PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, July 23, 2002, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard K. Koh, M.D. (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Shane Kearney-Masaschi, Ms.Maureen Pompeo, Ms. Janet Slemenda, and Dr. Martin Williams. Mr. Benjamin Rubin and Dr. Thomas Sterne absent. Also in attendance was Attorney Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health; Ms. Susan Keyes, MPH, DrPH, Senior Analyst, Mr. Zi Zhang, MPH, Director, Health Survey Program, Bureau of Health Statistics, Research and Evaluation; Ms. Beth Barden, PhD, Nutrition Project Manager, Bureau of Family and Community Health; Mr. Paul Hunter, Director, and Mr. Roy Petre, Senior Policy Analyst, Childhood Lead Poisoning Prevention Program, Bureau of Environmental Health Assessment; Ms. Joyce James, Director and Ms. Joan Gorga, Analyst, Determination of Need Program.

RECORDS OF THE PUBLIC HEALTH COUNCIL

Records of the Public Health Council Meeting of April 23, 2002 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve Records of the Public Health Council Meeting of April 23, 2002.

PERSONNEL ACTIONS:

In a letter dated July 5, 2002, Katherine Domoto M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewskbury, recommended approval of an appointment and reappointments to the medical and dental staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That , in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointment and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning July 1, 2002 to July 1, 2004.

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MEDICAL LICENSE NO.:**
Janine Fredericks-Younger, DMD	Active Staff Dentist	19843
Mimi Thein, M.D.	Affiliate Staff Psychiatry	153783

APPOINTMENT:	**STATUS/SPECIALTY:**	**MEDICAL LICENSE NO.:**
Susan Rudman, PsyD	Provisional Allied Psychology	6593

In a letter dated July 8, 2002, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of reappointments to the consulting medical staff of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MEDICAL LICENSE NO.:**
Chabilal Neergheen, M.D.	Geriatric Medicine/ Nephrology	14059
Marc Fisher, DPM	Podiatric Medicine	1588
Gary Kaskey, M.D.	Psychiatry	47764

In a letter date June 26, 2002, Anton B. Dodek, M.D., Associate Medical Director, Philip E. Dould, Executive Director, and Arthur M. Pappas, M.D., Chairman, Board of Trustees, Massachusetts Hospital School, recommended approval of the reappointments to the medical staff of Massachusetts Hospital School. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Medical Director, Executive Director, and Chairman, Board of Trustees of Massachusetts Hospital School, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the reappointments to the medical staff of Massachusetts Hospital be approved as follows:

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MEDICAL LICENSE NO.:**
John Emans, M.D.	Consulting/Othopedics	35118
Timothy M. Hresko, M.D.	Consulting/Orthopedics	50281
William J. Morgan, M.D.	Consulting/Hand Surgery	12926
Flores, Alejandro, M.D.	Consulting/Gastroenterology	59316

In a letter dated July 9, 2002, Mr. Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of initial appointments and reappointments to the medical and allied health professional staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the medical and allied health professional staffs of Lemuel Shattuck Hospital be approved as follows:

PHYSICIAN INITIAL APPOINTMENTS:	**RESPONSIBILITY:**	**MED. LICENSE NO.:**
Ina Bhan, M.D.	Pathology Consultant	38417
Philip R. Daoust, M.D.	Pathology Consultant	38150
Yogeshwar Dayal, M.D.	Pathology Consultant	34017
Jeremy Ditelberg, M.D.	Pathology Consultant	159430
Nora Laver, M.D.	Pathology Consultant	158034
Arthur Rabson, M.D.	Pathology Consultant	71947
Angleo Ucci, M.D.	Pathology Consultant	40805
Padmanabhan Bharani, M.D.	Neurology Active	209168

