

**MINUTES OF THE
PUBLIC HEALTH COUNCIL MEETING OF
August 10, 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, August 10, 2011, 9:07 AM

1. ROUTINE ITEM: No Floor Discussion

- A. Compliance with Massachusetts General Laws, Chapter 30A **(No Vote)**
- B. Record of the Public Health Council Meeting of June 8, 2011 **(APPROVED)**

2. DETERMINATION OF NEED: CATEGORY 1 APPLICATIONS (APPROVED)

- I. **Project Application No. 2-4940 of New England Surgical Center for Outpatient Endoscopy, LLC** – Transfer of ownership of ambulatory surgery center
- II. **Project Application No. 2 -4941 of Surgical Eye Experts of New England, LLC** – Transfer of ownership of ambulatory surgery center

3. REGULATION: No Floor Discussion (APPROVED)

Request for Final Promulgation of Amendments to Regulations at 105 CMR 700.000 (Implementation of the Controlled Substances Act) – Nurse Anesthetists

4. REGULATION: No Floor Discussion (APPROVED)

Request for Final Approval to Promulgate Amendments to Regulations Authorizing expedited partner Therapy (EPT), 105 CMR 700.000 (Implementation of the Controlled Substances Act) and 105 CMR 721.000 (Standards for Prescription Format and Security in Massachusetts)

5. PRESENTATION: No Vote/Information Only

Occupational Sharps Injury Report – Bureau of Health Statistics, Research and Evaluation

6. PRESENTATION: No Vote/Information Only

Presentation of Emmy to the Department of Public Health in response to the 2009 H1N1 Pandemic

7. PRESENTATION: No Vote/Information Only

2009 Birth Report – Bureau of Health Statistics, Research and Evaluation

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 Public Health Council (M.G.L. C17, §§ 1,3) was held on August 10, 2011, at 9:07 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen Caulton-Harris, Dr. John Cunningham, Dr. Michele David, Mr. Paul Lanzikos, Mr. Jose Rafael Rivera, Mr. Denis Leary, Mr. Albert Sherman, Dr. Alan Woodward, Dr. Barry Zuckerman. Absent members were: Harold Cox, Dr. Muriel Gillick, Ms. Lucilia Prates Ramos, Dr. Meredith Rosenthal, Dr. Michael Wong. Also in attendance was Attorney Donna Levin, General Counsel, Massachusetts Department of Public Health.

Chair Auerbach announced that notice of the meeting has been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF JUNE 8, 2011:

Council member Albert Sherman made the motion to approve the minutes of June 8, 2011. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the minutes of June 8, 2011 as presented.

DETERMINATION OF NEED: CATEGORY 1 APPLICATIONS: PROJECT APPLICATIONS NO. 2-4940 OF NEW ENGLAND SURGICAL CENTER FOR OUTPATIENT ENDOSCOPY, LLC – TRANSFER OF OWNERSHIP OF AMBULATORY SURGERY CENTER & PROJECT APPLICATION NO. 2-4941 OF SURGICAL EYE EXPERTS OF NEW ENGLAND, LLC – TRANSFER OF OWNERSHIP OF AMBULATORY SURGERY CENTER

For the record, Chair Auerbach noted that there will be two separate votes. First vote will be to approve Project Application No. 2-4940 and then another vote to approve Project Application No. 2-4941.

Joan Gorga, Director of the Determination of Need Program, joined by Bernard Plovnick, Senior Analyst in the Determination of Need Program, presented on the applications for transfer of ownership of two ambulatory surgery centers. Mr. Plovnick explained that both facilities are licensed, single-specialty ambulatory surgery centers located in Worcester and currently owned and operated by the same parent organization, namely Fallon Clinic, Incorporated, a large multi-specialty medical group practice serving Central Massachusetts.

