MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of April 9, 2025

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: \*\*\*REMOTE MEETING\*\*\* Wednesday, April 9, 2025 – 9:00AM**

***Note: The April 9 Public Health Council meeting will be held remotely as a video conference consistent with St. 2021, c. 20, s. 20, which provides for certain modifications to the Massachusetts Open Meeting Law.***

Members of the public may listen to the meeting proceedings by using the information below:

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Dial in Telephone Number: 929-436-2866

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Passcode: 623322

1. **ROUTINE ITEMS**
   1. Introductions.
   2. Updates from Commissioner Robert Goldstein.
   3. Record of the Public Health Council Meeting held March 20, 2025 **(Vote)**.
2. **OTHER ITEMS**
   1. Letter to the public health workforce from the Council **(Vote)**.
3. **DETERMINATION OF NEED**
   1. Request by Sturdy Health Foundation, Inc. for a Substantial Capital Expenditure **(Vote).**
4. **INFORMATIONAL PRESENTATIONS**
   1. Update on the Health Survey Program.
   2. Update on Implementation of the Statewide Accelerated Public Health for Every Community Act.

*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.*

Attendance and Summary of Votes:

Presented below is a summary of the meeting, including timekeeping, attendance and votes cast.

Date of Meeting: April 9, 2025

Start Time: 9:04 am. Ending Time: 11:39 am.

| **Board Member** | **Attended** | **First Order:**  **Approval of**  **March 20, 2025 Minutes (Vote)** | **Second Order:**  **Letter to the Public Health Workforce from the Council (Vote)** | **DON**  **Request by Sturdy Health Foundation, Inc. for a Substantial Capital Expenditure (Vote)** |
| --- | --- | --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes | Yes | Yes |
| **Damian Archer** | Yes | Abstain | Yes | Yes |
| **Lissette Blondet** | No | Absent | Absent | Absent |
| **Kathleen Carey** | No | Absent | Absent | Absent |
| **Emily Cooper** | Yes | Yes | Yes | Yes |
| **Harold Cox** | Yes | Yes | Yes | Yes |
| **Robert Engell** | Yes | Yes | Yes | Yes |
| **Elizabeth Evans** | Yes | Abstain | Yes | Yes |
| **Marcia Hams** | Yes | Abstain | Yes | Yes |
| **Joanna Lambert** | Yes | Yes | Yes | Yes |
| **Stewart Landers** | Yes | Yes | Yes | Yes |
| **Mary Moscato** | Yes | Yes | Yes | Yes |
| **Ellana Stinson** | Yes | Abstain | Yes | Yes |
| **Ram Subbaraman** | Yes | Abstain | Yes | Yes |
| **Gregory Volturo** | Yes | Yes | Yes | Yes |
| **Summary** | 13 Members Present;  2 Members Absent | 8 Members Approved;  2 Members Absent;  5  Member Abstained | 13 Members Approved;  2 Members Absent | 13 Members Approved;  2 Members 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, April 9, 2025, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Commissioner Robert Goldstein; Damian Archer, MD; Emily Cooper; Dean Harold Cox; Robert Engell; Liz Evans; Marcia Hams; Joanna Lambert; Stewart Landers; Mary Moscato; Ellana Stinson, MD; Ram Subbaraman, MD; Gregory Volturo, MD.

Also in attendance was Beth McLaughlin, General Counsel at the Massachusetts Department of Public Health.

Commissioner Goldstein called the meeting to order at 9:04 am and made opening remarks before reviewing the docket.