PHYSICIAN INITIAL APPOINTMENTS:	**RESPONSIBILITY:**	**MED. LICENSE NO.:**
David Rickland, M.D.	Pathology Consultant	81423
Homa Safaii, M.D.	Pathology Consultant	34341
Robert N. Salomon, M.D.	Pathology Consultant	52936
Arthur S. Tishker, M.D.	Pathology Consultant	34593
Manish Amin, M.D.	Internal Medicine Consultant	212889
Imran Imir, M.D.	Internal Medicine Consultant	213345
Danielle L. Brook, M.D.	Internal Medicine Consultant	213867
Andrew Feingold, M.D.	Internal Medicine Consultant	213794
Ahmer Iberhim, M.D.	Internal Medicine Consultant	213909
Sunny Srivastava, M.D.	Internal Medicine Consultant	214243
John Tenbrook, M.D.	Internal Medicine Consultant	209991
Brendan Bottari, M.D.	Radiology Consultant	213802
Abedelhamid Elgazzar, M.D.	Radiology Consultant	213283

PHYSICIAN INITIAL PPOINTMENTS:	**RESPONSIBILITY:**	**MED. LIC. NO.:**
Joseph Cohen, M.D.	Internal Medicine Active	27226
Neil Halin, D.O	Radiology Consultant	74366
John M. Harris, M.D.	Orthopedic Surgery Consultant	32488
St. John Donnie McGrath, M.D.	Internal Medicine Active	78054
James R. Quirk, M.D.	Internal Medicine Infectious Diseases Active	72941
Richard Patten, M.D.	Cardiology Consultant	75891

ALLIED HEALTH PROFESSIONAL REAPPOINTMENTS:

Omega M.A. Bradley, P.A.	AHP	382

In a letter dated July 10, 2002, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Catherine Annas to Program Manager V, Director of Patient Safety. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Catherine Annas to Program Manager V (Director of Patient Safety) be approved.

STAFF PRESENTATION:

"GROWING CONCERNS ABOUT OBESITY IN MASSACHUSETTS FROM PREGNANCY TO ADULTHOOD: A STATISTICAL ANALYSIS", BY SUSAN KEYES, MPH, DrPH, SENIOR ANALYST, ZI ZHANG, MPH, DIRECTOR OF HEALTH SURVEY PROGRAM, BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION, AND BETH BARDEN, PhD, NUTRITION PROJECT MANAGER, BUREAU OF FAMILY AND COMMUNITY HEALTH:

Assistant Commissioner Sally Fogerty addressed the Council. She said in part, "…We are going to present you with data that we can use to talk about the issues related to overweight and obesity, and then we can integrate it into our programs to help people make the right choice…"

Ms. Susan Keyes, MPH, DrPH, Senior Analyst, Bureau of Health Statistics Research and Evaluation, said in part, "..According to our former U.S. Surgeon General, David Satcher, overweight and obesity may not be infectious diseases, but they have reached epidemic proportions in the United States. Overweight and obesity are increasing in both genders and among all populations. What concerns us about overweight and obesity is that we find increased levels of certain diseases among those who are overweight and obese. These include heart disease, type II diabetes, hypertension and elevated incidence of joint and mobility problems. We also find some types of cancer, and that includes endometrial cancer, cancer of the lining of the uterus, colon, gallbladder, prostate, kidney, and postmenopausal cancer. …The data used for today's presentation are from the year 2000…If we look at a man or woman who is 5'4" tall, if they are 145 pounds, they are considered overweight. If they are 174 pounds, they are considered obese…Men are at greater risk for overweight than women are with men at 64% and women at 42%. Rates of obesity are about the same for men and women, at 18% and 16%, respectively. If we add race and ethnicity to the picture, this changes somewhat. We see 65% of White men and 41% of White women being overweight. We find higher rates of overweight among Black and Hispanic women…We also find lower rates among Asian Americans, although the greatest difference also exists in that group, between Asian men and Asian women."