Mr. Plovnick explained that the two ambulatory surgery centers are undergoing a change in corporate control. Fallon is to become the sixth medical group under the Atrius umbrella whereby Atrius Health Incorporated will become its sole corporate member. Atrius Health is a non-profit alliance of five medical groups in Eastern Massachusetts. The planned affiliation was investigated by the Anti-Trust Division of the Office of Attorney General. The Attorney General, Atrius and Fallon signed an agreement in Suffolk Superior Court on June 11, 2011 to permit the affiliations subject to conditions that would allow the Attorney General to monitor Atrius agreements with commercial health insurance third party payers. Because physicians and medical clinics are not subject to Determination of Need (DoN), DoN review of the Atrius-Fallon affiliations has been limited to the two ambulatory surgery centers.

Mr. Plovnick noted further that these are technical transfers of ownership as defined in the DoN regulations. After the closing of the agreement between Fallon and Atrius, Fallon will continue to be the sole corporate member and manager of New England SCOPE and SEE New England. There is no capital expenditure associated with either proposed transfer of ownership. In addition, there will be no change in the services provided by each of the two ambulatory surgery centers. Mr. Plovnick stated, "...The recommendation of Staff for both projects, numbers 2-4940 and 2-4941, is approval with one condition, that being a standard condition requiring the Applicants' continued participation in the Medicare Program..."

A brief discussion followed the presentation. Please see transcript for full discussion.

Mr. Sherman moved approval of the transfer of ownership of the first ambulatory surgery center, New England Surgical Center for Outpatient Endoscopy, Ltd. Mr. Jose Rafael Rivera seconded the motion. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project 2-4940** [Dr. David abstained from the vote.]

Dr. Woodward moved approval of the transfer of ownership of Surgical Eye Experts of New England, LLC. Ms. Caulton– Harris seconded the motion. After consideration, upon motion and duly seconded, it was voted unanimously to approve **Project 2-4941** [Dr. David abstained from the vote.]

NO FLOOR DISCUSSION, VOTE ONLY

REGULATION: REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO REGULATIONS AT 105 CMR 700.000 (IMPLEMENTATION OF THE CONTROLLED SUBSTANCES ACT) – NURSE ANESTHETISTS

Dr. Madeline Biondolillo, Medical Director, Bureau of Health Care Safety and Quality and Dr. Grant Carrow, Director, Drug Control Program reviewed the basis for these regulations and reported on the public comments and staff response to the public

comment. Chapter 191 of the Acts of 2010 was signed by the Governor Patrick in July 2010. The Act amended the Controlled Substance Act as well as the Nursing License and Provisions. This law was to improve access to safe patient care, reduce medication errors and adverse effect and health care costs.

Grant Carrow said further, "The provisions of the Act that amended Chapter 94C of the Controlled Substances Act required the Commissioner to promulgate rules and regulations to allow Nurse Anesthetists to register with the Department to write prescriptions in accordance with guidelines that they developed mutually with the supervising physician. The Act also provides that the Nurse Anesthetists registered with the Department may issue medication orders, dispense medication for immediate treatment, administer without the order of a physician, and dispense a sample medication. All of these points are addressed in the regulations that were proposed in November."

Dr. Carrow also discussed the provision that amended the Control Substance Act are parallel for other advice practice nurses, which include nurse practitioners, nurse midwives and psychiatric nurse mental health clinical specialists.

Dr. Carrow reviewed the different roles of the various partners in this project. He said in part "...for the two boards involved, the regulations of Board of Registration in Nursing set the licensing and clinical practice standards for nurse anesthetists, including prescribing. The regulations of the Board of Medicine set the standards for the supervising physician with whom the nurse anesthetist has established mutually-developed and agreed upon the guidelines. A nurse anesthetist who has already been authorized by the Board of Nursing to have the ability to register for prescribing and dispensing controlled substances. The law permits a nurse anesthetist to also order tests and therapeutics for the immediate per-operative care of a patient in accordance with the guidelines."

Dr. Carrow said further "...In concert with the regulatory amendments being proposed to you today, the other regulations of the other Boards are described here so that the Nursing Board regulations would define the scope of prescriptive practice of a nurse anesthetist, require the nurse anesthetist to have the appropriate training and experience, and specify the requirements for the guidelines. On the other hand, the Board of Medicine's regulations would set the requirements for the supervising physician, and also specify requirements for the guidelines."

