PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, April 8, 2009, 9:00 a.m., at the Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Dr. John Cunningham, Dr. Michèle David, Mr. Paul J. Lanzikos, Mr. Denis Leary, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, Dr. Alan C. Woodward and Dr. Barry Zuckerman. Absent Members were: Ms. Helen Caulton-Harris, Mr. Harold Cox, Dr. Muriel Gillick, and Dr. Michael Wong. Also in attendance was Attorney Donna Levin, DPH General Counsel.

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

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF JANUARY 14, 2009 AND FEBRUARY 11, 2009:

A record of the Public Health Council Meeting of January 14, 2009 was presented to the Public Health Council for approval. Council Member John Cunningham moved approval. After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Sherman and Dr. Zuckerman not present to vote] to approve the January 14, 2009 minutes of the Public Health Council meeting as presented.

A record of the Public Health Council Meeting of February 11, 2009 was presented to the Public Health Council for approval. Council Member Dr. Woodward moved approval. After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Sherman and Dr. Zuckerman not present to vote] to approve the February 11, 2009 minutes of the Public Health Council meeting as presented.

FINAL REGULATION: REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO REGULATIONS 105 CMR 200.000 REGULATIONS GOVERNING PHYSICAL EXAMINATION OF SCHOOL CHILDREN:

For the record, Council Member Sherman arrived at the meeting at approximately 9:20 a.m. just before Dr. Mullen began her presentation. Council Member Zuckerman arrived at approximately 9:25 a.m., just after Dr. Mullen began her presentation. They were not present to vote on the minutes above.

Dr. Jewel Mullen, Director, Bureau of Community Health Access and Promotion presented the request for final promulgation of 105 CMR 200.000 to the Council. She said in part, "...Our focus has been to have our Body Mass Index Measurement initiative (BMI) be part of the overall State Wellness Initiative, which while, in one way, we are looking to decrease the prevalence of overweight and risk factors for obesity, cardiovascular disease and diabetes, we are also generally wanting to educate parents about their children's weight status and whether or not that is a healthy weight, under weight or over weight. Body Mass Index is already being measured in our schools that participate in our Essential School-based Health Services programs, and right now we haven't been using that information, reporting it, or tracking it, to see whether or not any other wellness initiatives have actually had any impact on decreasing obesity prevalence, which we know has been on the rise over the past decade. The new regulations will enable us to get parents information, to promote healthy lifestyles, and then encourage parents to communicate with their primary care providers if they have any concerns about their children's weight status, whether or not it is maintaining a healthy weight, or dealing with issues of under and over weight."

Staff noted that two public hearings had been held, one on February 27, 2009 in Boston and one on March 2, 2009 in Marlboro and the Department received written testimony until March 6, 2009. Written testimony was received from seven organizations, 37 individuals and two people testified at the Boston hearing. She said, "There was one

note of opposition from the Multi-Service Eating Disorders Association, whose concern was the BMI measuring causing negative self-image or self-esteem among children or that we may create home environments where parents react negatively to the information."

Dr. Mullen stated in response to the Multi-Service Eating Disorders Association comment, "To address that, we strengthened the wording about privacy and confidentiality in the regulations and we have continued to engage, and will engage, in conversations about the kinds of communication materials that we develop to disseminate to families, to be sure that we give them as much information as possible, and to, again, remind them that the information that we provide is just the starting point for them to continue talking to their primary care clinicians if they have other concerns. To help us with that, we will expand our internal advisory committee, making sure that we have representatives from education and from healthy weight promotion groups, to make sure that we are really on track, both internally and within the school.

The organizations that sent supportive written testimony are listed in the staff memorandum. Some of the feedback from supporters is that we should be language sensitive and have a clear evaluation plan from the beginning so we know if we are being successful..."

Staff's memorandum dated April 8, 2009 to the Council explained:

"Current regulations require the measurement of height and weight among Massachusetts public school students, but do not require further calculation and screening for underweight, overweight and obesity, nor is data required to be reported to parents or the Department. The enhancements proposed in the revised regulations seek to improve data quality and prevent underweight, overweight and obesity among Massachusetts youth. Specifically, the amendments would:

1. Replace the current requirement that schools do an annual assessment of the height and weight of all students with a

requirement to collect the heights and weights of students in grades 1,4,7, and 10;
2. Require public schools to calculate each measured student's BMI and obtain a percentile ranking for each child to determine weight status according to CDC guidelines;
3. Require public schools to communicate these findings directly and confidentially to each student's parent/guardian;
4. Require every public school/district to report aggregate BMI data to DPH.

