospital remain accessible in this community..." He noted that in both communities, there was

unanimous support by all elected officials, both from the School Committee, City Council to the State Legislative Delegations - a strong bipartisan support for this transaction in both communities.

Mr. Bernard Plovnick, Senior Program Analyst presented the request by Steward Medical Holdings Two, Inc. for Transfer of Ownership of **Nashoba Valley Medical Center** to the Council. He stated in part, "...Steward is seeking a DoN for transfer of ownership of Nashoba Valley Medical Center (Nashoba Valley). Nashoba Valley is a 57-bed for profit community acute care hospital located at 200 Groton Road, Ayer, Massachusetts. The Hospital is currently owned and operated by Essent Healthcare of Massachusetts, Inc., a subsidiary of Essent Healthcare, Inc., a Delaware for profit corporation. The applicant is a subsidiary of Steward Health Care System LLC, a Delaware limited liability company affiliated with Cerberus Capital Management, L.P..."

He continued, "The Hospital's service area is comprised of 11 towns in north central Massachusetts, including Ayer, Devens, Dunstable, Groton, Harvard, Littleton, Lunenburg, Pepperell, Shirley, Townsend, and Westford...The purchase and sale agreement for this transaction sets the selling price for the two hospitals at approximately 21 million dollars. It also provides for continued employment of virtually all employees with recognition of existing collective bargaining agreements. Steward underscored its intent to retain the existing management team at the hospital and does not anticipate any immediate changes in the services provided at Nashoba Valley. No capital expenditure is associated with this transfer of ownership...staff finds that the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600...The Division of Health Care Quality found that Steward meets the requirements for suitability set forth in 105 CMR 130.104."

Mr. Plovnick noted further that a public hearing was ordered by the DoN Program Director and held on January 13, 2011 at Ayer High School, "...The hearing, attended by 75 people, was conducted jointly with the Department's Division of Health Care Quality. All 21 of the speakers at the hearing testified in support of the acquisition of Nashoba Valley by Steward. No one spoke in opposition to the

proposed transfer of ownership. Commenters included the applicant, state and local government officials, community residents, local business leaders, hospital staff and physicians, and representatives of organized labor. Several parties submitted comments during the comment period, which extended through February 7, 2011. All of the speakers underscored the importance of keeping Nashoba Valley in the community to serve the many area residents who depend upon it. Most endorsed the acquisition by Steward, anticipating that it will strengthen the Hospital, its services, and the local economy. No one spoke in opposition to the proposed transfer of ownership. In conclusion, Staff recommends approval of this project with one condition, a condition related to the continued provision of interpreter services at the hospital.”

The staff summary states that Steward will provide the following benefits to the patients, employees, and community:

- Steward will provide the scale and depth to bring added clinical resources to the local community, making Nashoba Valley and attractive, high-quality alternative to the more expensive and less convenient downtown academic medical centers.
- Steward will retain the existing management team and will assure economic security for Nashoba Valley’s employees.
- Steward will implement its electronic medical record system and access to Steward’s network of 1600 physicians and state-of-the-art care management, case management and chronic disease management to all Nashoba Valley patients.
- Steward will make substantial investments toward providing local private-practice physicians with the resources needed to be clinically and financially successful and to remain in the local community.
- Steward will undertake major infrastructure improvements including a new power plant for the Hospital and will invest in the development of new clinical programs.

Mr. Mark Rich, Executive Vice President for Corporate Strategy and Management at Steward Health Care System, Boston, addressed the Council. He said in part, “...Merrimack Valley Hospital and Nashoba

