MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of August 10, 2022

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, August 10, 2022 – 9:00AM**

***Note: The August 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 due to COVID-19.***

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1. **ROUTINE ITEMS**
   1. Introductions.
   2. Updates from Commissioner Margret Cooke.
   3. Record of the Public Health Council Meeting held July 13, 2022 **(Vote)**.
2. **DETERMINATIONS OF NEED** 
   1. Request by Fairlawn Rehabilitation Hospital for a substantial capital expenditure (**Vote**).
   2. Request by the Children’s Medical Center Corporation for a transfer of ownership (**Vote**).
3. **PRESENTATIONS**
   1. Overview of Serious Reportable Events in Healthcare Facilities, 2021.
   2. Update from the COVID-19 Community Impact Survey (CCIS).

*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: August 10, 2022

Start Time: 9:05am Ending Time: 11:09am

| **Board Member** | **Attended** | **First Order: Approval of July 13, 2022 Meeting Minutes (Vote)** | **Second Order: DoN a. Request by Fairlawn Rehabilitation Hospital for a substantial capital expenditure (Vote)** | **Third Order: DoN b. Request by Children’s Medical Center Corporation for a transfer of ownership (Vote).** |
| --- | --- | --- | --- | --- |
| **Commissioner Margret Cooke** | Yes | Yes | Yes | Yes |
| **Edward Bernstein** | Yes | Yes | Yes | Yes |
| **Lissette Blondet** | Yes | Yes | Yes | Yes |
| **Kathleen Carey** | Yes | Yes | Yes | Yes |
| **Secretary Elizabeth Chen** | Yes | Yes | Yes | Yes |
| **Harold Cox** | Yes | Yes | Yes | Yes |
| **Alba Cruz-Davis** | Yes | Yes | Yes | Yes |
| **Michele David** | Yes | Yes | Yes | Yes |
| **Elizabeth Evans** | Yes | Yes | Yes | Yes |
| **Joanna Lambert** | Yes | Abstain | Yes | Yes |
| **Stewart Landers** | Yes | Yes | Yes | Yes |
| **Mary Moscato** | Absent | Absent | Absent | Absent |
| **Secretary Cheryl Poppe** | Yes | Yes | Yes | Yes |
| **Summary** | 12 Members Present; 1 Absent | 11 Members Approved; 1 Abstain; 1 Absent | 12 Members Approved; 1 Absent | 12 Members Approved; 1 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, August 10th, 2022, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Margret Cooke; Edward Bernstein, MD; Lissette Blondet; Kathleen Carey PhD; Secretary Elizabeth Chen, PhD; Harold Cox; Alba Cruz-Davis PhD; Michele David, MD; Elizabeth Evans, PhD; Joanna Lambert; Stewart Landers, JD, and Secretary Cheryl Poppe.

Also in attendance was Rebecca Rodman, General Council at the Massachusetts Department of Public Health.

Commissioner Cooke called the meeting to order at 9:05am and made opening remarks before reviewing the agenda.

**1. ROUTINE ITEMS**

*b. Updates from Commissioner Margret Cooke*

Commissioner Cooke proceeded to update the council on the following:

**COVID-19 Boosters**

Commissioner Cooke shared that she had recently signed letter with the Massachusetts Health and Hospital Association, the Massachusetts Medical Society, and the League of Community Health Centers, urging health care providers to provide booster doses now for anyone eligible to receive one. She urged those that are eligible for a booster to get one and reminded everyone that although vaccine protection decreases over time, boosters can restimulate the immune system and increase vaccine efficacy again. She emphasized that staying up to date with COVID-19 vaccines is the most effective way to lower the risk of severe illness. She said that there are hundreds of locations across the Commonwealth to get a booster.

**988 Launch**

Commissioner Cooke said that last month 988 replaced the 10-digit National Suicide Prevention Lifeline number.