**1. ROUTINE ITEMS**

*b. Updates from Commissioner Robert Goldstein*

**Spotlight on Chelsea Board of Health**

To commemorate National Public Health Week, Commissioner Goldstein joined the Council from the City of Chelsea Board of Health to highlight some of the essential work being done by the state’s local public health colleagues, including Chelsea. In recent years, the Chelsea Public Health Division has been at the forefront, responding to an ever changing public health landscape. The Chelsea Public Health Division has leaned on and partnered with diverse stakeholders to continue the work beyond COVID. Chelsea’s Public Health Division was among the first to support on the ground efforts to provide medical assessments and vaccinations to newly arrived families a couple of years ago, providing close coordination across neighboring municipalities and state agencies. The Chelsea Public Health Division has also played a pivotal role responding to lead paint chips falling off the Tobin Bridge. In partnership with community based organization Green Roots, medical partners Mass General Brigham, Cambridge Health Alliance, and Neighbor Health; municipal departments including the Department of Public Works, Constituent Services, and Housing and Community Development, along with the Department of Public Health and the Massachusetts Department of Environmental Protection, significant efforts have been made to increase childhood blood lead testing, provide lead awareness education workshops, and advance efforts to remove lead from the water through the service line replacement program.

**250th Anniversary of Midnight Ride**

Commissioner Goldstein relayed the story of April 18, 1775, and the midnight ride of Paul Revere, but added how it ushered in a new era of public health. A devastating smallpox epidemic broke out in Boston as the Continental Army was mobilizing. During the eight years of the Revolutionary War, two-thirds of casualties were from disease, primarily smallpox. General George Washington recognized the threat of smallpox to the troops and ordered the inoculation of all Continental Army soldiers, a controversial move given that inoculation was in its infancy and not wholly understood. By mandating inoculation, Washington protected his soldiers and enacted the first medical mandate in American history. After the war, Paul Revere became the first health officer in Boston and in the new country. He monitored and managed a variety of epidemics, developed strategies for isolation and quarantine, and improved hygiene, promoted cleanliness, and educated the population about sanitation and disease prevention. These acts remind us that public health has always been an essential part of our freedom.

**Measles**

Commissioner Goldstein said DPH and CDC are monitoring large numbers of measles cases occurring in various areas throughout the country. As of April 4, 2025, a total of 607 measles cases have been reported to CDC by twenty-two U.S. jurisdictions so far this year. The number of US measles cases in the first three months of 2025 has already surpassed the total number of US measles cases for all of 2024. Many of this year’s cases are linked to an outbreak beginning in West Texas two months ago. Cases in New Mexico, Kansas and Oklahoma have been linked to the Texas outbreak. Measles in 2025 has resulted in over 74 hospitalizations, and two confirmed and one probable death. There continue to be no recent measles cases reported in Massachusetts. Measles is an airborne, extremely infectious, and potentially severe rash illness. Before the measles vaccine was introduced, an estimated 48,000 people were hospitalized and 400–500 people died in the United States each year from the disease. DPH continues to advocate for immunization with the widely available, safe and effective measles vaccine. For this highly contagious disease that can cause serious complications, particularly in children, getting vaccinated for measles is the most effective way to protect individuals and communities.

**Marathon Monday/Emergency Preparedness**

Commissioner Goldstein updated the Council on the Department’s preparedness efforts for the 250th Anniversary of the American Revolution and the 129th running of the Boston Marathon. While the Boston Athletic Association leads the overall planning for the Marathon, DPH works closely with the Massachusetts Emergency Management Agency, MEMA, and more than 70 federal, state, regional, and local partners that come together to support the event. On Monday, April 21, he will formally activate the Department’s Emergency Operations Plan. Priorities that day include supporting the hospitals along the route, facilitating seamless Emergency Management System coordination, and preparing for any potential mass casualty incidents by being ready to implement patient tracking and family reunification efforts. DPH has a comprehensive staffing plan that enables it to have good visibility of the race at virtually every point along the way. The Department Operations Center will be activated with representation from key agencies, and DPH staff will be part of the Executive Decision Group at MEMA and will have liaisons at various key operational locations. In addition to the Marathon, DPH is preparing for the 250th Anniversary of the birth of our nation, which will be commemorated with a series of events in local communities. Depending on the weather, the events could draw several hundred thousand people to the various towns and venues. DPH will be supporting local hospitals, including Emerson and BI Lahey, coordinating with EMS resources, and preparing to implement appropriate processes in the unlikely event of a mass casualty incident. Both the Marathon and the 250th Anniversary are truly special events not only for people in the Commonwealth, but for the nation. DPH is committed to protecting the health of all participants and attendees, and helping this special weekend be celebratory, memorable, and safe.