Valley Medical Center are high quality health care providers that together employ over a thousand people. Today's health care environment is very challenging, and it is difficult for community hospitals to thrive when they are not part of a larger, local system that has significant resources. By joining Steward, these two hospitals will ensure their long term viability. The terms of the transaction are designed to preserve the vital health care services, jobs, and community benefits that these hospitals provide to their communities. Steward is committed to maintaining programs currently at both hospitals, including inpatient Behavioral Health programs. This transaction will also give patients at both facilities access to Steward's network of 1700 Massachusetts based primary and specialty care physicians. Steward is also committed to preserve jobs at both hospitals and maintain their current management teams and their local boards. These jobs will be preserved at current salary and benefits...Steward will maintain the hospitals' community benefits programs at current levels...This transaction provides 21.5 million dollars for capital improvements in these two hospitals, a minimum of ten million dollars will be spent at Merrimack Valley. This will create a better environment for patient care, and improved working environment for employees. One of the most capital intensive aspects of running a hospital in today's world is technology...At Steward, we have successfully integrated the latest technology into our hospitals and physician offices. To date, more than 85% of our 1700 physicians in all of our hospitals have fully functioning electronic health records, computerized physician order entry systems. All of Steward's physicians and hospitals are on schedule to be paperless by 2012. By joining Steward, both Merrimack Valley and Nashoba Valley will have immediate access to all these systems"

Mr. Rich said further, "...Steward's goal is to keep clinically appropriate care in a community setting. We believe the community hospitals can offer high quality, lower cost alternative to Boston's academic medical centers. To achieve this goal, Steward is investing hundreds of millions of dollars in capital in local hospitals. We will be investing over 215 million dollars in six hospitals in this year alone. We are investing in technology; infrastructure and equipment to give the patients at our hospitals a downtown Boston experience without

making them leave their community. Steward has created a lower cost, high performing accountable care organization. Steward is focused on keeping patients healthy and has built an infrastructure to allow physicians a larger local system that has significant resources. By joining Steward, these two hospitals will ensure their long term viability..." He noted that the Haverhill Chamber of Commerce also supports the transaction.

Note for the record, Chair Auerbach asked if any members of the public who previously spoke at the public hearings or send in written comments during the formal comment period wished to address the Council. No one responded. Discussions followed by the Council, excerpts follow, please see the verbatim transcript for full discussion. Mr. Rich noted that the hospitals will function independently but their base electronic medical records systems will be Meditech. If these two hospitals are approved today, their systems will be updated within a year. Physicians throughout the Steward system in Massachusetts will be able to access the electronic medical records system and further consult with another physician. Steward does not plan on specializing specific care in one area at one location but rather have specialists at all their hospitals providing care in the community setting. Steward plans on building patient volume at each hospital to offset the fixed cost expenditures in the building and equipment. Mr. Rich said in part, "We believe that, only a capital investment in each of these community settings will enable the patients to stay there and get a wide range of service, but also the clinical integration with the information technology will provide a platform to also draw those patients in and pull them in tight to their community...We have the benefit of basically increasing the volume and keeping it close to home and in doing so, lowering the cost of health care."

During discussion, Mr. Paul Lanzikos asked in regards to condition #9 in the agreement with the City of Haverhill, which states that Steward will provide transportation for Haverhill residents to Holy Family Hospital if existing services at Merrimack Valley Hospital are transferred there. Mr. Lanzikos asked if Steward would be agreeable to expanding transportation services to other people besides

Haverhill residents in the Merrimack Valley to Holy Family or to Saints Hospital in Lowell if they acquire that in the future. Steward responded that #9 was in response to a specific request by Haverhill but that he would share the sentiment with the Steward administrators at various facilities so that they will enter into it in spirit. Mr. Lanzikos asked further about condition #5 of the agreement between the City of Haverhill and Steward, "Why is the word "consider" used instead of just outright stating that they would appoint a member by the Mayor?" Mr. Rich replied "because of the requirements of DoN that require that 50% of the board live in the community." Mr. Lanzikos replied, "This can be interpreted as qualifying candidates." Mr. Rich said, "Yes".

Discussion continued, Ms. Prates Ramos inquired about the composition of the Patient and Family Council at Merrimack Valley Hospital. She asked if it represented the Latino community, noting that 70% of the residents of Lawrence are Latino who frequents the hospital. Mr. Michael Collins, President of Merrimack Valley Hospital responded by stating that they have tried to engage members of the Latino community in Haverhill without success. Mr. Prates Ramos stated that she strongly thinks that they should look into this matter and look to Lawrence for Latino members.

