

MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of December 16, 2015

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

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

Docket: Wednesday, December 16, 2015 9:00 AM

1. ROUTINE ITEMS:

- a. Introductions
- b. Updates from Commissioner Monica Bharel, MD
- c. Record of the Public Health Council Meeting November 18, 2015 **(Vote)**

2. DETERMINATION OF NEED

- a. Shields Signature Imaging, LLC (“Shields Signature” or “Applicant”) has filed a Determination of Need (“DoN”) for a mobile Positron Emission Tomography-Computed Tomography (“PET-CT”) service one day per week. No. 5- 4958 **(Vote)**

- b. Shields Sturdy PET-CT, LLC (“Shields Sturdy” or “Applicant”) has filed a Determination of Need (“DoN”) for a mobile Positron Emission Tomography-Computed Tomography (“PET-CT”) service one day per week. No. 5- 4959 **(Vote)**

- c. The Massachusetts General Hospital (“MGH” or “Hospital”) MGH has filed a Determination of Need (“DoN”) application seeking approval of a three-phased renovation project of existing space to reconfigure the design and upgrade the infrastructure of the Hospital’s existing perioperative services. No. 4-3C45 **(Vote)**

3. FINAL REGULATIONS

- a. Final Promulgation on Proposed Amendments to 105 CMR 153.000 (*Licensure Procedure and Suitability Requirements for Long-Term Care Facilities*), to Establish a Hearing Process for Closures and Changes of Ownership of Long Term Care Facilities **(Vote)**

4. PRESENTATIONS

- a. Update on the Prevention and Wellness Trust

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

Presented below is a summary of the meeting, including time-keeping, attendance and votes cast.

Date of Meeting: Wednesday, December 16, 2015

Beginning Time: 9:12AM

Ending Time: 11:15AM

Attendance and Summary of Votes:

Board Member	Attended	Item 1c Minutes of the November 18, 2015 Meeting	Item 2a Determination of Need No. 5- 4958 Shields Signature Imaging, LLC	Item 2b Determination of Need No. 5- 4959 Shields Sturdy PET-CT, LLC	Item 2c Determination of Need No. 4- 3C45 The Massachusetts General Hospital	Item 3a Request for Approval to Promulgate Final Regulations Amending 105 CMR 153.000: <i>Licensure Procedure and Suitability Requirements for Long-Term Care Facilities</i>
Monica Bharel	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Edward Bernstein	Absent	Absent	Absent	Absent	Absent	Absent
Derek Brindisi	Yes; Arrived at 9:14	Yes, as Amended	Yes	Yes	Yes	Yes
Harold Cox	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
John Cunningham	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Michele David	Yes; Arrived at 9:17	Yes, as Amended	Yes	Yes	Yes	Yes
Meg Doherty	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Michael Kneeland	Yes	Yes, as Amended	Recusal	Recusal	Yes	Yes

Board Member	Attended	Item 1c Minutes of the November 18, 2015 Meeting	Item 2a Determination of Need No. 5- 4958 Shields Signature Imaging, LLC	Item 2b Determination of Need No. 5- 4959 Shields Sturdy PET-CT, LLC	Item 2c Determination of Need No. 4- 3C45 The Massachusetts General Hospital	Item 3a Request for Approval to Promulgate Final Regulations Amending 105 CMR 153.000: <i>Licensure Procedure and Suitability Requirements for Long-Term Care Facilities</i>
Paul Lanzikos	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Denis Leary	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Lucilia Prates-Ramos	Absent	Absent	Absent	Absent	Absent	Absent
Jose Rafael Rivera	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Meredith Rosenthal	Yes	Yes, as Amended	Yes	Yes	Recusal	Yes
Alan Woodward	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Michael Wong	Yes	Yes, as Amended	Yes	Yes	Yes	Yes
Summary	13	13 Approved; 2 Absent	12 Approved; 1 Recusal; 2 Absent	12 Approved; 1 Recusal; 2 Absent	12 Approved; 1 Recusal; 2 Absent	13 Approved; 2 Absent

PROCEEDINGS

A regular meeting of the Massachusetts Department of Public Health's Public Health Council (M.G.L. c. 17, §§ 1, 3) was held on Wednesday, December 16, 2015 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: Department of Public Health Commissioner Monica Bharel (chair); Derek Brindisi; Harold Cox; John Cunningham, PhD; Michele David, MD; Meg Doherty; Michael Kneeland, MD; Paul Lanzikos; Denis Leary; Jose Rafael Rivera; Meredith Rosenthal, PhD; Michael Wong, MD; Alan Woodward, MD.