**Pappas Working Group**

Commissioner Goldstein provided an update on the working group established by Governor Healey on the future of the Pappas Rehabilitation Hospital for Children. DPH has convened a working group to bring together a diverse group of stakeholders including families, advocates, labor, state and local officials, and medical professionals. to conduct a review of the pediatric care offered at Pappas and make viable recommendations on the best provision of high-quality pediatric care within the public health hospital system. These recommendations will be submitted to the Governor and Legislature to inform them of their decisions*.*

**Federal Updates**

Commissioner Goldstein spoke to the Council of the challenges DPH has been facing as the Trump Administration seeks to make federal cuts and changes that would significantly challenge the work we do. These past few weeks have been particularly difficult for public health, as we learned of the decision by the U.S. Department of Health and Human Services and HHS Secretary Robert F. Kennedy, Jr. to cut $11 billion in the critical funding supporting COVID-19 initiatives and other public health programs across the country. For Massachusetts, this translates into a staggering $118 million loss of funding critical to our work in vaccines, emergency preparedness, substance use disorder programs, laboratory operations, and data modernization. These cuts are not just numbers on a page. They represent a direct threat to the very services that keep our communities safe and healthy. Across the country, many states have already been forced to lay off employees and discontinue vital public health programs. To fight back against these cuts, Massachusetts, along with 22 other states and the District of Columbia, filed a lawsuit seeking a temporary restraining order to block these devastating actions. Thankfully, the U.S. District Court in Rhode Island granted that order last week, halting the cuts. At least for now. In addition, HHS Secretary Kennedy recently announced plans to cut about 10,000 jobs at HHS, including approximately 2,400 positions at the Centers for Disease Control and Prevention. These cuts are particularly troubling as they signal a shift in priorities, with CDC seemingly narrowing its focus to infectious disease and leaving behind the more holistic approach to public health that has been essential in addressing the full scope of health issues facing our communities. This restructuring at CDC includes the elimination of a significant number of staff at CDC’s National Center for HIV, Viral Hepatitis, STD and Tuberculosis Prevention, as well as a third of the staff at CDC’s Injury Center. Beyond these staffing cuts, last week, the Trump Administration’s Department of Government Efficiency tasked CDC with cutting an additional $2.9 billion in contracts, which is roughly 35 percent of its contract spending. These changes are deeply concerning for public health professionals everywhere, and they present significant challenges to the work of DPH. DPH remains committed to our mission of keeping Massachusetts healthy and safe.

**Members Sendoff**

Commissioner Goldstein mentioned that this was the last Public Health Council meeting for Harold Cox, Dr. Liz Evans, and Joanna Lambert. He thanked each member and said they would be recognized for their service with a Commissioner’s Citation.

**Welcome New Members**

Commissioner Goldstein welcomed four new members onto the Council: Dr. Damian Archer, Marcia Hams, Dr. Ellana Stinson, and Dr. Ram Subbaraman.

Commissioner Goldstein asked if there were any questions.

Ms. Moscato thanked the departing members’ contributions to the Council, and mentioned that a US District judge in Texas reviewed and threw out the a federal rule under the Biden administration for mandating staffing and nursing homes across the country, which is significant for the nursing home industry across the country. She said from a public health perspective, this is something new for Massachusetts to look at from both a care delivery, a cost perspective and the opportunity to serve more seniors.

Mr. Landers also thanked the departing members for their service.

With no further questions, Commissioner Goldstein turned to the docket.

**1****. ROUTINE ITEMS**

*c. March 20, 2025 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the March 20, 2025, minutes. Mr. Landers had a change to the minutes. They were amended.

Commissioner Goldstein asked if there was a motion to approve the amended March 20, 2025 minutes.

Dr. Volturo made the motion, which was seconded by Ms. Moscato. Dr. Archer, Ms. Evans, Ms. Hams, Dr. Stinson, and Dr. Subbaraman abstained. All other present members voted to approve the amended minutes.