Dr. Alan Woodward asked of the applicant, "Is Steward willing to commit to a similar obligation that it did for all of the Caritas hospitals, that it would be at least a three-year commitment to maintaining a hospital?" Mr. Rich replied in part, "Yes, we can do that. We would be willing to add that in...It is in our plan. We are not interested in spending ten, fifteen million dollars in the next three years only to abandon our investment....It would be consistent with what we agreed to with Caritas."

Mr. Sherman asked the applicant about its financial viability. Mr. Rich responded in part, "...Our capital partner, Cerberus, has 25 billion dollars of assets, 2.5 billion dollars in cash, and not that they had to borrow, but that people have contributed to them, and this cash is actually effectively a line of credit for us. So, it is not dealing with a bank. It is what our partner has in their wallet..." Ms. Helen Caulton-

Harris clarified with the applicant that both institutions are operating in a positive margin and that Steward's business model is to increase market share by keeping people in the community utilizing the hospitals. Chair Auerbach summarized the additions to the conditions of approval that Steward has agreed to for the record: (1) multi-year commitment to Nashoba Valley Medical Center, similar to the Caritas agreements, not to close the facility or limit the general purpose of Nashoba Valley Medical Center (3/2 year agreement); (2) exploration of expanding the transportation commitment in the Merrimack Valley (#9 in the Haverhill agreement with Steward) to include residents beyond Haverhill to include all current users of the hospital; (3) investigation into IT compatibility for medical students and the feasibility of attending to that; (4) that the composition of the Patient/Family Councils at both Merrimack Valley and Nashoba Valley be reflective of those communities that have been historically underserved such as Latinos and the disabled and other groups, to reflect the diverse communities in the patient catchment areas; and (5) add clarification to condition #5 of the Haverhill Steward agreement that Steward will recommend to the local board that a "qualified" candidate would be required.

Dr. Alan Woodward made a motion to approve Project Application No. 3-3B96. After consideration upon motion made and duly seconded, it was voted unanimously to approve with conditions **Project Application No. 3-3B96 of Steward Medical Holdings Subsidiary One, Inc. for Transfer of Ownership of Merrimack Valley Hospital in Haverhill** through the sale of its assets to Steward Medical Holdings Subsidiary One, Inc., a subsidiary of Steward Health Care System, LLC, a Delaware limited liability company affiliated with Cerberus Capital Management, L.P. The application, as approved, provides for the transfer of ownership and original licensure of Merrimack Valley Hospital located at 140 Lincoln Avenue, Haverhill, Massachusetts. When the acquisition is completed, Steward will own, operate, and become the licensee of the Hospital. No capital expenditure is contemplated with this transfer of ownership nor is there any associated incremental operating cost. Supporting material is attached and made a part of

this record as **Exhibit No. 14, 975**. This Determination is subject to the following conditions:

1. Steward shall provide interpreter services as described in the document prepared by the Office of Health Equity, which is attached to the staff summary as Attachment 4.
2. Steward shall comply with the nine conditions set forth in the agreement of January 19, 2011 between Steward Health Care System, LLC and the City of Haverhill (the "Haverhill Agreement").

The following conditions were added by the Public Health Council at the Meeting of April 13, 2011 as noted above:

3. Condition #5 of the Haverhill Agreement is clarified as follows: If Steward and the City of Haverhill are successful in completing condition #4 of the Haverhill Agreement, Steward will recommend for appointment to the local governing board of Merrimack Valley Hospital a candidate recommended for such appointment by the Mayor of the City of Haverhill, provided that Steward determines that such candidate is qualified to fulfill the responsibilities of a member of such governing board and that such appointment will enable the Applicant to remain in compliance with 105 CMR 100.602.
4. Condition #9 of the Haverhill Agreement is clarified as follows: If Steward provides transportation services pursuant to condition #9 of the Haverhill Agreement, Steward will explore the possibility of expanding the transportation program to include additional communities served by the Hospital.
5. In accordance with 105 CMR 130.1801, at least 50% of the members of the Merrimack Valley Hospital Patient and Family Council shall be current or former patients and/or family members and representative of the community served by the Hospital. The Hospital will comply with the requirement that the Council should be representative of the community served by the Hospital and confirms that the Hospital will actively recruit members who reflect