Absent member(s) were: Edward Bernstein, MD; Lucilia Prates-Ramos

Also in attendance were Margret Cooke, General Counsel at the Massachusetts Department of Public Health and Jennifer Barrelle, Interim Deputy Chief of Staff for Policy and Regulatory Affairs at the Massachusetts Department of Public Health.

Commissioner Bharel called the meeting to order at 9:12AM and made opening remarks before reviewing the agenda.

ROUTINE ITEMS

Updates from Commissioner Monica Bharel, M.D., MPH

To open the meeting, Commissioner Bharel gave several updates to Council members.

The Commissioner gave an update on the breastfeeding promotion work presented at the November meeting, and let Council members know that staff within the Bureau of Family Health and Nutrition and Bureau of Community Health and Prevention co-authored three articles in the most recent Journal of Human Lactation.

Additionally, she noted that the Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS) program received the "Unique Partnership" award at the 2015 PRAMS national meeting on promoting oral health for pregnant and postpartum women, and highlighted staff from the Office of Data Translation within the Bureau of Family Health and Nutrition involved in that project. She indicated that Council members have a copy of the PRAMS report at their table, and noted it is also available on the DPH website.

Commissioner Bharel noted that staff members from the Massachusetts Sexual Assault Nurse Examiner (SANE) Program, the Elizabeth Freeman Center, and Berkshire Medical Center joined Lt. Governor Polito and Berkshire County District Attorney David Capeless to announce the designation of Berkshire Medical Center in Pittsfield as a DPH-designated SANE site, making it the 28th SANE site in Massachusetts.

The Commissioner then gave updates on DPH's actions on the opioid epidemic. She summarized data from the social media elements of the State Without StigMA campaign also discussed implementation progress for the Naloxone Bulk Purchasing Trust Fund, which allows first responders to purchase naloxone at a discounted price while any other state or local agency can purchase naloxone at the price

charged to the state. She noted that, to date, five communities have requested to purchase naloxone through the Bulk Purchasing Program.

Commissioner Bharel noted that she and Secretary Sudders recently met with Deans and faculty of Massachusetts' three schools of dental medicine, as well as the Mass Dental Society, and obtained a commitment from them to adopt an updated, dental-adjusted version of the Core Competencies previously discussed no later than January 2016. She also indicated a working group is currently engaged in drafting these adjusted Competencies and will be meeting with DPH and the Dental Society in early January.

The Commissioner congratulated UMass Medical who in mid-November incorporated the 10 Core Competencies identified by the Deans working group into this year's academic program. Additionally, she announced that the Prescription Monitoring Program (PMP) has developed a process for resident teaching facilities to get their medical residents enrolled quickly in the PMP, with an expectation that residents will gain access to the PMP system within 72 hours of receipt of enrollment information.

Lastly, the Commissioner noted that the Governor, First Lady, and Lieutenant Governor hosted a screening of HBO's documentary film, "Heroin: Cape Cod, USA," which follows eight addicts on the Cape highlighting the substance misuse epidemic. She concluded by saying the documentary is also being shown on the Cape tomorrow before the national television debut on December 28th.

Commissioner Bharel noted for the record that Dr. Michele David joined the meeting at 9:17AM.

Minutes

Commissioner Bharel asked if any members had any changes to be included in the November 18, 2015 meeting minutes. Mr. Rivera noted that the minutes reflect nine attendees while the votes tally 10, and asked if this should be updated.