Ms. Keyes continued, "…If we look at obesity by race and sex, we see 18% obesity among White men and 15% obesity among White women . The important thing to note is that both Black women and, to some extent, Hispanic women have higher levels of obesity than the general population, with 31% of Black women and 19% of Hispanic women being obese. Among Asians, men have lower rates, and none of the Asian women interviewed, that was about 89, actually qualified, were considered to be obese…As we get older, we gain weight. In the middle ages we tend to level off. Then, somewhere in the sixties and seventies, we tend to see the weight go down again. Studies have shown a consistent relationship between socioeconomic status and health, with poorer folks being less healthy. Education and income are the two most commonly used

indicators of socioeconomic status and there is a clear relationship of those having lower education being at an increased risk for obesity…Those with a high school education are at twice the risk of those with a four year college education of being obese. If we look at obesity by region, we don't see much of a difference. Metro West seems to have a little bit of a lower rate, but there are no tremendous differences. We also looked at some of the risk factors associated with obesity and overweight. We looked at the consumption of fruit and vegetables by overweight, and we find that men who are overweight or obese, are eating less fruit and vegetables than men who are not overweight, and the numbers among women are pretty similar. If we look at physical activity, we find that men who regularly exercise are less likely to be obese. And they are less likely to be overweight, as well….Women who regularly exercise have overweight levels of 34% as opposed to 46% and obesity levels of 11% as opposed to 18%. Because smoking status is so highly correlated with poor health, we decided to look at that, as well. The lowest numbers, actually, for overweight is among smokers, and the highest numbers are among the former smokers. This really highlights, for the Department of Public Health, the importance of a comprehensive treatment plan for people who are trying to stop smoking, which includes a focus on diet, nutrition, and exercise. We decided to look at a couple of major life events, and to see their impact on overweight and obesity. We are looking at the effect of marital status on overweight. Within marital status, we also include unmarried couples. Being single or married does not seem to have much of an impact, although the numbers among married men are slightly higher. It is interesting to note that over two thirds of married men are overweight or obese, as opposed to less than half of unmarried men. Another major life event is the addition of children to the home. Looking at the presence of children in the household, we found that the numbers are not actually terribly different. An aspect of concern regarding overweight and obesity is its effect on chronic illnesses. We look at diabetes among those who are overweight or obese compared to diabetes among those who are not. Among men who are overweight or obese, we find 7% of those men have diabetes, and among men who are not overweight or obese, we find it to be 3%. Among women, we have 8% and that is almost triple the 3% of women who are not overweight or obese. Next, we looked at CHD and angina. Again, we find men who are overweight or obese have CHD or angina at a level of 13%, as opposed to 8% of men who are not obese or overweight, 9% among women who are overweight, or obese, and 6% among women who are not."

Ms. Keyes concluded, "To put the Massachusetts situation in perspective, comparing the trends for both overweight and obesity in the United States and in Massachusetts, they are following the same trend, although we see a little bit lower rate in Massachusetts….In general, we are doing better than most of the states. We have the fourth lowest level of overweight. We have the fifth lowest level of obesity. We are not exercising as much and we should be, but we do eat our fruits and vegetables, and we smoke less. So, we are probably doing better than the rest of the states, for the most part. So, there is good news and there is bad news. The good news is that we are doing well in comparison to other states. The bad news is that we are following the same obesity trend that exists in the rest of the country. For us, the groups that are at greater risk include persons with low income or education, certain racial and ethnic groups, and more sedentary adults, and that is where we should be targeting some of our prevention efforts. So we hope that BRFSS

will develop prevention and treatment approaches in the future of obesity and overweight."