After the vote was taken on Merrimack Valley Hospital, Mr. Paul Lanzikos asked that the Council be kept informed as follows: "...I would ask for some communication so that we are maintaining a sense of the vital signs, to make sure that these hospitals are operating in accordance to expectations, both in terms of the financial plans but also in terms of service agreements. While we don't normally know when services are ended in a particular licensed facility, I would ask that that would be monitored and reported to us maybe every six month, that there has been no change or disruption in service, or maybe this service started to change, just as an early warning sign because we don't want to say, in two or three years, gee, we wish we had done something a year ago..."

Chair Auerbach, noted that in the agreement with the Massachusetts Attorney General's Office in the Caritas Steward transfers, Steward agreed to provide funding over a five year period so support financial monitoring to do exactly what you are suggesting, that is to look very closely at the financial operation of Steward in management and oversight of the six formerly Caritas hospitals, public reporting of the financial status of those hospitals and the overall operation...They agreed to share that information with us...Similarly, we also received as part of that agreement settlement funding that will allow us to do a utilization monitoring mechanism that would look at how a need and whether the need was being met in the communities that were served by the six original hospitals...We have built into the reporting mechanisms to the Council that there are periodic updates to address what you suggested..." Ms. Elizabeth Daake, Director of Planning, Bureau of Health Care Safety and Quality said yes, Mr. Lanzikos requests can be incorporating in the monitoring process. Mr. Rich said, yes to Mr. Lanzikos request, stating, "We agreed to it with the Attorney General." Mr. Auerbach clarified that Mr. Lanzikos' request is to add the additional information on services being added or reduced, be incorporated into the updates to the Council. Mr. Lanzikos added that the request for information on any significant changes to services should include any future Steward applications

coming before the Council, knowing that there are two more coming at this point and included in the staff analysis.

Mr. Albert Sherman moved approval of Project Application No. 2-3B95. After consideration upon motion made and duly seconded, it was voted unanimously to approve with conditions **Project Application No. 2-3B95 of Steward Medical Holdings Subsidiary Two, Inc. for transfer of ownership of Nashoba Valley Medical Center** through the sale of its assets to Steward Medical Holdings Subsidiary Two Inc, a subsidiary of Steward Health Care System LLC, a Delaware limited liability company affiliated with Cerberus Capital Management, L.P. The application as approved provides for the transfer of ownership and original licensure of Nashoba Valley Medical Center located at 200 Groton Road, Ayer, MA. When the acquisition is completed, Steward will own, operate, and become the licensee of the Hospital. No capital expenditure is contemplated with this transfer of ownership nor is there any associated incremental operating cost. Supporting material is attached and made a part of this record as **Exhibit Number 14,976**. This Determination is subject to the following conditions:

1. Steward must provide interpreter services as described in the document prepared by the Office of Health Equity, which is appended to the Staff Summary as Attachment D and is incorporated herein by reference.

The following two conditions have been added by the Public Health Council at the Public Health Council Meeting of April 13, 2011:

2. Steward will not close, or limit the general purpose of, Nashoba Valley Medical Center within three years after the transfer is completed. In addition, Steward will conditionally extend the foregoing three year period for an additional two years. During that additional two-year period, Steward may not close the hospital or limit its general purpose unless the following conditions are met: the hospital has experienced two consecutive years of negative operating margins, and eighteen-month review and reporting period has been completed, and a six-month closure

3. In accordance with 105 CMR 130.1801, at least 50% of the members of the Nashoba Valley Medical Center Patient and Family Council shall be current or former patients and/or family members and representative of the community served by the Hospital. The Hospital will comply with the requirement that the Council should be representative of the community served by the hospital and confirms that the Hospital will actively recruit members who reflect the ethnic and cultural diversity of the community.