Dr. Wong made a motion to approve, pending an updated voting tally, and Dr. Woodward seconded the motion. All approved.

DETERMINATION OF NEED

a. Shields Signature Imaging, LLC ("Shields Signature" or "Applicant") has filed a Determination of Need ("DoN") for a mobile Positron Emission Tomography-Computed Tomography ("PET-CT") service one day per week. No. 5- 4958 **(Vote)**

Commissioner Bharel invited Michael Sinacola, Interim Deputy Director for the Bureau of Health Care Safety and Quality, and Rebecca Rodman, Deputy General Counsel for the Department, to the table to present on this application.

Before the presentation began, Commissioner Bharel noted for the record that Dr. Kneeland has recused himself from the two Shields DoN applications, and asked him to excuse himself. Dr. Kneeland left the room at 9:24AM.

Upon conclusion of the presentation, the Commissioner asked if Council members had any questions for Mr. Sinacola, Ms. Rodman, or the applicant's representative, Tom Shields, Jr., President and CEO of Shields Imaging.

Dr. Woodward noted that the utilization projection of 1,250 uses per year is based on seven days of operation with equal volumes per day. He asked if the provider had contracts with other institutions to provide these services.

Mr. Shields responded that currently the unit is a mobile service that goes to Cape Cod Hospital two days per week, Tufts Medical Center one day per week, and MetroWest Medical Center one day per week, leaving three days available for operation. One day will be used for Brockton Hospital, and two days per week will be used for Sturdy Memorial Hospital.

Dr. Woodward noted that the staff summary indicates there will not be an impact on volume at surrounding hospitals, and asked how this would affect Alliance Imaging's service and volume.

Mr. Sinacola responded he cannot fully answer that question, but indicated that for the region itself and the patients this proposal will have no impact.

Commissioner Bharel invited Andrew Levine, Esq., legal counsel for the applicant, to the table to respond further.

Mr. Levine responded that the current vendor is an unlicensed provider that operates under physician exemption authority, making it difficult to assess exactly where service is provided. Mr. Levine noted that in order for the current provider, Alliance Imaging, to go to another site they would need to make a similar regulatory filing for review by DoN and the Council.

Dr. Woodward noted that there are currently seven mobile units currently approved, so the question is what happens to Alliance's capacity and duplication of service.

Mr. Levine noted that the issue would be Alliance's unit would experience downtime, and to locate this service at a new site it would need to be brought back to the Council for review and to ensure no duplication of service or issues with other providers would be resolved.

Dr. Woodward asked who would be reviewing and interpreting the scans.

Mr. Shields indicated scans would be read and interpreted by the radiologists at Brockton Hospital and Sturdy Memorial Hospital.

Seeing no further questions, the Commissioner requested a motion to approve the Shields Signature Imaging, LLC application.

Mr. Leary made a motion to approve the application, Dr. Cunningham seconded the motion. All approved, except Dr. Kneeland who recused himself from this application.

b. Shields Sturdy PET-CT, LLC ("Shields Sturdy" or "Applicant") has filed a Determination of Need ("DoN") for a mobile Positron Emission Tomography-Computed Tomography ("PET-CT") service one day per week. No. 5- 4959 **(Vote)**

Commissioner Bharel invited Mr. Sinacola, joined by Ms. Rodman, to present the Shields Sturdy PET-CT, LLC DoN application. Upon conclusion of the presentation, Commissioner Bharel asked if Council members had any questions for Mr. Sinacola, Ms. Rodman, or Mr. Shields.

Dr. Woodward asked about the projected utilization and splitting utilization equally across seven days. He asked if this would be a new PET-CT unit.

Mr. Shields responded that this is an existing unit, currently providing service four days per week.

Dr. Woodward asked if Shields was currently performing 1,250 scans per year.

Mr. Shields responded that Shields is presently exceeding that utilization total.

Seeing no further questions, the Commissioner requested a motion to approve the Shields Sturdy PET-CT, LLC application.