Dr. Carrow pointed out that Chapter 191 amends both the Controlled Substance Act and the Nursing Practice Act. However, it did not amend the Physician Practice Act. The Board of Registration in Medicine has determined that their regulations are sufficient as they are and they do not need amendments in order to accommodate this statutory change. The Board of Registration in Nursing will be making amendments, and they will be filed at the same time as the Drug Control Program amendments.

Testimony is listed below from the public hearing which was held in January 2011. T

Comment	Action
Change the definition of “supervising physician” to include consistent reference to practice acts	Staff have simplified and clarified this definition by adding language requiring supervision by the physician to be in accordance with regulations of the Board of Registration in Medicine
Add language to permit a nurse anesthetist to obtain anesthetics from any registered practitioner, not only the supervising physician	Such language was added, with the caveat that such administration must be in accordance with guidelines of the Board of Registration in Medicine
Add language to state that the administration of anesthesia by a nurse anesthetist to a patient shall not require a written prescription and is not an activity requiring registration under M.G.L. c. 94C and DPH regulations at 105 CMR 700.003©	Change not included because (1) there is no current requirement for a written prescription to administer anesthesia; (2) c. 191 of the Acts of 2012 requires registration of a nurse anesthetist with DPH for the prescribing, dispensing and administering of any controlled substance, including anesthetics, when conducted other than pursuant to the order of a registered practitioner; and (3) a nurse anesthetist without registration may administered anesthesia pursuant to the order of a registered practitioner
The definition of “medication order” does not appear to include all current, applicable health care delivery settings	Staff agree that the definition is unduly restrictive to inpatient health care settings, particularly given that the statue does not have such restrictions; staff have added language to broaden the definition to also cover ambulatory and other health care settings

Discussion followed by the Council. Please see verbatim transcript for full discussion.

Mr. Denis Leary moved approval of the request for **Final Promulgation of Amendments to Regulations at 105 CMR 700.000**. Dr. Cunningham seconds the motion. After consideration, upon motion made and duly seconded, it was voted unanimously to approve Amendments to Regulations at **105 CMR 700.000**.

NO FLOOR DISCUSSION, VOTE ONLY

REGULATION: REQUEST FOR FINAL APPROVAL TO PROMULGATE AMENDMENTS TO REGULATIONS AUTHORIZING EXPEDITED PARTNER THERAPY (EPT), 105 CMR 700.00 (IMPLEMENTATION OF THE CONTROLLED SUBSTANCES ACT) AND 105 CMR 721.000 (STANDARDS FOR PRESCRIPTION FORMAT AND SECURITY IN MASSACHUSETTS)

Kevin Cranston, Director, Bureau of Infectious Disease Prevention, Response and Services, Dr. Madeleine Biondolillo, Medical Director, Bureau of Health Care Safety and Quality and Dr. Katherine Hsu, Medical Director, Division of STD Prevention in the Bureau of Infectious Disease.

Dr. Biondolillo reviewed the issue of Chapter 31 – 131, Section 62 of the Acts of 2010 which requires that the Department regulates authorization of certain health care providers to prescribe or dispense antibiotics to treat Chlamydia infections in the sex partners of infected patients without examination of the partner. This practice is known as EPT, or Expedited Partner Therapy. The regulatory changes are amendments to 105 CMR 700.000, Implementation of the M.G.L. Chapter 94C, which is the Controlled Substances Act, and 105 CMR 721.000, Standards for Prescription Format and Security in Massachusetts. The Expedited Partner Therapy (EPT) does not permit the prescription to indicate either EPT an information sheet listing the field required by the regulation. In addition, the provision of EPT by clinicians is voluntary.

Dr. Katherine Hsu noted to the council members that Chlamydia infection is the most common reported sexually transmitted infection in the U.S., and in Massachusetts the number of reported cases has more than doubled in the last decade, from approximately nine thousand to over thirteen – approximately nineteen thousand at this moment. Dr. Hsu stated “Despite its prevalence, Chlamydia infection is often undiagnosed as most individuals are in fact asymptomatic, and patients with Chlamydia infection are at increased risk for re-infection after treatment if their sex partners are not also treated. EPT helps prevent re-infection by increasing the likelihood that sex partners are effectively treated, even if they are unwilling or unable to seek medical care on their own. EPT has been shown to be safe and effective in the treatment of sex partners in several studies, and most states with long-standing EPT programs also have no reports of adverse events.”