Staff noted further that the Department recognizes the burden put on schools of any new screening requirements; therefore the Department has offset this additional requirement by:

- Reducing the hearing screening requirements from annually to entry through grade 3, one middle school grade and one high school grade

- Reducing the vision screening requirements from annually to entry through grade 5, one middle school grade and one high school grade

- Reducing height and weight assessments from annually to grades 1, 4, 7, and 10.

Dr. Mullen mentioned further that they removed the word "score" from the regulations in order to remove any pass/fail value to it; strengthened the language regarding parental prenotification about screening so parents will know before the measurements are taken; strengthened the language around privacy, confidentiality, and communication; clarified the role of the primary care provider so children can have their pre-entry examination done by a mid-level provider (nurse practitioner physician assistant); incorporated a religious exemption for physical examination and evaluation; will continue reviewing growth and screening guidelines, will develop best practices guidelines around communication; continue trainings for school nurses and will consult with the Mass Medical Society and

Members of the Massachusetts Association of the American Academy of Pediatrics.

In closing, Dr. Mullen stated in part, "We will phase in the implementation, starting this year just with the Essential School Health Services, with the plan for next year to roll out to all school districts..." It was noted that the regulations have not been updated in 50 years.

Discussion followed by the Council (see verbatim transcript for full text). Dr. Barry Zuckerman asked in part, "...How do we imbed this in children's education and their growing knowledge...If we are going to go to a healthier society, the children need to own the knowledge, and not just be the passive recipient of it.... In their math class they could calculate the BMI and understand what it means." Dr. Mullen and Chair Auerbach concurred with Dr. Zuckerman on the need for integrated comprehensive health education in the schools. Chair Auerbach noted however, that the Council and Department do not have the authority to mandate certain curriculum-related activities, only the Legislature can and bills have been introduced that the Department supported and will be introduced in the future that the Department will support.

Ms. Anne Sheetz, Director of the Essential School Nurses Program, DPH, responded to Mr. Lanzikos' concerns about the costs to implement the requirements of the regulations. She said, "...We looked at the cost and one of the things that happened in the past, with all the K through 12 vision and hearing screening and heights and weights screening is that schools hired substitute nurses to assist in that and now with the new regulations, they won't have to do that. We are funding 80 school systems through the Essential School Health Program, a minimum of $50,000 dollars to really strengthen the School Nursing Programs and so some of the costs of the regulations can come out of that. With each of the Experience Grants we fund, there are two partner schools that they are providing five thousand dollars to strengthen their programs – that will reach another 136 school districts in well over 200 cities and towns. That will help to defray the costs but the reduction in substitute nurses for

some of those will probably be the major one." Ms. Sheetz said there were no public comments on costs.

In response to comments by Council Member Lucilia Prates Ramos, Dr. Mullen agreed that as she talks to focus groups and key informants and stakeholders that they will be certain to obtain feedback on communication materials so they are not just translated but also in culturally appropriate languages. Council Member Josè Rafael Rivera asked, "Are there going to be any attempts to see if there is any correlation between the Body Mass Index and other risky behaviors that may be exhibited by children in school; substance abuse, depression, sexual behavior because, at least anecdotally, there has been some correlation indicated in the past, and it would be helpful if those studies continued?" Dr. Mullen said in the context of these regulations, they are not collecting information on individual children so they will not be able to link Body Mass Index or trends to individual behaviors. They will have information about trends within schools. His concerns however are being discussed in her other work in the bureau.

Mr. Albert Sherman moved approval of the final regulations. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Final Promulgation of Amendments to Regulations 105 CMR 200.000 – Regulations Governing Physical Examination of School Children**; a copy of the regulation and staff's memorandum to the Council are attached and made a part of this record as **Exhibit No. 14, 924**.

PRESENTATION - "MASSACHUSETTS WIC NUTRITION PROGRAM: GOOD FOOD…AND A WHOLE LOT MORE!":

Ms. Mary Kelligrew Kassler, Director, Nutrition Division and WIC Nutrition Program made the presentation before the Council. Chair Auerbach stated in part, "Mary Kassler has been the Director for almost 25 years and has done an outstanding job…She has been a phenomenal manager at the Department over her quarter century leadership of these programs, and has made very significant improvements in terms of the functioning of the WIC Program and

the Nutrition Programs. Mary Kassler is retiring momentarily and I will say more at the end of her presentation."