Mr. Rivera made a motion to approve the application, Dr. Wong seconded the motion. All approved, except Dr. Kneeland who recused himself from this application.

d. The Massachusetts General Hospital (“MGH” or “Hospital”) MGH has filed a Determination of Need (“DoN”) application seeking approval of a three-phased renovation project of existing space to reconfigure the design and upgrade the infrastructure of the Hospital’s existing perioperative services.
No. 4-3C45 (Vote)

Commissioner Bharel invited Mr. Sinacola, joined by Ms. Rodman, to present the Massachusetts General Hospital (MGH) DoN application.

Commissioner Bharel noted for the record that Dr. Rosenthal has recused herself from the Massachusetts General Hospital DoN application, and asked her to excuse herself from the room. Dr. Rosenthal left the room at 9:38AM.

Dr. Kneeland returned to the meeting at 9:40AM.

Upon conclusion of the presentation, Commissioner Bharel asked if Council members had any questions for Mr. Sinacola or the applicant’s representative, Dr. Peter Slavin, President of MGH.

Dr. Woodward noted that MGH is looking to add preoperative and postoperative space, while the application focuses on renovation versus expansion.

Dr. Slavin noted that, as staff indicated, this is a multi-phase project and this application seeks approval for phase one. He noted that at the end of phase one there will be fewer operating rooms, but that phase two would be a more operating room-intensive phase.

Dr. Woodward asked if there would be new construction with the subsequent phases.

Dr. Slavin noted that the other phases would be renovation only, and occur within the existing footprint. He also noted that there would be no additional operating rooms upon completion of this project.

Dr. Woodward asked if the increased surgical volume noted in the staff summary was due to a projected increase in efficiency.

Dr. Slavin responded that is correct.

Dr. Woodward asked about the total costs of the project, and if new construction would have been less expensive.

Dr. Slavin responded that given how central the operating rooms are to the hospital there needed to be proximity to the emergency department and the inpatient units, the Hospital needed to complete these renovations within the existing footprint.

Dr. Woodward asked whether the proposed \$41M for this project was for phase one only.

Dr. Slavin responded that is correct, and noted that it is very costly to do construction in buildings that are in some instances over 80 years old.

Dr. Wong asked staff that since the capacity is actually decreasing if there was any emergency planning concern over a lack of surge capacity in the event of an emergency.

Mr. Sinacola responded that staff determined the increased efficiencies gained would allow for that capacity.

Mr. Lanzikos noted that in the short term operating capacity would be removed, while current operations show these operating rooms are operating at capacity. He asked how this reduction would be accommodated in the short term.

Dr. Slavin invited Dr. Peter Dunn, MGH Medical Director for Perioperative Services, to the table to respond.

Dr. Dunn responded that the operating rooms are currently running at an 82-89% deficiency rate of utilization, done through the processing flow of patients throughout the day. He indicated that there are additional enhancements to those processes that can be employed to make better use of those resources, both for elective and last-minute surgical patients.

Mr. Lanzikos asked Dr. Dunn if the Hospital anticipated any patient delay or disruption of patient experience.

Dr. Dunn responded that he did not anticipate any delay, and noted that the Hospital overhauled its processes several years ago in an effort to decrease delays and increase capacity through existing footprint that allow the Hospital to maintain current efficiency, even with one or two operating rooms coming offline at a time.

Ms. Doherty asked about the request for an additional 24 full-time equivalent employees, despite a reduction in operating room capacity.

Dr. Dunn responded that the additional staff would support new pre- and post-operative space.

Dr. Woodward asked about elective surgery and if there would be expanded hours or weekend availability.

Dr. Dunn responded that through the improvements several years ago the Hospital has been able to incorporate its elective surgeries into the peak operating hours when staff are present and fully staff. He noted that the majority of elective surgeries were scheduled Monday through Friday, with some availability on Saturdays, and that the Hospital does not anticipate increasing elective surgery time.