Dr. Hsu provided an updated on the implementation she stated in part, “The clinical advisory and clinical prior notification will -- have already been drafted. It is Utilizing Expedited Partner Therapy for Chlamydia Infection in Massachusetts is its title, and of course it will be posted on the MDPH web site. The advisory will also be distributed through a number of licensing boards and a number of provider networks within the Division of STD Prevention, as well as throughout the Bureau of Infectious Diseases and across bureaus, as well. We will collaborate to provide links on the MMS web site, as well as other professional organizations. In terms of partner and patient information, the draft of a documentation information sheet has also been made. The message for

partners about Chlamydia infection, Expedited Partner Therapy, and this information sheet, provided by the Department of Public Health or comparable to that provided by the Department of Public Health will be given out whenever possible with each dose of the Azithromycin and be available on line for release.”

Testimony listed below from the public hearing which was held in April 29, 2011. They received testimony from a number of organizations and individuals, and that testimony was generally supportive.

Comment	Action
Amend the BORIM Prescribing Practices Policy and Guidelines to support prescribing for EPT	Completed at the end of 2010 http://www.mass.gov/Eeohhs2/docs/borim/policies_guidelines/policy_89_01.doc
Revise language on dissemination of partner information sheet so that the need to disseminate information about EPT does not prevent the provision of needed care	Language revised (see attached regulations) to require information sheet “whenever possible”, and to allow provider to disseminate comparable information sheet
Address barriers to EPT posed by Electronic Medical Record (EMR) or other e-prescribing systems	If an electronic medical record (EMR) or other e-prescribing system does not permit an electronic prescription for “Expedited Partner Therapy,” “E.P.T.,” or “EPT,” an information sheet listing fields required by 105 CMR 721.000 will be available online to assist prescribers with generating a written prescription
Translate Partner Information sheet into languages other than English	Translation will take place over the coming year
Include a statement that EPT for same-sex partners is not prohibited	Because the statute and regulations don’t draw any distractions as to the nature of the relationship between the patient and the sex partner, staff believes that this language does not need to be added
Include an additional statement legally protecting physicians who prescribe for an individual whom they have not seen and for whom they have no medical record	Statutory and regulatory language authorizes providers to issue a prescription for an individual whom they have not seen and for whom they have no medical record
Partner Information Sheet Section 3 – list all medications, not just drug categories	Not feasible in terms of space for this document. Prescriber or pharmacist can best answer any questions

Discussion followed by the Council. Please see verbatim transcript for full presentation and discussion.

Mr. Rivera moved approval of the request for **Final Approval to Promulgate Amendments to Regulations Authorizing Expedited Partner Therapy (EPT), 105 CMR 700.000 and 105 CMR 721.000**. Dr. David seconds the motion. After consideration, upon motion made and duly seconded, it was voted unanimously on regulations **105 CMR 700.000 and 105 CMR 721.000**.

NO VOTE, INFORMATION ONLY

For the record, this discussion was not listed on the docket of the August 10, 2011 meeting.

INFLUENZA VACCINE

Chair Auerbach recognized Dr. Woodward, who wished to present information to the Council pertaining to influenza vaccination among health care workers.

Mr. Auerbach stated, "We will be, next month, having a presentation.. on the outcome of the regulation that we passed two years ago, that requires that health care workers, certain health care workers, must be offered an influenza vaccine by their employer, and if they choose not to be vaccinated, they have to sign a declination form, which indicates the reason why. We gathered that information, and we will be presenting it during next month's meeting, but Dr. Woodward's comments are relevant to the issue."

Dr. Woodward shared a letter that was sent to the Commissioner and others by the Eastern Massachusetts Health Care Initiative, which includes hospital, health plans, provider groups, academic experts in the Boston area. This group works to improve health care systems and specially focusing on eliminating hospital associated infections as well as optimizing influenza vaccinations.