Ms. Kelligrew Kassler said in part, "...What is WIC? Women, Infants & Children. Our mission statement says it all. The Massachusetts Women, Infants & Children Nutrition Program improves the health of families by providing nutrition and health education, nutritious foods and referrals to other health and human services. We have achieved this by collaborating with community health care, retail stores, state collaborating with community health care, retail stores, state and federal partners. WIC is good food and a whole lot more! Our core services, the centerpiece of the program is nutrition and health assessment, and our education and counseling, breastfeeding promotion and support, and we back that up with checks to purchase specific healthy foods at retail grocery stores and pharmacies. We also coordinate with other health and human services, provide immunizations screening and coupons for fresh produce during the summer season at farmer's markets. All of this buttrices the Department's healthy foods and focus on lifestyles. We really feel very part of the wellness initiative."

She stated further, "Last year, we served over 211,380 individuals, 63,000 infants, 63,000 pregnant, breastfeeding and postpartum women, and 85,000 children under the age of five. Over the past year, we increased our caseload by 6,000, providing services to 92% of estimated eligibles, a record number. I think an amazing statistic is that nearly 40% of all babies born in Massachusetts access WIC services at some point in their infancy."

Ms. Kelligrew Kassler noted further, "...We are very proud of the fact that our program participation reflects the diversity that we enjoy here in Massachusetts. Thirty-two percent are Hispanic, 19% black, 6% Asian and Pacific, and 43% white and that is spread out across the state, depending on where the populations live...We have 35 local programs and 135 offices statewide. Each local program offers Saturday and early evening hours. We have more than a thousand authorized grocery stores and pharmacies who can accept the WIC checks and our application process is integrated into the Virtual

Gateway." Ms. Kelligrew Kassler noted that nearly half of their local program staff speak a second language and reflect the ethnic and cultural diversity of participants at the local programs and that they print nutrition and program information in multiple languages.

Ms. Rachel Colchamiro, Interim Director, Nutrition Services Unit, explained the changes coming to the WIC Nutrition Program to the Council. She noted that the program has had the same food content since it started in 1974 and included and still does the following foods: milk, cheese, eggs, cereal, juice, dry beans or peanut butter. The federal government revised the food package and the rationale for determining the new foods was to reduce the prevalence of inadequate and excessive nutrient intakes in excess fat and refined carbohydrates (too much sugar). She said, "The nutrition education messages that are reinforced by our new package are, obviously: eat more fruits and vegetables; choose foods lower in saturated fat; increase whole grains and fiber; drink less sweetened beverages and juice, and that babies are born to be breastfed." The new food package will be implemented in October of 2009 and includes the following foods: fruits and vegetables for every month of the year for all participants, adds soy-based beverages and tofu as a milk alternative for certain participants; increases the whole grain options offering bread as well as cereals, soft corn or whole wheat tortillas, or brown rice and reduces milk, cheese, eggs and juice. Participants will be able to buy fresh, frozen or canned vegetables and canned fish for breastfeeding women including salmon and sardines.

Ms. Colchamiro explained further in part, "In accordance with the American Academy of Pediatrics, we are eliminating juice from the infant food package, delaying complementary food introduction to six months, adding baby fruits and vegetables for all babies and adding baby food meat for those babies who are fully breastfed. In terms of providing incentives for breastfeeding, we have always provided a fuller package to women who fully breastfeed and don't require formula from us, but the package gets fuller with the new food package. They get the most variety and the largest quantity of food, and they get a ten dollar cash value voucher to buy fruits and vegetables. The babies who are fully breastfed at six months receive

double the volume of baby fruits and vegetables as the other babies on the program, and they also do receive infant meat as an incentive and as a way to increase the nutrient density of the food package...Ms. Colchamiro noted States have flexibility to select the foods for their list to reflect market availability and cultural make-up of their population and remain cost neutral. "

In closing, Ms. Colchamiro stated, "These changes to the WIC food package hold the potential for improving the nutrition and health of the nation, and especially for the nation's low income pregnant women, and new mothers, infants, and children...We think we have the power to do a lot..."