**2. OTHER ITEMS**

*a. Letter to the Public Health Workforce from the Public Health Council.* ***(Vote)***

Commissioner Goldstein invited Dean Harold Cox to read a letter, prepared by Council members, that he had proposed to be sent to State and Local Public Health Workforce.

Dean Cox made the motion which was seconded by Dr. Volturo. All present members approved.

**3. DETERMINATION OF NEED**

*a. Request by Sturdy Health Foundation, Inc. for a Substantial Capital Expenditure.*

Commissioner Goldstein invited Dennis Renaud, Director of the Determination of Need Program, to review the staff recommendation for Sturdy Health Foundation, Inc.’s request for a Substantial Capital Expenditure. He was joined by Jaclyn Gagne, Chief Deputy General Counsel.

After the presentation, Commissioner Goldstein asked if there were any questions from the Council.

Dr. Volturo expressed concern based on the bed numbers in the application, that after upgrading the ED with more beds there would still be boarding in the ED. He suggested adding flex space to the design.

 Aimee Brewer, CEO & President, Sturdy Health said this design has allowed them to have ample room for triage and for fast track. They will also retrofit their emergency department into some observation beds to move people through and have additional access to beds. She said they need OPS beds that are scattered throughout the hospital but believes the new space will allow them to dedicate 12 beds for behavioral health.

Dr. Brian Patel, Sr. Vice President Medical Affairs, Chief Medical and Quality Officer, said to reduce boarding in the emergency room, they've done significant work on the inpatient side to look at their throughput and length of stay and have created multiple different areas of opportunity to help reduce the length of stay on the inpatient side to help reduce boarding on the emergent in within the emergency department, things are just creating multidisciplinary rounds, augmenting our case management staff, augmenting or utilization management staff, adding a physician advisor, all of which has worked successfully to help reduce length of stay. With many initiatives on the behavioral health boarding side, that the state has put in place, like the behavioral health referral platform, they have seen some reduction in the length of stay of behavioral health patients in the boarding tied to that. Within the behavioral health space and the acute care space, there are a couple of beds that will be designated as flex beds. Lastly, he said the 31 beds that include 5 behavioral beds will open to acute care when they have added more behavioral health beds and patients are moved to the newer beds.

Dr. Volturo mentioned that observation units that are run through the emergency department rather than hospital medicine generally have a length of stay of 20 hours to 24 hours. He mentioned that the applicant had reduced their turn around in observation to 39 hours. He suggested it may be advantageous to run these new operational beds through the emergency department.

Dr. Patel said they are in the process of developing the plan around the observation unit. They are considering space that would be adjacent to the emergency department and determine whether it be staffed by emergency medicine versus hospitalist medicine. He agreed that historically and by data lower lengths of stay occur when it's overseen by emergency medicine. They would look to create a process that's very tightly managed between the ED and the observation unit so that they are continuing to reduce that length of stay for those patients as well.

Ms. Moscato said the Council has had other health systems come with a Determination of Need application to expand their emergency department based on overcrowding. One of the components not mentioned in their application is the continuum of care and transitions of care related to inpatient care. She said emergency room DoNs in the past had addressed that they were at a hundred 100% capacity of their inpatient beds, which added to their overcrowding. She asked for more clarity regarding space for inpatient and transitions of care in their application as it did not speak to its capacity.

Dr. Patel said they have ability and space within their hospital to open up alternative care sites as necessary to be able to continue to pull patients from the Ed into the inpatient side and do everything possible to mitigate Ed boarding. Their goal on a daily basis is to review their census when they are at those capacities and do everything possible to reduce the boarding within the emergency department and pull patients to other areas as necessary. The vertical treatment space was a direct result of the increased volumes in the ED and being able to better manage lower acuity patients or patients with less resource needs more expeditiously to get them through the system faster. They look at the patients that are potentially boarding or need to get admitted into the inpatient unit to try to reduce their stays in the ED. An observation unit will help them further manage that boarding and allow them to pull those patients out of the ED into another space that allows for more efficient care.