**Monkey Pox**

Commissioner Cooke said since the last Public Health Commission, the Department has continued its surveillance and prevention efforts regarding the monkeypox virus in Massachusetts and 157 cases have been identified since May 18, 2022 She spoke of the characteristic rash and flu-like symptoms of the disease and reminded members that it can spread to anyone through close, personal contact. She said anyone can get monkeypox, but most cases have been in men who have sex with men. Vaccines can help protect against monkeypox when properly administered. The JYNNEOS vaccine is available to those who live or work in Massachusetts and meet the current CDC’s eligibility criteria. She said there are more than a dozen vaccine sites across the Commonwealth. Press releases are issued weekly on Thursday with updates concerning monkeypox.

**First West Nile Sample**

Commissioner Cooke said the first detection of West Nile Virus in mosquitos was announced July 13th. No human or animal cases have been detected so far this year, nor have we seen evidence of Eastern equine encephalitis this season. She reminded us that now is the time to start taking steps to prevent mosquito bites.

**Visit to State Lab**

Commissioner Cooke reported that the state lab in Jamaica Plain is undergoing extensive renovation. She said she had the opportunity to visit the staff working at the lab last month and was pleased with the progress made and thanked the team for their critical work.

**MA Named Healthiest State**

Commissioner Cooke reported the findings published by the Boston University School of Public Health and the digital health company Sharecare, which named Massachusetts the number one healthiest state for the second year in a row. She said the Commonwealth had strong scores across both social determinants of health and individual health risk factors, ranking in the top 10 for eight out of 10 well-being domains. She added that Massachusetts was also ranked one of the nation’s top healthcare systems in the Commonwealth Fund’s annual rankings, with top scores in access and affordability, prevention and treatment, racial and ethnic equity, and healthy lives.

Upon the conclusion of the updates, Commissioner Cooke then asked if the Council members had any remarks or questions before proceeding. Mr. Landers asked if monkeypox vaccine doses would be given using 1/6th of a dose intradermally rather than intramuscularly in Massachusetts.

Commissioner Cooke said the announcement was made and the federal government is promoting intradermal smaller 1/5th doses that can be given as a second dose after the prior full dose. She said that the supply is being evaluated and an announcement will come in the short-term dictating next steps.

Secretary Poppe thanked everyone for the work that was done on 988. It will be a huge help especially to veterans in terms of suicide prevention. She said they always suggested putting the suicide prevention number in phone contact lists, but this will be much easier to remember.

Dr. Bernstein stated that the MBTA orange line shutdown should be considered a public health issue. Commissioner Cooke thanked Dr. Bernstein for his remarks.

Ms. Blondet concurred stating that it was an excellent point. She then asked if there was any data on the incidents of monkeypox across the state either geographically or with particular groups, or ages.

Commissioner Cooke introduced Dr. Estevan Garcia, DPH Chief Medical Officer, to offer specifics.

Dr. Garcia said that DPH is tracking that information and sharing it as appropriate with other individuals at the CDC. He said when vaccine clinics were first opened, they looked at the highest incidence and the communities that were at highest risk and have been able to increase clinics across the state. He said there are now 14 clinics statewide and based on the new announcement mentioned earlier, the hope is to increase those vaccine sites to accommodate the availability of the vaccine.

Commissioner Cooke added that there is also a mobile vaccination unit for areas that may not have a large percentage of cases but may need the vaccination effort.

Ms. Blondet qualified that her question had more to do with what we know so far as opposed to the potential response that we have through these sites.

Dr. Garcia replied that he did not have the information on hand but that he can follow up with details.

Mr. Landers asked if DPH’s recommendation would be single doses rather than double doses to extend the supply or has that not yet been determined.

Commissioner Cooke said they are still working on determining that, but they still don’t know the full supply that they will be getting from the federal government. She said they are trying to determine the numbers and the dosage and how best to protect the residents of the Commonwealth.

With no further questions or comments from the council members. Commissioner Cooke then turned to the docket.

**1. ROUTINE ITEMS**

*c. July 13, 2022 Minutes (Vote)*

Commissioner Cooke asked if there were any changes to the July 13, 2022 minutes. There were none.

Commissioner Cooke asked if there was a motion to approve the July 13, 2022 minutes.