Ms. Joyce Chania, Director and Senior Nutritionist at the Dorchester North WIC Program, addressed the Council. She said in part, "...One of the things I can say is Dorchester North WIC Program is an integral part of the health of our communities at Uphams Corner Health Center and serves the neediest of the needy populations. WIC provides food for our population at that critical time when it is really needed, when a pregnant women needs increased nutrient intake, when an infant needs to eat adequately and have sufficient food to be able to grow well, and children under five years when all faculties of their lives are developing and having adequate food at this point is also important...At Uphams Corner Dorchester North, we do not only focus on nutritional interventions, but we work in collaboration with other community agencies. What we cannot offer at the WIC program, we can refer. We refer our participants to Smoking Cessation, especially for prenatals, postpartum women who are breastfeeding and non-breastfeeding. We also refer them to agencies that can help them with drug issues and alcohol issues, domestic violence issues because these populations are able to talk to us. Using the Touching Hearts, Touching Minds Emotion-based Nutrition Counseling, we are able to connect with participants much more and they are able to open up to us on issues that probably they may not be able to do at other levels. We encourage them to have their children immunized at the right time, and that is something that is really worthwhile for our population."

She continued, "...Diversity is the key component of the services that we offer at Dorchester North WIC Program and this is reflected by the profile of our staff. We have staff that speaks Spanish, Portuguese, Cape Verdean, Creole, Vietnamese, Swahili, Hindi, and English. This reflects the population that we serve...Our participants state that they feel much better and more confident when they are served by people who speak their language, and when you speak the language of the population that you serve, we feel that we are able to connect with them, and we are able to offer effective counseling to encourage healthy behavior changes..." Ms. Chania noted how excited they are about the new food package, especially the new fruit and vegetable component and the baby food.

A brief discussion followed by the Council. Dr. Zuckerman inquired about the low participation rate in the Food Stamp Program (now being called SNAP). It was noted that under the new Administration and a new Commissioner at the Dept. of Transitional Assistance, SNAP staff have collaborated with WIC staff to learn their successful marketing techniques and that the SNAP program has had a huge increase in enrollment in the past year.

Mr. Lanzikos said in part, "...I would put on the table that the Public Health Department convenes a meeting of all the State Nutritionists, to share the information [from the WIC Nutrition Program], that insight you have because in my daily work with older adults, we have the very same issues. They are not making the right food decisions, not because rationally they don't know that, but emotionally there is a connection there, and if you could take those same principles and we could apply them broadly, I think we would be doing the Commonwealth a great service." WIC staff noted that they have done trainings with other state programs and other States and will continue to do so.

Council Member Denis Leary asked WIC staff how he could access WIC services for returning Iraqi and Afghanistan Veterans with young families. Ms. Kelligrew Kassler offered to meet with Mr. Leary after the meeting to figure out how to connect the veterans with WIC and Food Pantries. Chair Auerbach added, "That is a classic Mary Kassler

response and Classic WIC response, which is, we will figure it out and we will do it." Chair Auerbach spoke of Mary Kelligrew Kassler's accomplishments over her 25 years as WIC Nutrition Director – the program being a success due to her. He presented her with a Governor's Citation in recognition of her 25 years of dedicated service to the Commonwealth.

Chair Auerbach noted that Council Member Lanzikos has become a celebrity over his losing weight and participating in the Department's Mass in Motion program. Mr. Lanzikos stated in part, "...I have worked with older adults for almost four decades now and one of the things I espouse is a healthy old age, and the best way to achieve that, through all my experience is to live a good healthy middle age and I said if I am going to be advocating that, particularly now in the role I have here on the Public Health Council, I should be living that myself..." He noted further that they have set-up a Mass in Motion program at his agency and that his staff has embraced it, they offer their employees one hour of compensated time a week so employees can invest it in pursuit of wellness, a walking club, fitness program or attending Weight Watchers or Stress management. Chair Auerbach thanked him for being a public role model that inspires other people.

PRESENTATION: "INFECTION PREVENTION AND CONTROL PRELIMINARY REPORT", by Dr. Alfred DeMaria, Medical Director, Bureau of Infectious Disease Prevention, Response and Services

Chair Auerbach thanked Nancy Ridley, Director of The Betsy Lehman Center and Laurie Kunches from JSI Health for doing the initial ground breaking work on Hospital Associated Infections in Massachusetts.