Ms. Moscato confirmed that there are no inpatient psychiatric beds at this time, and that they are not running at 100% capacity.

Dr. Patel confirmed.

Ms. Moscato was concerned about the number of staff that will be needed in the new emergency department, and their plan for staffing growth with today’s shortage in the workforce.

Ms. Brewer said that they are not exempt from the current staffing crisis, but they have focused on retention and recruitment and do not have the same level of reliance on travel nurses or turnover like most other healthcare systems. They have fewer than 100 open positions across their health system and fewer than 30 open RN positions. They have partnered with schools, do job training, and attract and retain staff. Their increase in volume will not require dozens of new employees. They will be shifting people’s work and how they focus their care, versus having to go and add a lot more staff.

Alyssa Jolicouer, Director of Emergency Services, echoed what Ms. Brewer said, that they shifted staffing in the ED, with the increase in their volume, they have already increased FTEs to meet that volume. With their new front end workflow process, they will need to increase the staffing there as well as the behavioral health area, but she does not anticipate difficulty in recruiting and with retention.

Dr. Stinson asked what the percentage of behavioral health visits was.

Ms. Jolicouer said with their current EHR system it's difficult to separate the ED visits from the behavioral health visits. She has developed a process in order to separate that volume. They'll be able to get better metrics on length of stay for medical patients versus behavioral health patients versus number of visits.

Dr. Stinson wanted to know how much staffing issues may add to the high volume of boarding in the ED.

Ms. Jolicouer said the problem is the rate limiting step. Oftentimes, a patient is ready to be moved but cannot be due to lack of beds. The staff are working in very tight quarters. It’s more about efficient patient flow and staff workplace versus having the staff to treat the patients.

Dr. Patel added that they’re already staffed for RN staffing based on volume, which accounts for 52,000 visits a year. With the 5% increase they can manage within existing staffing plus the 2.8 FTEs to manage the volume.

Justine Zilliken, VP, and Chief Strategy Officer, said the challenge is discharge, having the ability to transition patients to acute care psychiatric beds, or the ability to get patients into those step down facilities. The number of beds and availability match the need for those being admitted. The challenge then becomes working through those external processes.

Ms. Hams asked about primary care and behavioral health care. She mentioned factors leading to overcrowding suggesting a stronger collaboration with the community and primary care.

Ms. Brewer agreed and said they have been working the past several years on their primary care investment. Over the past year they have hired 8 new primary care physicians and 5 more starting this year. They are continuously recruiting. They've been strong advocates with their legislators on how they can as a state attract new primary care physicians to Massachusetts through different loan forgiveness and student loans, perhaps housing support, whatever it may be. They acknowledge there is a behavioral health shortage in the Commonwealth. They have a successful partnership with Concert Health. Their primary care patients, physicians, and providers have access to real time consultation for those that need the access and can be provided psychiatric and medication oversight.

Dr. Patel added they partner closely with community partners to help care for their behavioral health patients in the outpatient setting. Their Community Behavioral Health Center (CBHC) is with Community Counseling of Bristol County (CCBC), which does their crisis evaluations in the emergency department and has helped reduce ED utilization. CCBC also has a high utilization program with which Sturdy Health works closely and have very successfully reduced ED utilization through that program with MBHP. The last day was over a 60% reduction in those patients’ utilization in the emergency department. They also work closely with McLean Services who provides the hospital based types of evaluations as well while helping to divert patients to the appropriate outpatient facilities in an attempt to reduce length of stay in boarding for patients. They have multiple community partnerships with substance use disorder clinics in the area and utilize them aggressively to get patients into those resources as well. A liaison from one of the local centers comes into the hospital three days a week, connecting directly with patients and gets them set up with their appointments and referrals. They are in the process of implementing Vivitrol injection use in one of their practices so they can get patients that care through primary care practices directly rather than having to use MAT clinic to provide it. They are growing their primary care based education and treatment processes to manage substance use disorder directly through primary care. He said lastly, they have a social worker in their outpatient setting that helps provide in person care for patients with behavioral health related issues. A collaboration of all of that has helped augment the services they provide their patients with behavioral health and substance use disorder and needs within the community.