Dr. Woodward mentioned " ... I would just circulate this letter, and suggest that we might even invite Ken Sands, that will be up to the Commissioner, who chaired this task force, it was co-chaired actually by he and Stu Altman, but it is signed by Dana Farber, and Tufts, and Beth Israel, and Blue Cross/Blue Shield, and Neighborhood Health Plan, and Children's Hospital, and Mass Eye and Ear, and Partners, and Lahey, and Atrius, and Brigham and Women's, you can see, and all other major plans in Eastern Massachusetts, and most of the -- and Harvard Medical Schools, (M. Thayer) and (Ellen Zane) from Tufts."

Dr. Woodward pointed out how important it was to recognize vaccinations, in times of an epidemic/pandemic, since health care workers and providers can be one of the primary vectors.

Discussion followed by the Council. Please see verbatim transcript for full discussion.

PRESENTATION: NO VOTE/INFORMATION ONLY

OCCUPATIONAL SHARPS INJURY REPORT – BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION:

Angela Laramie, Coordinator, Massachusetts Sharps Injury Surveillance System and Dr. Tish Davis, Director, Occupational Health Surveillance Program made a PowerPoint presentation highlighting sharps injuries to hospital workers in Massachusetts.

Dr. Davis spoke about the Sharps program and the collaborative efforts since the beginning of 2000. They have worked together with Mass. Hospital Association, Mass. Nurse Association, Mass. Medical Society, local experts and consumer representatives.

Ms. Laramie shared information about the current system and provided background, as well as data from 2002 through 2009, which was published in Infection Control and Hospital Epidemiology.

Ms. Laramie stated “ ... the CDC has estimated that there are more than three hundred and eighty-five thousand sharps injuries that occur in hospitals across the United States. This has been adjusted to account for under reporting, and we know that about half of injuries in general go unreported. We also know that sharps injuries present a risk of transmission of more than twenty blood-borne pathogens. The most common are Hepatitis B, Hepatitis C, and HIV, and we also know that the cost of exposure, they can range up to almost five thousand dollars, and those costs include lab tests for both the source patient, as well as the exposed hospital personnel, and lost time due to taking the post-exposure prophylaxis, which the drugs can make you actually quite ill. What this does not include is the human cost, the anxiety, the loss of productivity, the effects on families.”

Ms. Laramie discussed the history of Karen Daley, a nurse working in an emergency room in Massachusetts. During her shift she sustained a needle stick. At the time of her injury, she was the president of the Mass. Nurse Association and it was because of her position and her subsequent zero conversion to two diseases, that she was able to take action, and put together a legislation that was filed by the MNA in 1998, and that was passed in 2000. The Department filed a federal legislation in 2000, which asked Occupational Safety and Health Administration (OSHA) to revise the blood-borne pathogens standard. MDPH promulgated their regulations in April of 2001.

Chart listed below of regulations and interventions required for Sharps

MDPH Sharps Injury Prevention Regulations
Incorporate the use of needles/ sharps devices with engineered sharps injury

prevention features (SESIPs)
Maintain a written exposure control plan – with procedure for selecting safer devices
Maintain a Sharps Injury Log – use data for continuous quality improvement
Report to MDPH annually
Interventions
Site visits to hospital <ul style="list-style-type: none"> - with BHCS&Q, verify compliance or non-compliance with regulations - demonstrate ways to use data - work with committees & departments within hospitals
Regional meetings with hospitals
Provide technical assistance on prevention and surveillance

Ms. Laramie briefly described the system in which a specific population is under surveillance. She stated, “We are interested in looking at all health care providers within the licensed hospitals. So, we are not interested in whether they are just employees. We want to know about everybody who is at risk. So, that includes volunteers. It does include interns and residents. It includes non-employee practitioners, physicians who have privileges. If somebody is providing services from another company, say its anesthesia or dialysis the hospital contracts with, if there is a needle stick injury, it should end up on the log. We are interested in any percutaneous injury. We capture our data on a calendar year basis, and then, you can see the list of data elements that we collect to characterize the nature of these injuries.”

Discussion followed by the Council. Please refer to the verbatim transcript for a full presentation and discussion.

NO VOTE, INFORMATION ONLY

For the record, this discussion was not listed on the docket of the August 10, 2011 meeting.