Dr. Alfred DeMaria, Medical Director, Bureau of Infectious Disease, Department of Public Health, addressed the Council. He said in part, "...Today I am going to give a progress report on the Infection Prevention Program but not reporting results because these results are much too preliminary...The point here is it is doable. We will be able to generate the kind of information that will be useful to

consumers, to policy makers, and others to address health care associated infections in Massachusetts…This came out of the Health Care Reform legislation of 2006, which essentially mandated a Prevention and Control Program and funded it. The first part of this process was an expert panel that worked diligently with the Department, with Laurie Kunches of JSI to develop 324 best practice recommendations for a prevention program and to have reportable outcomes and process measures…A decision was made to use the National Health Care Safety Network, which is a CDC system of collecting health care associated infections that came out of the National Nosocomial Infection Surveillance System, which was started in 1970. After the Expert Panel process, now there is a Technical Advisory Group of Infection Preventionists, Consumer Advocates, Health Care Industry Representatives that are helping us move this process along…We chose the National Health Care Safety Network because it is web-based. It was tested and validated. It was customizable and free of charge and will probably become the national standard."

Dr. DeMaria noted, "…We are reporting for the first four months that we received reports for. Eight hospitals are not included out of 74 acute care hospitals due to technical reasons but will be included in the future. Five hospitals with NICUs reported, 42 hospitals with bed size of less than 200 reported, non-teaching community, community, and university hospitals included. He went over the statistics from the progress report (reporting period July 1, 2008 to October 31, 2008), which is attached and made a part of this record as **Exhibit Number 14,925.**

Dr. DeMaria noted other issues the Department has been working on: a survey was conducted on MRSAs which suggests that infections are decreasing with MRSA in general in Massachusetts; the Department is looking at influenza vaccinations of employees for this year, assessment visits were made to some hospitals by the new Infection Control nurses the Department hired, and working with Partnership for Health Care Excellence to improve public awareness; and talking about including other types of facilities in the reporting.

A brief discussion followed. Dr. DeMaria noted that when the information is ready there will be a web site, probably the Health Care Quality and Cost Council web site which will be user friendly for the public to access. Dr. Paul Dreyer, Director, Bureau of Health Care Safety and Quality stated, "The data we are presenting now are not hospital-specific, and that is intentional. They are clearly not ready to be released on a hospital-specific basis. This is just a progress report. Our intent is next year's report will come out in February 2010 which will be hospital specific and at that point be useful for consumers."

Chair Auerbach after thanking staff for their hard work, stated in part, "...I want to thank the Council. This is your regulation. This is happening because of work that you have undertaken and had us do...While the reporting is important and transparency is important, that is not the end goal. The end goal is preventing infections and that this is only useful if it a tool in terms of creating additional pressure to eliminate the infections themselves and there were four actions steps we are taking in response to The Betsy Lehman Center report. The first was the reporting and the transparency of the data, and we are well on our way for that. The second point was the contract that we mentioned earlier with Paula Griswold, Executive Director, Coalition for the Prevention of Medical Errors, sharing best practices information with the hospitals via tools kits and speakers and trainings (had 100% participation rate by Massachusetts acute care hospitals). Thirdly, the Department hired two infection control preventionists to be in the field continually working with the hospitals to prevent poor practices and finely, the consumer based partnership directed by Marilyn Kramer - Partnership for Health Care Excellence, the idea that patients have a role in this too, in terms of talking to their physicians and asking questions like, 'Did you wash your hands?' In addition, the new hospital family Councils. We must make sure we don't lose sight of the goal that is no infections."

DPH staffs were acknowledged for their tremendous amount of work on this project and for their continued work: Roberta Bernstein, Eileen McHale, Shauna Onofrey and Archie Arreche. Discussion continued briefly where it was noted that it may not be possible to

prevent all infections but Dr. Dreyer quoted the President of the United States by stating, 'If we don't set a goal of zero, we will never get there.' If we set a goal of zero, we might get there...I think it is perfectly reasonable to set a goal of zero." It was noted that DPH staff have seen culture change at hospitals and nursing homes for instance, seeing hand sanitizers around facilities so people are paying attention to infection control.

No Vote/Information Only

PRESENTATION: "SERIOUS REPORTABLE EVENTS IN MASSACHUSETTS HOSPITALS: JANUARY 1, 2008 – DECEMBER 31, 2008, By Paul Dreyer, Director, Bureau of Health Care Safety and Quality:

Dr. Dreyer said in part, "...This report is the first full year of data and as such, its conclusions are somewhat tentative. We do report data by individual hospital, but the question with self-reported data, which we have not validated, is always whether the variation that we see is a function of a true variation of incident rates, or a variation in reporting practices, and this is a theme that I will come back to. This report focuses on acute care hospitals. We had a total of 338 events in acute care hospitals. The acute care hospitals reported in all six NQF categories. The non-acutes reported on an additional 104 SREs, of which 84% were falls. We will be talking about the non-acutes in a later report, perhaps in the context of long term care.