Dr. Woodward asked, relative to emergency planning and surge capacity and the issue of emergency department boarding, if there was a thought to the pattern of boarding patients in the emergency department as a result of the increased inpatient capacity with building electives during the week and closing them on the weekends. He suggested further consideration of shifting more elective surgeries to weekend days to help for smoother patient flow and limit boarding.

Dr. Slavin responded that this is an issue MGH has looked at for years, and it has restructured over 50% of their surgical volume scheduling to maximize use of the operating room while minimizing the non-random inpatient variation.

Dr. David noted that some of MGH's surrounding communities, like Chelsea and Revere, have needs for Community Health Initiative funding while there are many fragile organizations currently providing needed services in those communities. She asked if there was a process for that funding to get to such organizations.

Dr. Slavin noted that the process is underway and that MGH works closely with those communities and other nonprofit organizations serving needs in those communities, and will continue to work with those communities and DPH staff to finalize the use of that funding.

Mr. Levine noted for clarification that while the efficiency proposal does indicate a short term reduction in the number of operating rooms, the long term plan at MGH is to bring those operating rooms back online through additional projects.

Seeing no further questions, the Commissioner requested a motion to approve the MGH application.

Mr. Lanzikos made a motion to approve the application, Dr. Woodward seconded the motion. All approved, except Dr. Rosenthal who recused herself from the vote.

Dr. Rosenthal rejoined the meeting at 10AM.

FINAL REGULATIONS

a. Final Promulgation on Proposed Amendments to 105 CMR 153.000 (*Licensure Procedure and Suitability Requirements for Long-Term Care Facilities*), to Establish a Hearing Process for Closures and Changes of Ownership of Long Term Care Facilities **(Vote)**

Commissioner Bharel invited Lauren Nelson, Director of Policy and Quality Improvement for the Bureau of Health Care Safety and Quality, and Sherman Lohnes, Director of the Division of Health Care Facility Licensure and Certification within the Bureau of Health Care Safety and Quality, to the table to present

on and request final approval of amendments to 105 CMR 153.000, Licensure Procedure and Suitability Requirements for Long-Term Care Facilities, which establish a hearing process for closures and changes of ownership of long term care facilities.

Upon conclusion of the presentation, the Commissioner asked if Council members had any questions for Ms. Nelson or Mr. Lohnes.

Mr. Rivera noted that he was pleased to see the addition of notification requirements. He asked if there is a way to ensure the CLAS standards are adhered to during the process.

Mr. Lohnes responded that this is something staff can look into, and that the purpose of the amendments is to maximize transparency during the closure and change of ownership process.

Mr. Lanzikos asked for clarification on the notification and approval timeline, noting that residents and staff must receive notification of a closure at least 60 days prior.

Mr. Lohnes responded that he believed Mr. Lanzikos was referencing the federal notification requirement of 60 days advance notice.

Mr. Lanzikos asked if that means that everything pertaining to the closure needs to be approved at least 60 days prior to the proposed closure. He then requested further clarification of the closure timeline.

Mr. Lohnes responded that is correct. He stated further that the closure timeline is a bit confusing, and staff has prepared a graph to summarize the process. He noted that the closure process starts 120 days out, so that prior to the hearing there is a meaningful closure plan for residents and families to consider.

Mr. Lanzikos asked what the licensee would need to do at 120 days prior to the proposed closure [under this regulation].

Mr. Lohnes responded that for a closure the licensee would need to give their initial notice to the Department and other interested parties. He noted that after that, the facility would develop a draft closure plan to be available 14 days prior to and at the closure hearing. Mr. Lohnes further clarified that after the hearing, there would be a closure plan review process similar to that of a hospital's proposed closure of an essential service.

Mr. Lanzikos asked whether the hearing date for a closure was set prior to receiving a draft closure plan, meaning once the initial closure notice is received 120 days prior to closure there would be two weeks to schedule a hearing.

Mr. Lohnes confirmed the hearing date would be set prior to receiving the draft closure plan, allowing two weeks from submission to schedule a hearing.

Commissioner Bharel stated that the clock starts at 120 days, and the next time milestone is 90 days. During that 30 day period, the draft closure plan would need to be submitted.