Dr. Carey made the motion, which was seconded by Dr. Bernstein. Ms. Lambert abstained and all other present members approved.

**2. DETERMINATIONS OF NEED**

*a. Request by Fairlawn Rehabilitation Hospital for a substantial capital investment (Vote)*

Commissioner Cooke invited Elizabeth Kelley, Director of the Bureau of Health Care Safety and Quality to review the staff recommendation for Fairlawn Rehabilitation Hospital’s request for a substantial capital expenditure. She was joined by Rebecca Rodman, General Counsel. Also, representatives from the applicant were available to answer questions after the presentation.

Upon conclusion of the presentation, Commissioner Cooke asked the council members if there are any questions or comments.

Dr. Carey commented that the presentation made a very compelling case for improving not only quality, but patient safety and she found that to be encouraging. She had a question regarding the presentation’s suggestion that Medicare patients would pay less when she understood Medicare payments to be non-negotiable. She also questioned the decrease in Medicare patients over the last three years.

Patrick Tuer, President of Fairlawn Rehabilitation Hospital responded that though Medicare reimbursement is flat by CMG and diagnosis, there is a mechanism to get enhanced reimbursement that is through outlier thresholds. With the cost of care being so high, the Medicare program recognizes a need for additional reimbursement. He said Fairlawn has virtually zero outlier cases that prevent them from getting additional reimbursement. Also, there is some pricing disparity for them being a freestanding inpatient rehab provider. He asked Dr. Carey to repeat the second part of her question.

Dr. Carey repeated her curiosity regarding the shift in Fairlawn’s payer mix over the last three years away from Medicare.

Mr. Tuer stated that the shift away from Medicare is something they are seeing across not only the northeast region, but across the country. He said that there is trend that as the generation of baby boomers advances in age, there is a lot of transition to Medicare advantage plans. Although there is still a healthy number of traditional Medicare patients in their service area, Medicare advantage enrollment has close to doubled in the last few years. He said they still feel well positioned both through Medicare advantage and a traditional Medicare perspective that when they look at population demographics in the Worcester service area as well as the region, and the nation, the demand for inpatient rehab services is growing, but the shift to Medicare advantage is the culprit of the declining Medicare numbers. He said the 90% of their patients are over 50 years old with 65% being over Medicare age and is the largest book of business that they serve.

Dr. Carey thanked him.

Dr. Bernstein wanted to follow up on patient safety and said while looking at the data in the reduction of patients they have been able to serve during COVID or other contingencies with multi patient rooms, he said they predicted a decrease in serious reportable injuries or events. He asked if they foresaw anything that could be a metric to look at for improvement. A second part of his question was around staffing. He imagined that Fairlawn was forced to downsize the staff they had. How are they now, he asked, going to recruit and compete in the marketplace for staff with emphasis on patient safety?

Mr. Tuer replied by saying that they are starting to see some positive trends in both clinical and non-clinical applications from a staffing perspective this year after a significant lull in nursing application flow. He said their staffing is up 22 full-time employees with 15 of those being in nursing. He said there are a couple of different reasons for this; they have always tried to pay their employees competitively through merit increases but also making sure that they are competitive from a market perspective. They have done a 7-figure market adjustment in the state of Massachusetts in the past 12 to 18 months. He said another factor is the healthy stock market allowing people to return after fears in 2019. He deferred to his colleague Peter Lancette, CEO of Fairlawn Rehabilitation Hospital to speak of some of the partnerships and collaboration with UMass Memorial around recruiting new grads.

Mr. Lancette stated that they are in an extremely competitive market nestled between two major medical centers, one of which, he said, had a significant labor action last year that impacted their ability to staff the hospital, with a lot of their staff seeking the higher rate contract labor positions that were available. He said that gave them some initiatives like some grassroots efforts where they partnered with local universities. He believes they are up to partnering with 55 nursing programs for clinical rotations. They have also enhanced their graduate nurse programs and are actively employing graduate nurses and supporting them up and until they take their boards. He said that when they pass their boards, they are becoming registered nurses there. He added they are also encouraging employee referrals.