I want to remind folks, the purpose of reporting is not to punish hospitals or to regulate events, it is to prevent them. Our goal is to gain a greater understanding of how these events happen and how they can be prevented in the future. So, as a result of that goal, we have given hospitals an opportunity to share their responses to the SREs that they have experienced in order to spur improvement."

Dr. Dreyer indicated that Massachusetts acute care hospitals reported 338 SREs in 2008: 68.3% (231 events) were environmental events; 97% of these events (224) were falls; retained foreign object 9% (32 events) wrong side surgery 7% (24 events),

medication error 4% (12 events), stage 3 or 4 pressure ulcer 4% (12 events), sexual assault 3% (11 events), burn 2% (6 events), wrong surgical procedure 1% (5 events), device malfunction 1% (3 events), suicide/suicide attempt 1% (3 events), air embolism 1% (2 events), wrong patient surgery 0% (1 event), maternal death/disability 0% (1 event), hyperbilirubinemia in neonate 0% (1 event), restraints/bedrails 0% (1 event).

Dr. Dreyer said further regarding individual hospital SREs, "I want to stress that we can't really draw conclusions about the overall quality of care in an individual hospital based on the raw number or types of SREs. A high number may indicate a strong reporting culture rather than a quality concern and it is the case that not all SREs may be preventable. An obvious explanation of the variation in SREs is simply volume. It seems common sensical that facilities with greater volume would report more SREs and this is just an empirical verification of that, a scatter plot showing total SREs as a function of patient days and you see that, indeed, larger hospitals have more SREs, an unremarkable finding...So, that suggests that what we ought to do is calculate SRE rates. This is a controversial concept, calculating SRE rates. People argue that SREs should never happen and that by calculating and reporting rates, you are essentially legitimizing the occurrence of events that should never happen. We believe we should report rates because it is the only way that you can compare and track improvement....For instance, St. Vincent's Hospital had a high rate. We believe very strongly that St. Vincent's is a really excellent reporter. We have had several different surveyors in that facility over the past few months, and unsolicited they expressed their delight at the transparency with which that facility operates."

Dr. Dreyer noted further, "...One of the mandates of the Quality and Cost Council is that we look at these data by race and ethnicity. We began collecting race and ethnicity last August using the common set of definitions from the Department and from the Division of Health Care Quality. There are some reporting issues. In addition, the ethnicity measure is very new and the data was sparse so we didn't include any ethnicity data in this year's report....I think with

respect to disparities, it is encouraging. We will get a much better handle on this when the next report comes out, when hopefully we will have fewer unknowns."

Dr. Dreyer noted that training and education with hospitals is ongoing and is largely focused around reporting. He said "The data collection process is working well and improving, and hospitals are responding to SREs, again as we have spoken about previously. We think that lessons learned, that are going to pop up on our web site will be a valuable resource to the public and to individual hospitals."

Dr. Dreyer said in part, "...Our next steps are we need to continue to ensure the accuracy of reporting; to do that we need to continue providing training to hospitals on SRE definitions. We also need to work with NQF on definitions and on what I think is that major issue, which is the fact that SREs account for only a small portion of medical errors, which is the point that our colleague, Jim Conway from IHI makes whenever we speak with him. The patient safety movement started due to the report 'To Err is Human'. That report suggests that there are a hundred thousand deaths due to medical errors. If you give Massachusetts its share, that would be around two thousand and these SREs included 19 deaths. If you believe the NQF report is accurate then there are many events that we are not going to get reports of because the NQF definition is for public reporting. The goal is to leverage the steps hospitals take to improve processes so that those will generalize to all events, including those we are not getting public reporting on..."

Discussion followed, Chair Auerbach noted that as of May it will be illegal for institutions to bill for the medical services that result from a SRE and that should increase the degree to which Serious Reportable Events are priorities within institutions. Chair Auerbach noted further that in order for Dr. Dreyer's bureau to gather the information on the SREs and for staff to do the follow-up investigations they need funding. Due to the budget reductions, there was a proposed 20% reduction in staffing to Dr. Dreyer's Bureau (Bureau of Health Care Safety and Quality) and Governor Patrick has identified Federal Stimulus Package money toward

restoration of that money. Chair Auerbach stated, "Without the staffing, we just can't do the work necessary to make sure we both have accurate reporting and that we are working to prevent future events."