Ms. Cooper directed her question to DPH staff and asked if the requests made through multiple Determination of Need applications are tracked and compiled to show an overall request for additional beds leading to the need for additional staffing, or if DPH looked only at each individual DoN.

Commissioner Goldstein said yes, the Department is tracking this both through the Determination of Need program and through the Office of Healthcare Strategy and Planning that takes a comprehensive look at what is happening in healthcare across Massachusetts. Also, the healthcare financing bill that was recently passed at the end of last year asked for a health planning council and for work being done collaboratively between the Department of Public Health and HPC so that it can understand what is needed, what is being supplied, and how the supply demand in Massachusetts is met. There is a need for beds and there is a limited supply of staff, so withholding the beds is not the right answer. He noted that a current determination of need regulations are limited to the health system that is applying to DPH.

Mr. Renaud agreed that from the point of a DoN, the specific application presented is what is being determined and evaluated.

Mr. Landers questioned language access in the behavioral health setting, stating that the application spoke more about this in terms of medical services.

Dr. Patel said within the emergency department itself, they use virtual interpreter services that has over 200 languages available and is available to patients as well as the behavioral health patients. When crisis clinicians are doing evaluations with a patient who has a preferred language other than English, they will use those virtual services to help make sure that they're communicating effectively with the patient and utilize those services. If the patient needs to speak with a family member over the phone, they can connect interpreter services directly through the phone to be able to communicate with the family.

Mr. Landers said he appreciated what Dr. Patel offered for interpretive services, but the importance of having mental health and other behavioral health providers who are culturally knowledgeable and have language accessibility is something that is needed and should strive towards finding more resources.

Dr. Patel agreed and added that when the influx of Haitian Creole refugees came into our area, they worked very closely with community partners to provide resources for them, in a culturally competent manner and with appropriate language access. He said Sturdy wants to participate with community partners to augment those services so they can make sure that their patients get the care they need in a way that they understand.

Mr. Engell said that they had spoke to increasing their primary care network and recruitment, but it appears like they’re building the receiver for a demand that's in the community. He wanted to know what they’re doing in the community and what level of outreach to historically underserved populations in their marketplace the system is doing.

Ms. Zilliken said they focus on making sure that they’re serving their community in a way that the community can embrace, understand, and that's culturally sensitive. As was mentioned earlier, they do a community benefit in different languages that are available and it lists all the community services and their community partners to make sure that they're addressing everything from food insecurity, the special needs for our aging populations, to our newest neighbors from other countries. They make sure that as part of their community benefit advisory committee, they invite those community leaders in like the Executive Director for the Council on Aging who sits on their committee. It’s important because it is a hub for all of their migrant community, typically disenfranchised communities to make sure that they're partnering on services, education and availability. Also, they make sure that they're in the community providing screenings, providing education and providing resources in all corners of the communities that we're privileged to serve.

Mr. Engell noted in the application the elimination of the vertical treatment spaces. It seemed like that was a fix to a problem to decompress their emergency room. But they also spoke about the value of that functional area and that space. He wanted to know if they have maintained that programmatically within the new design, because there aren't vertical treatment spaces included.

Dr. Patel said they will be moving it to the front end. Adding the four triage bays that are essentially 4 full size rooms, they'll be able to render some of that care in that area. Within the ED, there's also a fast track area, so some of those patients can get diverted to that area. They're not calling it vertical treatment, they're just redistributing that same similar workflow to different parts of the new emergency department.

Mr. Engell’s final question was that they mentioned there was a 30% reduction or increase in cost with wait times that increase every 60 minutes. Their application identified where wait times had been increasing by 30 minutes, yet he didn't see an academic reference for the 30% increase in cost. He asked where that came from and whether it's been substantiated since it is a metric that the DoN program used to satisfy the cost parameter.