Mr. Tuer added that their move to private rooms, from having two beds, would improve safety, but he says as a company they have leveraged their technology to reduce the events to which Dr. Bernstein was referring. He said that their hospitals have been on an electronic medical record for almost a decade, accumulating data that can be analyzed if such an event does occur. They have leveraged that he said, using three predictive models that have been implemented in each of their hospitals, including Fairlawn. The most recent predictive model is for fall reduction. He compared the old model for fall reduction that assumed roughly 88% of patients were at risk for a fall. He explained that this model did not give them an opportunity to target specific patients that may be at an even more elevated risk. He said they developed a system using their electronic medical record in collaboration with Cerner to look at almost 50 clinical elements to determine if a patient was at an enhanced risk to fall. Through that, they have reduced their falls and serious falls. The other two predictive models that they have implemented with the same kind of logic, he continued, is readmission reduction; analyzing patients that for many reasons, are at a high risk of readmitting to an acute care hospital. They use a discharge metric and make sure that patients have a primary care appointment set up within a timely interval. Also, they ensure that patients have any needed durable medical equipment upon their return home. Lastly, is reducing acute care transfers. He said anytime you have a transfer and a break in care for any reason, it can be traumatic to them as an organization, the patient, and the patient’s family, not to mention the hospital that is struggling with bed availability and overloaded ERs. The last thing they want to do is send a patient back, and they have systems to prevent that. He explained that every patient in their hospital is assigned a risk score of a potential acute care transfer. The list is reviewed multiple times a day. If a patient shifts from low risk to mid risk, to high risk, or even very high, there are certain interventions that are put in place to try to minimize that acute care transfer. He emphasized that he wanted the members to understand as an organization, how seriously they take reducing serious events and negative burdens of care for patients and families.

With no further questions, Commissioner Cooke asked if there was a motion to approve Fairlawn Hospital’s request for a substantial capital expenditure.

Dr. Carey made the motion which was seconded by Dr. Bernstein. All present members approved.

**2. DETERMINATIONS OF NEED**

*b. Request by Children’s Medical Center Corporation for a transfer or ownership (Vote).*

Commissioner Cooke invited Elizabeth Kelley, Director of the Bureau of Health Care Safety and Quality to review the staff recommendation for a request by Children’s Medical Center Corporation for a transfer of ownership. She was joined by Rebecca Rodman, General Counsel. Also, representatives from the applicant were available to answer questions after the presentation.

Upon conclusion of the presentation, Commissioner Cooke asked the council members if there were any questions or comments.

Ms. Blondet said she was hoping for reassurance that the new entity will maintain both the Kennedy School and excellent behavioral services that are now provided by Franciscan. She said she assumes that they are not their best source of reimbursement or income, so she wanted to hear from the applicant about the commitment to both services.

Kevin B. Churchwell, MD, President and CEO of The Children’s Medical Center Corporation introduced himself and thanked Commissioner Cooke and the staff for reviewing and recommending approval as they move forward. He stated that their new affiliation that they are presenting will enhance those opportunities. The importance of what Franciscan has done in that space in terms of Kennedy rehab should be very much appreciated and also speaks to the support to Children’s as they go through the next evolution. He stated that they are very much committed to moving those programs forward.

Dr. Evans added that she appreciated the report as it was detailed and informative. She said she was struck by the wait list times and that there is a real need, a real problem that the proposed plan is aiming to fix, especially around the wait times. The issue in her mind was around the continuity of care plans and she asked if they could provide more detail about the few lines mentioned in the report about an intent to explore joint electronic health records as a way to ensure continuity of care across the campuses. She asked for them to share a little more about the concrete plans around creating shared electronic health plans.

Dr. Churchwell answered that their current plan is to move to the Epic system at Boston Children’s, and in doing that, they would want to also help facilitate that system being part of Franciscan’s. He stated that this system provides a very strong opportunity in terms of that connectivity which Dr. Evans had described. “Epic in one place is Epic in another place” and access to the patient record is made easier because of that. He said they look forward to that opportunity.