During discussion, Council Member Lanzikos noted that the hospital patient/family Councils should look at SREs that occurred at said hospitals at least once per year. Dr. Dreyer concurred and said he believes they have recommended that be one of the roles of the Family Councils. Chair Auerbach noted how hospitals can learn from each other by sharing innovative approaches that work to prevent SREs.

No Vote/Information Only

For the record, Council Member Sherman left the meeting during Dr. Dreyer's SRE presentation at approximately 11:20 a.m.

PRESENTATION: "MASSACHUSETTS DEATHS 2007", BY DR. BRUCE COHEN, PH.D, DIRECTOR, DIVISION OF RESEARCH AND EVALUATION, BUREAU OF HEALTH INFORMATION, STATISTICS, RESEARCH AND EVALUATION AND MS. CARLENE PAVLOS, DIRECTOR, DIVISION OF VIOLENCE AND INJURY PREVENTION

Dr. Cohen noted, "I will give a brief summary of this year's annual mortality report, Massachusetts Deaths for 2007…I will talk about some highlights and look at some selective causes, and then focus on an interesting use of the data called 'Amenable Mortality' and then I will briefly summarize the results." Please see verbatim transcript for his full presentation. He thanked the primary authors of the report, Malena Hood, James West and Isabelle Cáceres; and the staff at the Registry of Vital Records and Statistics for collecting the data. Some statistics follow from his presentation:

- On an average day in Massachusetts, there are about a 144 deaths. There were 52,690 deaths in 2007, 600 fewer than in

2006.

- Cancer was the leading cause of death with about 36 deaths a day and there was about one infant death per day.

- A person born in Massachusetts in 2007 can expect to live to be over eighty years of age. This is the longest life expectancy in recorded history in Massachusetts. A woman an expect to live to be about 83 years of age and a man about 78 years of age. A 65 year old in Massachusetts in 2007 can expect to live at least 20 more years.

- The age adjusted mortality rate for Massachusetts is 9% lower the US. Average rate. Homicide, suicide, diabetes, infant mortality, heart disease and cancer have lower rates in Massachusetts than nationwide.

- Cancer and heart disease account for about half of all deaths in Massachusetts. Injury is the third leading cause, accounting for almost 6% of deaths in Massachusetts.

- Cancer and heart disease is number one for all race and ethnicities. Nephritis is the third leading cause for blacks, which might be related to diabetes; and unintentional injuries are the third leading cause for Hispanics. HIV and AIDS are in the top ten for blacks and Hispanics but not for whites and Asians.

- Injuries are the leading cause of death for persons one to 44, followed by cancer, 45 to 84 years, and heart disease is the overwhelming leading cause of death for persons over 85 years of age. Two-thirds of all deaths in Massachusetts occur at age 75 and greater.

Dr. Cohen said further regarding mortality rates, “There have been some dramatic declines in cancer, heart disease, stroke and respiratory diseases, having declined since 2000. Injuries have increased dramatically…Nephritis is relatively constant in

Massachusetts over the last seven years and diabetes has declined. Diabetes is interesting because, while we are seeing declines in diabetes mortality, we are certainly seeing increases in diabetes prevalence. Both could be due to improved diagnosis leading to earlier, more effective care, and better clinical management once diagnosed, and this would have the effect of reducing the case fatality rate for diabetes, while increasing the number of persons living with diabetes."

Dr. Cohen said further, "I will close with one final topic and this is Amenable Mortality. This is about trying to use mortality data to evaluate medical care delivery. In Massachusetts, our Health Care Reform has been focused on expanding access to care. One question that we have is, can we use mortality data to examine the outcomes of this increased access? I think we can. There is a concept called Mortality Amenable to Health Care, which is defined as death to a person under the age of 75 years that shouldn't occur in the presence of timely and effective health care. This might be a way for us to begin looking at outcomes related to changes in access. The model essentially says increased access and coverage can lead to earlier recognition and prompt diagnosis, earlier entry in the treatment, and more effective integration of services and finally better medical care management, and for a set of given diagnoses, outcomes will be vastly improved by improving access, and mortality rates can go down. There is a list of 34 causes that have been identified as potentially amenable to health care due to causes that are amenable to secondary prevention and amenable to improved treatment and better medical care management."