PRESENTATION: “MOLST: The First Six Month Pilot Project Report, Lessons Learned and Plans for Statewide Expansion”:

Ms. Andy Epstein, Special Assistant to the Commissioner, Department of Public Health, made introductory remarks. She said, “For those of us who have been working on the End-of-Life Report and the MOLST, this is a thrilling time for us to present what we feel will be a transformational difference in how care is received and given at end-of-life. I think this is key...”

Ms. Ruth Palumbo, Assistant Secretary, Executive Office of Elder Affairs, addressed the Council. She said, “...This is very much a part of patient-centered, patient focused approach, where choices are made available to patients, families and their care givers, and the process of developing the pilot and implementing the pilot in the Worcester area has been an incredibly rich experience. There has been input from all kinds of constituencies, and there has been very careful work with the medical community, the hospitals, nursing homes, and other facilities, that the folks at the steering committee, under the leadership of Chris McCluskey and Mary Valliere, has taken place, and we are very proud of the work that has been done, and I think the comments that we have received about the implementation to date really encourage us to move forward.”

Ms. Christine McCluskey, R.N., Community Outreach Director, Commonwealth Medicine, Center for Health Policy and Research,

stated in part, "...Just a brief overview of MOLST in Massachusetts. MOLST really is a process for discussing, documenting and sustaining treatments, and it is a standardized pink form, and I would like to emphasize this, it is the Medical Order form for writing and communicating these orders for treatments, for patients who are very ill and are expected not to recover, and they would be nearing the end of life, and those patients with serious advancing illness, including but not limited to life-threatening illness or injury, which may also include medical frailty and dementia. It is a portable document. It is meant to travel with patients from one care setting to the next, and it is voluntary, and it is for patients of any age who are at the end of life."

Ms. McCluskey said further, "...The Demonstration Project focused on the Greater Worcester area. The form itself, the original form, was implemented on April 1st and continues to be used to the present, but the demonstration period officially ended in December. It included acute care, primary care, managed care, emergency medical services, nursing homes, home health and hospice. The demonstration lasted long enough for us to be able to evaluate the process and identify barriers and facilitators for implementing MOLST in these various settings, but not really to look at patient outcomes specifically."

She continued, "In terms of the key findings, the nursing homes and the Home Run Program, which is a geriatric managed care home visiting program in the Worcester area, just in terms of looking at some of the utilization of MOLST in those sites, there were three participating nursing homes with a total of 351 patients. Over a period of about five months, in those three nursing homes, 65 or 19% of the patients were offered the use of MOLST and this was done on a very gradual basis, really looking at patients, residents first for whom MOLST would be most likely indicated, although we know many residents in nursing homes would be interested in having Medical Orders for Life Sustaining Treatment. Out of 65% of the patients offered the form in the nursing homes, 13% signed the MOLST form....For the Geriatric Home Visiting Program, which is at DOW clinic with a census of 265 at the time of the study...115

patients were offered the MOLST Form or 44%. Fifty percent of the patients accepted it over a period of eight months. In the Fallon Group, nurse practitioners specifically were working with those visiting, and talking with those patients at home. There was an average of four visits before the patient decided to finally sign the MOLST form and the visits occurred about 15 minutes on average. So it does take time to talk through the program with patients."

Ms. McCluskey indicated that some of the patients already signed a Comfort Care Form, which indicates their wish not to be resuscitated, so they were not seen most urgently in need of a MOLST form but would eventually be approached over time. Hospice patients having accepted Hospice had already worked through their goals of care and life-sustaining treatment and many had the Comfort Care Form in place too so they were not inclined to work through the form. Hospice staff saw the benefit of MOLST for their patients if provided earlier in their treatment and Hospice staff thought the form would be helpful if the patient is transferred to another setting of care. She noted that it is no longer a requirement under Hospice that a Do Not Resuscitate Order be in place "because one can't make that assumption with patients."