Ms. Beth Barden, PhD, Nutrition Project Manager, Bureau of Family and Community Health, said in part, "…The data that I am presenting today is collected through the Massachusetts WIC Program. The WIC Program is a large, preventive public health nutrition program that is administered nationally through the USDA . I am going to show you data relevant to the pregnant women, and this reflects data collected during normal service operations by the WIC Program here in Massachusetts during calendar year 1999. The majority of the women were between the ages of 20 and 29, but about one fifth were adolescents, and just over a quarter of the women were 30 years old or older. The majority of the women, at about 71%, have at least a high school education, and about 22% have less than 12 years of education…About 43% of the women were either overweight or obese prior to the pregnancy which led them to participate in WIC. 23.8% were overweight based on a BMI between 25 and 30, and about 18.89 % were obese based on a BMI greater than 30. When the women are certified, they are already pregnant, so this BMI is computed based on weight and height that are self-reported by the women when they enter the program. When the pre-pregnancy weight status are looked at by age, the pattern that emerges is that, for each category of increasing age, there is a greater proportion of women who were either overweight or obese prior to pregnancy. It is likely that, in large part, this reflects weight gained with successive pregnancies that is not lost after birth, with older women having had more opportunity to have more children. The adolescents, in contrast, are the least likely to be overweight or obese, and the most likely to enter their pregnancy underweight. The problem of overweight and obesity affects all women from all racial and ethnic groups. For White, Non-Hispanic , Black Non-Hispanic and Hispanic women, the proportion of women who are overweight or obese approaches or exceeds 50%. Among Asian women, however, less than 17% of the women enter pregnancy overweight or obese, although a much larger proportion of these women are also likely to be underweight prior to their pregnancy…Children in Massachusetts have a lower proportion of underweight compared to the national data…. The high prevalence of underweight among children less than 12 months, that you are seeing is reflecting low birth weight status, or multiple birth status of some kids..."

Ms. Barden concluded, "…To sum up, about 43% of pregnant or post partum women were either overweight or obese prior to the current pregnancy. More than half of them gained too much weight during their pregnancy. More than one third of the children between the ages of 2 and 5 were either at risk or already overweight, and the prevalence of risk for overweight was high among all ethnic groups with some small differences. So we are going to look at points of intervention to be able to target this very serious problem."

Mr. Zi Zhang, MPH, Director, Health Survey Program, Bureau of Health Statistics, Research and Evaluation, said, "Regarding the BRFSS data for Asians, it might very well be underestimated because of the sample scheme that we have for BRFSS, and we may not have a lot of Asians in the program. That is part of the reason we may get lower

numbers, and it is pretty much consistent, we find relatively lower prevalence of other health risks and health behaviors for Asians."

Chairman Koh said in part, "…We are getting a better understanding that this is a preventable epidemic that fuels other epidemics, such as heart disease, diabetes, hypertension, arthritis, some forms of cancer. This area is receiving attention from everybody in our society, from the Surgeon General on down… We are asking everyone to heed the message today, try to adhere to an ideal body weight if possible. I have been told that the concept of diet and dieting, those terms sometimes send a negative connotation, and I have been urged to instead express the concept of healthy eating. I like that concept. By encouraging the consumption of fruits, vegetables, fish, and other nutritious foods, we can fight disease with our fork, literally. For the exercise concept, which is also critical to reaching our full potential in health, it has been said before, and I will say it again, that we should encourage people to walk thirty minutes a day…"

Ms. Sally Fogerty, Assistant Commissioner, said in part, "I think that the other intervention is, as we look at smoking and the interventions around smoking, really making sure we have comprehensive programs in place, and that we are addressing all of the issues of an individual, and building these into our multiple programs. A change in focus, maybe over the last two years, has been really thinking about writing in physical activity into every program we have and discussing it. So we talk about domestic violence. We talk about substance abuse. It is just as important to talk about helping people to realize that they need to not sit at their computers for ten hours a day. They really need to get up and walk. They really need to move around, and we really need to make those good choices about what we eat. Thank you."

REGULATION:

REQUEST APPROVAL OF PROMULGATION OF FINAL AMENDMENTS TO 105 CMR 460.000: REGULATIONS FOR LEAD POISONING PREVENTION AND CONTROL:

The purpose of this memorandum is to request the Council's approval to promulgate amendments to 105 CMR 460.000: Regulations for Lead Poisoning Prevention and Control. The regulations implement the Massachusetts Lead Laws, MGL c.111, ss.189A-199B, which have two fundamental purposes. The first is to ensure that all Massachusetts children under six years of age are screened for lead poisoning, and if found to have a blood lead evaluation, receive appropriate medical and environmental services. The second purpose is the preventative abatement of lead paint from the Massachusetts housing stock by requiring that all residences built before 1978 in which children under six reside receive a lead inspection or risk assessment. If lead hazards are found, they must be abated. Three types of final regulatory amendments are proposed. The first type comprises amendments that make certain definitions and procedures equivalent to those of the US Environmental Protection Agency (EPA) and the US Department of Housing and Urban Development (HUD). These amendments modify the definition of dangerous levels of lead in paint, lower dust lead level clearance standards,