Health Resource Planning as Outlined in *An Act Improving Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments*

Chair Auerbach presented on Health Resource Planning. This topic is both important for the Bureau of Health Care Safety and Quality and Determination of Need Program. Chair Auerbach states “...This is a presentation that relates to an important component of the Payment Reform Legislation that the Governor has filed and, as Members of the Council I think are aware, the Governor’s highest priority in the Legislature this year is for a comprehensive bill that would alter payment reform, our payment mechanism for the State, and so, while the largest section of that proposed law deals with issues related to Account Care organizations, moving away from fee-for-service to global payment with the creation of quality indicators, there is a section of the proposed law that is very much related to the work of the Council and to the work of the Bureau of Health Care Safety

and Quality, and to the Determination of Need Office, and so, I thought I would share with you the following presentation, which is one that I have used in some of the legislative hearings on the consideration of the Governor's proposed legislation."

Chair Auerbach discussed the Governor's proposed legislation that would allow a new unit in the Bureau of Health Care Safety and Quality. This unit would need an estimated 20 additional staff members. The state health plan would include the following: an inventory of current health care facilities, an assessment of the need for every service or supply on a state-wide or regional basis and it would require a five-year projection for such need. The Department currently has an inventory on current health care facilities. He also noted that this information presented is not comprehensive.

Chair Auerbach also mentions the changes the Council has made over the last four years and the two separate major regulatory changes to the Determination of Need (DoN) provisions. Those projects are reviewed at the Department while the outpatient capital project now is reviewed by the DoN. Although the Department is expanding the area of work, there are not enough resources to be able to address the related issues to health planning and regulatory oversight. Currently, the DoN programs has less than three fulltime people and are challenged by the growing complexity of the health care environment, new technology developments that continue to occur and well as those increase regulator responsibilities.

Please refer to the verbatim transcript for a full account of the Chair Auerbach discussion and a full account of the Council discussion.

PRESENTATION: NO VOTE/INFORMATION ONLY: 2009 BIRTH REPORT – BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION

Dr. Lauren Smith, Medical Director, Department of Public Health presented 2009 data on the overall trends in birth outcomes, infant mortality and gestational diabetes.

Dr. Smith began "...I have talked about it before, but I want to give you an update on that, as well as some good news around prenatal care and breast feeding, and some updates around cesarean deliveries, which I spoke to you about last time. We have been doing some work, additional work on that. So, in terms of recent birth trends, what you see here is that the trend continues to decrease in terms of overall numbers of births per year in Massachusetts. Whereas, in 1990, we had a high of about ninety-two thousand births, now we are down to about seventy-five thousand births, and that trend seems to be quite consistent."

Dr. Smith also mentioned the trends in births by gestational age. She said in part, "...I want to show here the trends in births by gestational age. Note, full term gestation is anywhere from really sort of thirty-eight to thirty-nine to forty-one weeks, and what has been very interesting in Massachusetts is the shift of the distribution of gestational age

births to earlier births. So, if you look at 1990, this is what the trend looks like. You know, obviously, most of the births happening around term, which is the way we like it, but look at 2000, you will see it has moved ever so slightly to the left, which means that there are increased numbers in that late term or late preterm and early term period, thirty-seven, thirty-eight weeks. Then you look at 2009, and the shift has continued to occur."

Dr. Smith discusses the increase in preterm births during this twelve year to thirteen year period. She stated "The main take-away here is that the very early preterm births of less than twenty-eight weeks, the very smallest infants, that rate has really been unchanged for this entire period, as has the twenty-eight to thirty-three week preterm birth. Really, the increase in preterm births during this twelve year period, or thirteen year period, I guess, has been in the late preterm, so thirty-four to thirty-six, and I highlight that because that is something that we are under-taking as part of our Massachusetts Prenatal Quality that I want to tell you about, but that's where we are looking."

She noted that DPH has recognized these ongoing, major issues in clinical care. They have convened a meeting of stakeholder from different health systems across Massachusetts to look at the current system. They are trying to implement new approaches to screening without having to cause implications to lab systems, reporting and diagnosis.