Dr. Mary Valliere of UMass Medical School followed with information on the acute care setting. Some excerpts from her presentation follow. "...In the acute care setting there was no data for any of this information at the hospital, UMass where I work and practice. We needed to go out and do physical chart reviews and collect this data ourselves...We did snapshots of the use of the MOLST form...so during the Demonstration Project, we sampled the hospital medicine services, inpatient services for mostly medical patients and reviewed those charts for the presence of any types of limitations on treatments that patients had while they were inpatient. We then sampled to see how those limitations of treatment were communicated to the next care giver, the next segment of care...From this sample which wasn't a scientific sample, we did see an increase in the number of patients who had limitations of treatment actually reported. This coincided with a change in our documentation in the hospital that actually, through our electronic

medical record, which was instituted during this time, that the hospitals were triggered to ask questions about this. So, this in addition to the fact that MOLST became a very prominent pink presence on the wards during that time.” She noted that only one in five people had limitations of treatment, which was much lower than they expected; and that this data is not collected in any organized fashion in hospitals.

Regarding the Emergency Department, she said it was a challenging site to implement MOLST for a number of reasons: (1) the fast pace, (2) the variable patient populations, and (3) not many patients have the MOLST form in this setting (she was informed by ED clinicians). During the Demonstration, nursing homes said they sent the forms with the patients to the hospital setting but never received them back from the hospitals. The ED doctors said it was the nurses’ job to keep track of the form because of all the staffing changes on the medical side. She said that emergency medical technicians embraced the MOLST form, stating that it is an improvement on the current Comfort Care DNR protocol that they follow. She said, “We trained EMTs for the Region 2 Demonstration area and we surveyed them afterwards...There was overwhelming enthusiasm to continue this form by them...”

In conclusion, she said in part, “...The major lessons learned were really that we need to do this. We need champions in each care setting to help shepherd this through, and health professionals need training, coaching and support to have these conversations, to have the model translated into the MOLST form and that the biggest barrier everywhere is not enough time, and we learned from the setting, the home setting, that short, multiple visits probably leads to the completion of MOLST in that setting and that may be the ideal. The recommendations in the report (not released yet) going forward are that the expansion plan will be strategic and occur over time, that due to the barriers and the amount of education that needs to be provided to people, that just putting this on the web would not be a responsible way to pursue it. There needs to be an organizational home for this, a project coordinator to really carry out this expansion plan in sequential fashion, and develop materials and activities that

need to continue the process. There needs to be ongoing education for health professionals and there also needs to be a media campaign...We need to track and evaluate information about this...We do feel this is something that should be integrated into things that are already going on and our principles going forward are to really develop strategic collaborations with projects going on and the next step in expansion is looking at places that have capacity and interest already...It's really about transitions in care and as patients travel through these transitions of care, we want the MOLST form to go everywhere with them." Dr. Valliere noted that Partners Health Care has made a commitment to them of \$200,000 dollars to support the continuation of the MOLST project.

Discussion followed by the Council. Please see verbatim transcript of the proceedings for full presentation and discussion. Mr. Josè Rafael Rivera asked the MOLST presenters if they have worked with the faith communities because his experience shows in racially and ethnically different communities that is where they get their information and comfort in that stage of life. He offered to connect them with the Worcester Interfaith Church. Ms. McCluskey and Dr. Valliere said they have worked with some faith communities to get the MOLST information out and plan to do more. Dr. Alan Woodward made some comments and suggestions: (1) the MOLST form shouldn't be used just at the end of life but would be beneficial to others such as those with acute myocardial infarction and (2) we should encourage primary clinicians to talk to their patients about it and (3) maybe hospital discharge is a good time for the at least 15 minute discussion, and (4) there is no time in the ER for the discussion, but it should be used in the ER for patient care and (5) suggests having an arm band or bracelet which indicates they have a MOLST form for folks especially in the ER to see and (6) other foundations such as Blue Cross should be approached for funding so that the program can be implemented statewide. He said in part, "...Through the Office of Emergency Medical Services (OEMS), we rolled out the Comfort Care program statewide and we didn't have huge funding to do that. We got it in basically in almost every primary physician's office so I hope we can do the same with this..."