In closing he said, "Massachusetts is doing quite well. Our death rate was the lowest in recorded history. Our life expectancy has reached an all-time high. We compare favorably to the U.S. in many causes of deaths. Cancer rates are going down; and in particular, breast cancer declined significantly from 2006 to 2007. We have had the lowest number of HIV and AIDS related deaths and…there has been a leveling off in opioid related deaths in the last several years. We need to pay attention to the suicide rates, which may be increasing, and certainly the unintentional fall rates. Furthermore, disparities

continue to persist, disparities by gender, disparities by race, disparities by education and disparities by geography. We need to use these mortality data to help refine our targeting of prevention and interventions that will help eliminate these disparities."

For the record, Council Member Zuckerman left the meeting just before Ms. Pavlos' presentation below at approximately 11:45 a.m.

Ms. Carlene Pavlos, Director, Division of Violence and Injury Prevention, DPH addressed the Council. She commented on the overall increase in injury deaths of 18%. She said the largest contributors to that increase are the unintentional injury issues of falls and poisonings between 2000 and 2007. She noted that in 2006, there was a 67% increase in the crude rate of fall related deaths. Staff thought the increase at that time was due to the Medical Examiner's office changes in coding procedures. Ms. Pavlos noted that in 2007, the increases are more in line with national falls related death rates. Ms. Pavlos said, "Some of the reasons we believe that this is occurring are the changes in physical activity levels of older adults, medication and prescribing patterns, obesity, and/or other factors that might be playing a role in the falls."

Ms. Pavlos noted that her division continues to focus prevention on falls and is working with the Massachusetts Falls Prevention Coalition which has 55 members and will hold a Falls Prevention Conference in May which attracts over 800 participants.

Ms. Pavlos further noted that her division also works on suicide prevention. Dr. Cohen noted in his presentation and Ms. Pavlos noted statistically significant increases in both the rate and number of completed suicides amongst men. Ms. Pavlos noted that there was also an increase in suicide between 2006 and 2007 associated with intimate partner problems (no violence but problems such as break-up, divorce, arguments, jealousy). She said in part, "The Department's suicide prevention program has a life span approach that utilizes strategies to reach various populations who are at higher risk of suicidal ideation, suicide attempt and suicide completion. We have programs that specifically target youth, GLBT populations,

elders, men of middle age, and survivors of suicide who are at particularly high risk; family members, close friends of people who have completed suicide, as well as the population as a whole…" She noted that her division works with the Massachusetts Suicide Prevention Coalition. Ms. Pavlos noted they work with the Bureau of Health Statistics Injury Surveillance Program which participates in the National Violent Death Reporting System (NVDRS) and she further mentioned an initiative with the Department of Veteran Services SAVE (Statewide Advocacy for Veterans Empowerment Program) in which outreach workers go out into the community in a van and provide screenings for suicide.

A brief discussion followed. Council Member Lanzikos suggested that Ms. Pavlos target with suicide prevention efforts middle age men at Career Centers in the Division of Transitional Assistance where folks go for unemployment. Chair Auerbach noted the Department's concern for returning Veterans and suicide risk and asked Council Member Denis Leary to alert the Department of any needs of the Veteran populations. [Mr. Leary works with the Veteran community.] Mr. Leary agreed to alert the Department and also agreed that SAVE is a good program. Dr. Michéle David inquired about suicide prevention programs for communities where there is a "stigma around mental health". Ms. Pavlos said her program was beginning to make some progress and develop strategies in having their community based providers be more culturally competent and to work more effectively in immigrant and refugee communities. Ms. Pavlos asked Dr. David to provide her with contacts for community partners. Dr. David agreed. Dr. Cohen noted that the report is available on the internet via the DPH website: http://mass.gov/dph/bhsre/resep/resep.htm#birth or http://masschip.state.ma.us.

No Vote/Information Only

FOLLOW-UP ACTION STEPS:

- Have DPH convene a meeting of all state nutritionists to share the insight of the WIC program (Lanzikos to WIC Staff)

- WIC staff meet with Council Member Leary to figure out how to get WIC and Food to Veterans (Mary K. Kassler to Mr. Leary)

- Have Hospital Patient Family Councils review SREs occurring at their hospital at least once per year (Lanzikos to Dreyer)

- Target middle age men found at the Division of Transitional Assistance, where they seek unemployment benefits for suicide prevention (Lanzikos to Pavlos)

- Mr. Leary will alert DPH to any needs of the Veteran community especially in regard to suicide (Auerbach to Leary)

- Dr. David will provide Ms. Pavlos with contacts for future community partnering (Pavlos to Dr. David)

The meeting adjourned at 12:00 p.m.

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John Auerbach, Chair

LMH