Ms. Nelson responded that is correct, and further explained that the clock starts at 120 days with initial notice of the closure, leaving 14 days for the facility to submit the draft closure plan and to schedule the closure hearing to ensure those wishing to attend the hearing at the 90-day point have a plan to look at.

She noted that the draft closure plan isn't meant to be a final plan, and that the idea of the hearing is so that attendees have an opportunity for real input on the plan.

Mr. Lanzikos noted that he was concerned with the distribution of the proposed draft closure plan to interested parties in a way that gives people a way to review and understand it in order to actively participate in the hearing. He asked how much notice is required to hold a public hearing.

Ms. Nelson responded that for this process two weeks notice would be required.

Dr. Cunningham noted that the presentation indicates notice of the hearing must be given at day 104, not a copy of the proposed draft closure plan, meaning the plan would not be available until the date of the hearing.

Ms. Nelson responded that a proposed draft closure plan would need to be in place and available at the hearing.

Dr. Woodward noted that the presentation indicates a draft closure plan would not be submitted to the Department until after the hearing.

Ms. Nelson responded that is correct, and that the draft closure plan submitted to the Department would incorporate any updates based on comments at the public hearing. She stated that the basis for the hearing is the draft proposed closure plan.

Mr. Cox asked if this process is protecting anyone and if this is transparent. He noted that the intent is to protect residents, but it sounds as if this may not be so clear. He stated that he appreciates the intent of this is to be transparent, and noted that this process does not prevent a facility from closing but will provide notification of that process.

Commissioner Bharel indicated that the regulation itself and its intent is clear, but the Department can communicate that better, possibly with a graphic.

Dr. Kneeland noted that a horizontal timeline may be more useful in visualizing the process.

Dr. Cunningham indicated that a graphic would be useful, and also noted that this process will add an additional 30 days to the closure timeline that does not presently exist.

Commissioner Bharel responded that, as noted by Dr. Cunningham and Mr. Cox, this proposal does add more transparency and ability to comment on a proposed closure. She noted that a visual to help explain this process to Council members and the community is necessary, and will be brought back to Council members in the future.

Mr. Lanzikos stated that the changes are good, but we should ensure there are no areas of confusion and that everyone involved understands this process as much as possible. He noted that a graphic based on regulations that are confusing themselves will still be confusing, and we should make sure the regulations themselves are not confusing.

Mr. Lohnes held and reviewed a timeline graphic for the Council members. He noted that a hearing must be held 90 days prior to the proposed date of closure, and that a proposed draft closure plan

would need to be available 14 days in advance of that hearing. He further explained that the initial closure notice from the facility would need to be provided to all interested parties and indicate the reasons for the proposed closure.

Dr. Woodward noted that the point of confusion is that the slide itself does not indicate that the draft closure plan must be circulated prior to the public hearing, and that it is reassuring the plan will be available. He asked how many days prior to the hearing the facility has to provide the proposed draft closure plan.

Mr. Lohnes responded that the proposed draft closure plan would need to be provided at least 14 days in advance of the hearing.

Commissioner Bharel suggested if helpful to members, the Council could take a 10 minute recess and bring back a large timeline graphic for the Council to see.

Mr. Cox responded that he doesn't see a need to do that, because the intent is clear and he is confident that staff can produce a document that shows the timeline and process. He indicated that the Council has now gotten clarity around what the progression is.

Dr. Woodward agreed with Mr. Cox, and was reassured that the proposed draft closure plan would be distributed prior to the hearing. He indicated that seems to address a lot of the concerns raised by Mr. Lanzikos and other members of the Council.

Dr. Rosenthal asked if it would be possible to approve the regulation, contingent on subregulatory guidance on the timeline.

Commissioner Bharel noted that while the regulation cannot be approved with a contingency, the Department can note its good faith effort to effectively communicate the timeline and provide that communication to the Council.

Mr. Cox noted that the proposed regulation takes out exceptions for the Catholic Church and the First Church of Christ Scientist.