Dr. Smith discusses the Diabetes Prevention Program as an example of a positive affect of strong policy and programmatic interventions in order to reach all populations. She stated "And lastly, this is an example, there was -- the program, the Diabetes Prevention Program, held multiple key informant interviews with providers and women with gestational diabetes, gathered themes that people identified as being important, and developed two new TV ads on three channels in Spanish. Now, the reason Spanish was chosen, as you remember, Latino women didn't have the highest rates of gestational diabetes but when you look at their birth rate and the overall numbers of births, even with that rate of gestational diabetes, there was an opportunity for substantial impact in here where -- I said three, but there's four - sorry about that -- knowing the risk for Type 2 Diabetes, the importance of the follow-up testing for all the reasons we just talked about, and then, the broader issue that it is, of course, important for all Public Health to maintain a healthy weight sort of across the lifespan."

Dr. Lauren Smith then discussed the higher breastfeeding rates in Massachusetts compared to the U.S. This information is based on birth certificate data, which a fairly low bar for crossing. She also mentions that the Bureau of Family Health and Nutrition WIC Program have made significant and conscious efforts to increase breastfeeding. The WIC Program strengthened its WIC breastfeeding services and they have changed its food policy and its breastfeeding policy for recipients. There is a clear relationship between the policy decision of organizing nutrition benefits for breastfeeding women

and the rates of women exclusively breastfeeding. Dr. Smith acknowledges all the hard work and dedication to improving the rates of breastfeeding to the WIC department.

Lastly, Dr. Smith discussed the working relationship with hospitals and DPH. The Centers for Disease Control and Prevention (CDC) has a set of criteria for maternity practices and infant nutrition. Hospitals are then graded based on CDC criteria. Massachusetts received a seventy-nine out of a hundred for those states who are competitive. Massachusetts is ranked third in the US and is tied with Maine. Dr. Smith briefly discussed the steadily increased rate of cesarean sections in Massachusetts, while vaginal births are at an all time low.

Discussion followed by the Council. Please refer to the verbatim transcript for a full presentation and discussion.

PRESENTATION: NO VOTE/INFORMATION ONLY: PRESENTATION OF EMMY TO THE DEPARTMENT OF PUBLIC HEALTH IN RESPONSE TO THE 2009 H1N1 PANDEMIC

For the record, this presentation is out of sync with the docket approved.

Jennifer Manley, Communications Director was highlighted for the Department's response to H1N1 in 2009. Ms. Manley stated, "In addition to our already established Flu Facts campaign, we launched a multi-faceted campaign including radio, print, broadcast, messages with the MBTA, MassPort in several different languages with the four simple messages; Cover Your Cough, Wash Your Hands, Stay Home If You Are Sick, and Get Vaccinated. We had to do this quickly and efficiently, so we partnered with the Rendon Group for a series of thirteen different PSAs, and recently we won Outstanding Public Service Announcement at the Massachusetts Emmys for three of our PSAs that concentrated on populations that we saw were not getting vaccinated."

Rick Rendon from the Rendon Group presented the Commissioner with the Emmy for their partnership during the H1N1 outbreak. The Emmy award is equivalent to the National Awards. New England television stations and video productions submit their best work to be judge. The judges base their votes on the content, delivery, messaging, various production elements and public service campaigns of the submitted videos.

Discussion followed by the Council. Please see the verbatim transcript for full discussion.

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 PHC meetings of June 8, 2011
- Determination of Need (DoN) Category 1 Application memorandum on Project Application No. 2-4940 of New England Surgical Center for Outpatient Endoscopy, LLC
- Determination of Need (DoN) Category 1 Application memorandum on Project Application No. 2-4941 of Surgical Eye Experts of New England, LLC
- Informational briefing memorandum and proposed draft Regulations on 105 CMR 700.000: Implementation of the Controlled Substance Act – Nurse Anesthetists
- Informational briefing memorandum and proposed draft Regulations on 105 CMR 700.000: Implementation of the Controlled Substances Act
- Informational briefing memorandum and proposed draft Regulations on 105 CMR 721.000: Standards for Prescription Format and Security in Massachusetts

The meeting adjourned at 11:44 a.m.

Chair John Auerbach