Dr. Patel said although he didn’t have the exact reference in front of him, that statistic is referencing the significant risk of poor outcomes in patients who wait longer to be seen in the emergency department. They assume that they have more acute urgent care needs and the risk of delaying their evaluation can lead to potentially poorer outcomes, longer length of stay, etcetera. Extrapolating that to say if they can reduce the length of stay on wait times for these patients, deliver their care more timely, more efficiently, they would reduce cost of care both in the short term and the longer term perspective.

Janine Levinson, Director of Budget and Decision Support, said the cost savings they anticipate would also come from the ability to safely discharge those patients sooner and more efficiently they would then not encourage as much nursing overtime, staff overtime and they would have gains and cost savings in those areas as well.

Mr. Engell asked if the DoN program using that metric was comfortable with the cost basis of the analysis.

Mr. Renaud said yes and offered the source for that as a journal article related to economic inquiry from 2019.

Dr. Stinson said in regard to cost and also underserved communities, she noticed in their trends for fiscal year 2024 that there is a higher rate of Black and African American as well as Hispanic and Latin users of the emergency department as opposed to their outpatient services. She asked if they had recognized any trends why that may be happening in the community at a higher rate, and if there are any initiatives that they have in place to get those population to not over utilize the emergency department.

Dr. Patel said their health equity work is reviewing and identifying those potential disparities around chronic condition management, making sure that they're reviewing outcomes for their Black and Hispanic patients and seeing if there's disparities they're identifying if that population is less likely to have a primary care doctor and working on trying to see what they can do to get them connected to a PCP and get them managed in the outpatient setting to hopefully try to reduce some of that utilization. Currently, they've been working around diabetes management and have had a very successful initiative on a small cohort of patients. They found significant uncontrolled diabetes in the African American population, connected them with a continuous glucose monitor with their clinical pharmacist and improved their medication management and saw significant improvements in their hemoglobin A1 CS. They'll continue to look at any potential disparities based on race and ethnicity and work to mitigate that risk as well.

Dr. Stinson asked if that statistic was counted when there was the arrival of a number of migrants from Haiti and Venezuela. There was influx of patients that were coming to the ED for triage. There were a number of pregnant mothers that arrived for overall health and wellness check. There was an increase in those particular ethnic racial categories. She asked if that was an appropriate assumption.

Dr. Patel agreed and said as a result of that, they worked very closely with their community partners and management to get them connected to the outpatient setting. They worked with mobile health resources that went to some of the local shelters and the local hotels to help deliver some preventative healthcare for those patients and help mitigate some of the utilization of the ED for those patients.

With no further questions, Commissioner Goldstein asked if there was a motion to approve the recommendation for Sturdy Health Foundation, Inc.’s request for a Substantial Capital Expenditure/

Dr. Volturo made the motion which was seconded by Mr. Landers. All other present members voted to approve.

**INFORMATIONAL PRESENTATIONS**

1. *Update on the Health Survey Program*

Commissioner Goldstein introduced Dana Bernson, Director of the Data Science, Research, and Epidemiology Division within the Office of Population Health, to share an update on the Health Survey Program.

After the presentation, Commissioner Goldstein asked if there were any questions from the Council.

Mr. Engell noted the important information on youth suicide but there was none within the Behavioral Risk Factor Surveillance System (BRFSS).

Ms. Bernson said these were samples of the results that she presented focusing specifically on mental health and suicide. There is much more detailed information on the full results of the surveys on the website and especially with BRFSS.

Mr. Engell said with the noted decline in youth alcohol use, he wondered if there's a corresponding increase in marijuana with the changes in the legal status over time.

Ms. Berson said that the questions around marijuana and cannabis have changed over time so it’s hard to follow trend data, but they have multiple “point in time” estimates available.

Mr. Engell asked about specifying the impact for the veteran population in Massachusetts which is available through the BRFSS.

Ms. Bernson said it is not currently a population that’s identifiable through the survey.

Mr. Landers said CDC has always been supportive of collecting sexual orientation and gender identity data and wanted to know if there has been any indication from the new administration if they would not support asking those questions, or potentially under threat of pulling funding, would enforce not asking these questions.