Ms. Nelson noted that the exception from licensure for these institutions remains through statute, and instead that an obfuscation of the exemption is being removed from the regulation.

Mr. Lohnes responded that under statute these institutions are not required to obtain or renew a license, while the regulation for some reason requires these institutions to apply for license renewal.

Mr. Cox clarified that facilities run by these institutions do not need to obtain a license.

Mr. Lohnes responded that is correct, because these are facilities run for members solely for members of their religious order not the public. He noted that if those facilities participate in Medicaid and Medicare then they must comply with applicable requirements.

Seeing no additional questions or comments, the Commissioner requested a motion of approval for final promulgation of amendments to 105 CMR 153.000 – Licensure Procedure and Suitability Requirements

for Long Term Care Facilities. Dr. Cunningham made a motion to approve, Ms. Doherty seconded the motion. All approved.

Upon the vote, Mr. Lanzikos suggested that changes to regulations that require public input the Council see those documents to be used when communicating to the public.

Commissioner Bharel noted that is a good suggestion, and said the Department is working hard on ways to communicate complex information to the public in a way that is digestible. She noted that the Council's input on that will be invaluable.

Denis Leary left the meeting at 10:37AM and didn't return. Derek Brindisi left the meeting briefly at 10:37AM and returned at 10:43AM.

PRESENTATIONS

a. Update on the Prevention and Wellness Trust

Commissioner Bharel invited Carlene Pavlos, Director for the Bureau of Community Health and Prevention, and Jean Zotter, Manager of the Prevention and Wellness Trust Fund within the Bureau of Community Health and Prevention, to the table for an update on the Prevention and Wellness Trust Fund. Upon conclusion of the presentation, the Commissioner asked if Council members had any questions for Ms. Pavlos or Ms. Zotter.

Mr. Rivera commented that he was part of initial discussions around the Trust Fund where people questioned the conditions identified, and found it was helpful when communicating that these are local issues and also align with what the Centers for Disease Control calls winnable battles, so there's national evidence that says these conditions can be measured in the short term. He asked if there was still a place for community health workers on the Trust Fund's Advisory Board.

Ms. Pavlos noted that members for the Advisory Board are statutorily enumerated and that the community health worker seat is currently vacant but there is a nominee pending.

Dr. Rosenthal noted that she was intrigued to hear that permitting flexibility in implementation does present its own challenges and that this is something she has seen in her own work. She asked to what extent these communities are sharing lessons learned across communities and what cross-collaboration is occurring.

Ms. Zotter responded that staff are implementing the IHI learning collaborative model, which is data-driven and focused on quality improvement. She indicated that everyone involved is brought together on a regular basis to learn from one another. She further noted that this collaboration model has been used from the start with one big collaborative with certain time allotted for each condition, but now they are transitioning to a collaborative for each condition so there will be more time to share best practices.

Dr. Rosenthal commented that she wondered when targeting community resources through the DoN process if there was a way to leverage those funds for sustainability of these initiatives.

Mr. Cox indicated he is aware that collaboratives take time to build and see results, and asked if there were any plans to reauthorize the trust fund.

Ms. Pavlos indicated the PWTF Sustainability Subcommittee is considering multiple sustainability strategies. She noted that the Subcommittee's recommendations are due to the Prevention and Wellness Advisory Board in June 2016.

Mr. Cox noted that the push for this Trust Fund was long fought and in a different environment, and is aware of what was present then and what is different now. He indicated that while other funding mechanisms are a possibility, it becomes an issue of adding one more thing to any number of projects and he is very sensitive to what that means for sustainability.

Ms. Pavlos said they are sensitive to this and recognize this as an issue and that capacity for collaboration and partnership has a cost. She noted that chairs of the Sustainability Subcommittee are Ms. Zotter and Maddie Ribble from the Massachusetts Public Health Association, and indicated that other members include additional stakeholders as well as representatives of the legislative Joint Committees on Public Health and Health Care Financing.

Dr. Woodward noted that while tobacco control is a condition identified, it presently only reflects 2% of PWTF referrals for January to September 2015.