and facilitate the process for lead inspectors to become risk assessors. The second type of regulatory amendment improves the inspection and abatement compliance process. These amendments clarify the legal status of a lead inspection and risk assessment, and expand the prohibition of a conflict of interest for lead inspectors. The third type of amendment streamlines the regulations by eliminating redundancies and modifying nomenclature…The new regulations will strengthen the Department's lead inspection and residential compliance process. The process will be accomplished through the clarification of the legal status of a lead inspection and risk assessment. New standards for dust lead clearance levels for window sills and wells and floors are important advances in abatement safety and will enhance MDPH's efforts to protect children's health. Making risk assessment services more readily available statewide by simplifying the process for lead inspectors to become risk assessors meets an anticipated increase in demand. Finally, we will meet the criteria to ensure continued federal support for Massachusetts housing at a time when it is critical.

Mr. Roy Petre, Senior Policy Analyst, Childhood Lead Poisoning Prevention Program, Bureau of Environmental Health, said, "Seven individuals, the majority of who represented the housing industry or programs, offered comment on our proposed regulations. We received numerous public comments on the changes that we proposed and we received no substantive negative comments. The result is, the final regulations are literally the same as the proposed regulations, with the addition of a zero in front of a .5% threshold. There is common agreement that the new regulations will strengthen the Department's lead inspection and residential compliance process and enhance our ability to protect children's health."

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve Promulgation of Final Amendments to 105 CMR 460.00: Regulations for Lead Poisoning Prevention and Control**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,735.** A public hearing was held on April 4, 2002.

DETERMINATION OF NEED PROGRAM:

FINAL ADOPTION OF PROPOSED REVISIONS TO THE JANUARY 28, 1997 DETERMINATION OF NEED GUIDELINES FOR NEONATAL INTENSIVE CARE UNITS:

Ms. Joyce James, Director, Determination of Need Program, addressed the Council. She said, "The purpose of this memorandum is to request Council's final adoption of the proposed revisions to the 1997 Neonatal Intensive Care Determination of Need Guidelines. The revisions make two significant changes to the existing guidelines; the projected need for twenty-five additional NICU beds by the year 2005, and the planning area for neonatal intensive care services has been changed from a regional to the state as a whole. The revised guidelines also reflect a policy change by extending neonatal intensive care services to community hospitals. Following an informational briefing to

Council at its June 23, 2002 meeting, revised guidelines were released for public comment. South Shore Hospital and Children's Hospital submitted comments on the guidelines. Both hospitals expressed support for the guidelines. South Shore Hospital suggested three modifications to the guidelines. These modifications included changing the number of annual births to support a NICU from the absolute figure of 4,000 births to figures ranging from 3,500 to 4,000. The other two suggestions included adding to the annual number of births, transfers from other hospitals to the hospital's special care nursery, and also including obstetric discharges from the hospital in those annual births. We accepted the first two suggestions because we found them reasonable, and South Shore indicated they would allow more flexibility to applicants in meeting the annual birth requirements. We, however, rejected the third suggestion of including in the annual number of births, obstetric discharges from the hospital because of the implication that a NICU in a community hospital makes that hospital a regional perinatal center. Currently, we have nine regional perinatal centers which we find adequately meet the needs of the residents of Massachusetts. A major significant change to the guidelines was deletion of a requirement for supporting data from NICU, for meeting the need of the births required for the NICU, and we deleted that because we determined that the data could be obtained during review of the application. Instead, we added a new measure, Measure III, which required as a condition of approval, and requires the applicant to submit statistical data on the operation of the NICU to assist the Department in evaluating the effectiveness of a NICU in a community hospital. There were other minor changes, but they were merely editorial."