Ms. Bernson said that they are in the field with the 2025 survey. It has not been officially approved by OMB and we're using a modified version of our 2024 survey right now. One thing that did occur is that the sexual orientation gender identity module was removed as an optional module. However, here in Massachusetts, they've made the decision to keep that module as state-added questions and are using state funds to cover the cost of that module. They get about a third of their funding for the survey from CDC and the 2/3 is coming from other programs so they have flexibility, but not all states do, and in those cases the SOGI module has been removed.

Mr. Landers then asked about the implementation of the Youth Health Survey saying that in the past, there was difficulty in getting schools to participate. He asked what the situation now is and how it is administered across schools.

Ms. Bernson said that recruitment is a challenge, and they haven’t seen much deviation from that other than delays in getting the infrastructure for the Youth Risk Behavior Survey, leading to delays in the Youth Health Survey.

Mr. Landers mentioned that some communities have implemented their own version of YRBS and asked if that posed any challenges in terms of recruitment.

Ms. Bernson said there are districts and regional areas that have their own surveys. They do their best to work with them to get both administered.

Dr. Subbaraman asked if the surveys are representative only at a state level, or does it elevate to county level. If so, he wanted to know what efforts are involved in disseminating the information on local differences to county, local public health so they can act upon disparities across the state.

Ms. Bernson said they are able to calculate substate measures at the county level. They've also worked and are currently working to enhance our capacity to calculate small area estimates so they can get data at a more local municipality level. They are working very closely with the Office of Local and Regional Health. They help with their capacity around leveraging some of the resources that are going into local public health, so they can help be supportive. They make the results available on the population health information tool or our “PHIT” platform.

Dr. Volturo said looking at the mental health indicators across high school students is particularly disturbing because we see this increasing across the entire spectrum. He asked if anyone is looking at the potential impact of social media on this group and whether or not it is having an impact at all.

Ms. Bernson said she doesn’t have an answer to that right now, but it's something that they can look into.

Ms. Hams wondered what we would do at the state level if the current administration pulls support for the BRFSS altogether.

Ms. Bernson this is one of the points of uncertainty that they’re facing and can’t answer the question at this point. She reminded the council that this is just 1/3 of the funding. It is the support for complex survey methodology survey weighting as of today they don't have capacity to do internally in the state.

Dean Cox wanted to know if gathering data in the BRFSS, does the reliance on landline and cell phone survey exclude young adults who are less likely to answer telephone calls.

Ms. Berson said it's a general concern with people who answer their phone. They do the maximum amount of cell phone dials as we're allowed to under the grant conditions. Generally, people across age spectrums who answer the phone from a number they don't know are probably a little bit different than people who don't. It’s an unknown that’s hard to measure.

With no further questions, Commissioner Goldstein moved to the next item of the day.

1. *Update on the Implementation of the Statewide Accelerated Public Health Community Act.*

Commissioner Goldstein introduced Sam Wong, Director of the Office of Local and Regional Health, to share an update on the implementation of the Statewide Accelerated Public Health for Every Community Act, or SAPHE 2.0. This presentation included remarks from representatives from various local boards of health.

After the presentation, Commissioner Goldstein asked if there were any questions from the Council.

Mr. Landers shared as a representative on the Public Health Council representing the Mass Public Health Alliance the importance of passage of SAPHE 1.0 and SAPHE 2.0.

Dean Cox said the work that he and other public health professionals were doing nearly 30 years ago is just starting to bear fruit with the passages of SAPHE 1.0 and 2.0. He said there are two lessons learned. The first being the mission and the second the persistence.

With no further questions, Commissioner Goldstein stated that this concluded the final agenda item for the day and reminded the Council that the next regular meeting is scheduled for May 14, 2025, at 9:00 am.

Commissioner Goldstein asked if there was a motion to adjourn.

Dr. Volturo made the motion which was seconded by Ms. Moscato. All present members approved.

The meeting was adjourned at 11:39 am.