Ms. Pavlos responded that when this project initially began she was surprised to see that only five of the communities wanted to take on tobacco as a condition, but what she learned was that many communities felt they had already tackled the low hanging fruit in the area of tobacco and, given the short timeline for outcomes, were concerned that addressing tobacco would have low numbers associated with it and not result in adding many more people to cessation activities. She said that this is an area where some of the partnerships are not making the kinds of gains they wish they were.

Laura Coe, Manager for Quality Improvement Activities for the PWTF, indicated that part of the reason for the low tobacco numbers is also related to incomplete data collection. She also noted that the PWTF model of moving cessation activities to the community setting, is a fairly new concept for clinical sites.

Dr. Cunningham left the meeting at 10:56AM and did not return.

Mr. Lanzikos asked if the e-referral system could be extended to the prevention community beyond the Trust Fund. He asked if this is a referral from an organization, or if an individual can self-referral. He noted that his organization runs a falls prevention and hoarding prevention program and could see this being a useful resource to those he serves.

Ms. Pavlos responded that the e-referral system does need to be initiated at a clinical site as it is part of the electronic health record (EHR). She indicated that there have been conversations about extending the e-referral system to support the community-initiated referrals, but it is not something that there is capacity for at this time. She concluded by saying referral through the EHR is how the system is presently based.

Mr. Lanzikos responded that his organization works very closely with two large medical practices, and asked if this e-referral system could be adopted into their EHR at this point?

Ms. Pavlos noted that the current e-referral system was the design of Laura Nasuti and Tom Land who initiated e-referral work through the State Innovation Model (SIM) grant, and something that could be the subject of a future presentation to the Council. She added that with the bulk of the work associated

with implementation of e-referral is not related to IT, but instead around bringing clinical and community partners together to workflows and the referral process.

Mr. Lanzikos responded that he participates in several MassHealth work groups around reform and service integration, and increasingly behavioral health and long term care services and supports are coming front and center, and if we could facilitate referrals from practice sites to community programs it would go a long way.

Commissioner Bharel responded that e-referrals is supported in part by the SIM grant, which is the MassHealth Innovation grant, and that DPH is discussing how to further put this into communities. She stated this electronic system and feedback is really a first in the nation, and unique setup.

Mr. Rivera noted that he would like to see inclusive language for all of these conditions.

Commissioner Bharel noted that she was at the state health officer's meeting last week, and there was a lot emphasis on health beyond clinical settings and the importance of connecting clinical work to the community in ways we haven't done before. She indicated that the PWTF came out of Chapter 224, which was really about cost containment, and her hope is that we can use medical claims data to support this PWTF approach and of its impact on health care costs.

Mr. Lanzikos noted that if DPH hasn't already worked to collaborate with MassHealth and the Health Policy Commission, he would encourage that collaboration.

Commissioner Bharel indicated that DPH has a representative at each of those meetings.

The Commissioner reminded Council members that the next meeting would be held on January 13, 2016.

Commissioner Bharel asked for a motion to adjourn the meeting.

A motion was made by Dr. Kneeland, and seconded by Dr. David. All approved. The meeting adjourned 11:15AM.

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

1. Docket for the meeting
2. Minutes of the Public Health Council meeting held November 18, 2015
3. Determination of Need (DoN) Pending Projects
4. DoN Staff Summary for DoN Project No. 5- 4958
5. DoN Staff Summary for DoN Project No. 5- 4959
6. DoN Staff Summary for DoN Project No. 4-3C45
7. Copy of the proposed regulation, Council memo, and PowerPoint presentation for request for approval to promulgate final regulations on proposed amendments to 105 CMR 153.000: *Licensure Procedure and Suitability Requirements for Long-Term Care Facilities*, to Establish a Hearing Process for Closures and Changes of Ownership of Long Term Care Facilities
8. Copy of the PowerPoint presentation providing an update on the Prevention and Wellness Trust Fund

Commissioner Monica Bharel, Chair