After consideration, upon motion made and duly seconded, it was voted, unanimously to **approve for Final Adoption of Proposed Revisons to the January 29, 1997 Determination of Need Guidelines for Neonatal Intensive Care Units.**

ALTERNATE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATIONS:

PROJECT APPLICATION NO. 4-3A35 OF DEACONESS-GLOVER HOPSITAL CORPORATION – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF DEACONESS-GLOVER HOSPITAL, RESULTING FROM THE RESIGNATION OF CARE GOUP, INC., ITS SOLE CORPORATE MEMBER, AND THE SUBSTITUTION OF BETH ISRAEL DEACONESS MEDICAL CENTER, INC. AS THE SOLE CORPORATE MEMBER:

Ms. Joan Gorga, Analyst, Determination of Need Program, said, "Deaconess-Glover Hospital, Inc., is proposing a change of ownership and original licensure resulting from the resignation of Care Group, Inc. , its sole corporate member, and the substitution of Beth Israel Deaconess Medical Center, Inc. as the sole corporate member. Members of the Board of Trustees appointed by Care Group, Inc. will resign and three trustees will be appointed by Beth Israel Deaconess Medical Center The applicant states that the transfer of ownership is designed to enhance the integration and continuity of clinical services provided to Deaconess-Glover patients. Deaconess-Glover will continue to be the licensee of the hospital. The project satisfies the standards set forth under the alternate process for change of ownership of hospitals. Deaconess–Glover has agreed to maintain

or increase its level of free care of .96% of gross patient service revenues, which existed prior to the transfer. At the request of the Helen D Jursek interested party, a public hearing was held on June 24, 2002 at Deaconess-Glover's meeting room and was attended by thirty-seven people. Those testifying included the Chief Executive Officers of Deaconess-Glover and Beth Israel Deaconess Medical Center, Chairman of the Board and Chief of the Medical Staff at Deaconess-Glover, representatives of the Needham Health and Fire Departments, and Colleen Schaller, member of the Needham Board of Selectmen. All those testifying were in support of the proposed transfer of ownership. Staff finds that the proposed change of ownership meets the Alternative Process Transfer of Ownership Standards and is recommending approval of this project with the condition that the hospital maintain or increase its .96% of free care."

Mr. John Dalton, President, Deaconess-Glover Hospital, said in part, "We have had a number of relationships between our hospital and the Medical Center, most notably in emergency medicine, where the faculty members of the Department of Emergency Medicine at the Medical Center cover our emergency room twenty-four hours a day, seven days a week, which has significantly elevated the care in our Emergency Department and improved EMS education in the five communities we serve. Building on that model, we are in the early stages of implementing a hospital service, twenty-four hours, seven days a week presence of a physician, whose sole responsibility is to take care of and respond to emergencies for our patients. We are bringing out the Division of General Surgery from the Medical Center to provide general surgical services integrating our Cardiology Service with the division of Cardiovascular Medicine at the Medical Center. They have recruited two new cardiologists to our hospital, and I hope you are starting to hear a theme, and a offer has been extended to a radiologist to become our Chief of Radiology. Now what is happening is two things, particularly for a small hospital in Massachusetts, it is becoming increasingly difficult to recruit specialists into the community. So, with the Medical Center, we have been able to provide services. Secondly, we have found out over the years, you cannot ask a physician or a nurse to practice a different standard of care depending on which day of the week and what address they are at. So it challenges us to profoundly elevate the level of service we provide to our patients…"

After consideration, upon motion made and duly seconded, it was voted (unanimously): **to approve Project Application No. 4-3A35 of Deaconess-Glover Hospital, Request for Transfer of ownership and original licensure of Deaconess-Glover Hospital, resulting from the resignation of Care Group, Inc., its sole corporate member and the substitution of Beth Israel Deaconess Medical Center, Inc. as the sole corporate member.**
This approval is subject to the following condition:

1. The applicant has agreed to maintain or increase, for an indefinite period, the percentage of gross patient service revenue allocated to free care, as defined in M.G.L. c.118G or its successor statute covering uncompensated care, as existed prior to the transfer. The percentage of gross patient service revenue allocated to free care at Deaconess-Glover Hospital shall be .96%.

The meeting adjourned at 11:00 a.m.

_____
Howard K. Koh, M.D., M.P.H.
Chairman

LMH/SB