Discussion continued, Dr. Muriel Gillick added, "As a primary care physician and someone who has written a lot about Advance Care Planning, and has been on the End-of-Life Panel, this is something near and dear to my heart. I think it is important to keep remembering that the validity of this, the conceptual validity, is dependent on the discussions that precede completing the form...Advance Care Planning is a process and as lovely as the form is in its pink luminescence, the temptation is to measure outcome by completion of the form. I think, as we design any kind of performance measures in the future, it is really important to investigate...whether appropriate discussion is preceding completion of the form..." Dr. Gillick further noted that this is to a large extent about transitions of care but it is also about internal processes because a person may be staying in one place, like in a nursing home. In addition, Dr. Gillick noted that if everyone involved with the patients' care doesn't know what the MOLST form is all about, it will be useless and therefore she has reservations about step by step implementation. In this regard she stated, "It is imperative in starting with EMS but making sure critical players at all the potential receiving institutions, to get into the Transitions of Care model, do understand what this is."

Ending the discussion, Mr. Paul Lanzikos added his concern about the financing aspects, noting that it will take millions of dollars to get this started with a clinician getting paid for an hour of time, it takes to have the discussion with the patient. He said in part, "This needs to be worked into regular reimbursement systems. Otherwise, it is going to be a great idea with lots of potential but it won't happen...We need to get Medicaid to commit to this reimbursement, Elder Affairs needs to make this a service that we authorize for case managers, purchase the service, so we authorize an hour or two of consultation. Nursing facilities need to have this built into their rate. Otherwise, it's not going to happen and typically the people who need it most are the people who have the least resources, who don't have the attorneys to do advance planning. These are the people who are going to be relying on public resources to make this happen...It needs to be incorporated into major reimbursement and

financing schemes on an ongoing basis. Otherwise, this is just not going to have a lasting impact.”

NO VOTE/INFORMATION ONLY

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF MARCH 16, 2011:

Mr. Albert Sherman moved approval of the minutes of March 16, 2011. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the minutes of March 16, 2011 as presented.

FOLLOW-UP ACTONS STEPS:

- Modify Condition #5 of Haverhill Agreement to expand transportation to Merrimack Valley residents to Steward Hospitals (Lanzikos) [See page 16 of this document for details].
- Modify Condition #9 of Haverhill Agreement by replacing the word “consider” with “qualified candidate” (Lanzikos) [See page 17 of this document for details].
- Add Condition to both Steward applications to have Patient & Family Council board Members reflect the diversity of the patients (Prates Ramos) [See page 17 of this document for details].
- Add condition to Nashoba Valley Medical Center application not to close the Hospital, similar to Caritas applications (Woodward) [See page 17 of this document for details].
- Report to the Public Health Council every six months on the Steward applications in regards to any financial changes or change in services (Lanzikos) [See page 20 of this document for details].
- Work with Faith communities to get word out about the MOLST Form (Rivera) [See page 26 of this document for details].
- Have an armband or bracelet for MOLST users (Woodward) [See page 26 of this document for details].
- Approach Foundations like Blue Cross to seek funding for MOLST (Woodward) [See page 27 of this document for details].
- Make sure all critical players understand MOLST (Gillick) [See page 27 of this document for details].

- Contact Medicare Program and Elder Affairs (EOEA) and others about providing reimbursement for clinicians to have MOLST discussions (Lanzikos) [See page 27 of this document for details].

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

- Docket of the meeting
- Copy of the meeting notice to A&F and Secretary of the Commonwealth
- Draft minutes of the Public Health Council for the Meeting of March 16, 2011
- DoN Staff Summary to the Council on Project Application No. 2-3B95 of Steward Medical Holdings Subsidiary Two, Inc. for Transfer of Ownership of Nashoba Valley Medical Center
- DoN Staff Summary to the Council on Project Application No. 3-3B96 of Steward Medical Holdings Subsidiary One, Inc. for Transfer of Ownership of Merrimack Valley Hospital
- Comments from the public hearing on Merrimack Valley Hospital No. 3-3B96
- Letter from the Mayor of Haverhill dated April 12, 2011 on Project No. 3-3B96

The meeting adjourned at 12:10 p.m.

John Auerbach, Chair

LMH