Mr. Landers said that when you look at the ratio of unique patients to dental visits, it is similar between Children’s and Franciscan’s, but when you look at the ratio between unique patients to behavioral health visits, there’s quite a significant difference. It looks like four or five typical encounters for the Children’s Hospital patients compared to roughly 18 to 20 unique visits at Franciscan’s. He asked if anyone could explain why that is different and whether that reflects the level of care given at Franciscan’s that would maybe not be maintained after the transfer of ownership.

Joseph Mitchell, MD, President and CEO of Franciscan Children’s Hospital, introduced himself and thanked Commissioner Cooke and the Public Health Council and staff for advancing this request with speed and urgency. He continued that they do have a different level of care that is complimentary to the care delivered at Boston Children’s. They operate an acute crisis care unit for children and adolescents as well as a Community Based Acute Treatment (CBAT) unit. In addition, they also have an ambulatory program, and all of those settings are dealing with a higher acuity of care of mental health care for children and as a result of that, we are seeing an increase in the intensity of the care delivered. He said that they are committed to continuing and expanding that level of care, which is so desperately needed given the pediatric mental health crisis that we’re facing.

Mr. Landers asked with this merger, who would be other providers of this care, or this type of care in the Commonwealth?

Dr. Mitchell answered that there are a number of other providers who provide this type of care, such as Cambridge Health Alliance and others. He said that they have not yet done the detailed planning around the care program, and they intend to come back to the council in future Determination of Need (DoN) requests to talk in more detail about that. He emphasized that they are very proud of Franciscan Children’s, as they are a community asset that today takes referrals from all the major hospitals and system around the Commonwealth. They draw from the entire state and the broader New England region, and they intend to maintain their status as a real community asset that works with multiple partners including Boston University, McClain, and Boston Children’s as well as a number of referral partners around the state.

Dr. Churchwell added that across the Commonwealth, those hospitals that are engaged in taking care of children are also very much engaged in caring for children with behavioral issues, so UMass, Bay State, and Cambridge Health alliance are also dealing with these issues.

Dr. Carey followed by saying she also is encouraged by the strong case for improved care continuity because of this change in ownership. She said they operate many programs across the care continuum and Mr. Churchwell has filled the Council in on how the kind of connectivity of medical health records and patient tracking will be improved, and that is encouraging, she said. She mentioned a point that was alluded to several times in the report regarding improving staffing models but noted that there were not many specifics mentioned about how that would work. She asked for someone to explain how they can improve staffing models. We all know, she said, due to the pandemic, in addition to the demand for behavioral health services, there is also staffing shortages throughout the system.

Dr. Mitchell said that one of the central reasons why they want to move forward with this affiliation is to address what have been crippling staffing shortages that have limited both their ability to fully meet the needs of children and families, particularly, but not exclusively for their behavioral health part of their mission. He said they have had a long-standing relationship and collaboration with Boston Children’s, and that many of their frontline staff have worked at Boston Children’s and vice versa. They have demonstrated the ability to work together on this in the past, but the issue now is that they are competing for a limited pool of candidates. He believed that in coming together they can strengthen their value proposition to their employees and further provide competitive wages in a highly competitive labor market. He said they can enhance the training and professional development opportunities to their staff and continue to partner with local universities and higher education like Northeastern and Boston University to build the pipeline of the future. He continued that there are simply not enough mental health nurses, mental health specialists, and social workers to accommodate the mental health missions. He said they are going to have to work together to try to attract, recruit, retain, and train the next generation of leaders.

Dr. Bernstein commented that he can’t remember a more important request to come before the Council in a long time. He said, when we look at this crisis it also affects our future and the future of our state, and we see it throughout the whole country. He mentioned he read a report saying how fragmented the system was and that there is a lack of integration, lack of holistic approach to this problem. He believed the social determinants of health are the critical factor and help people’s lives. He said it is very encouraging to hear that there is a collaborative going on between all the experts and the hospital systems and he hoped that it will continue and not just a pipeline for children’s hospitals but all hospitals. He remembered as an ER physician for 30 years he has seen the impact and the boarding problem with people waiting 3 or 4 days for a bed and he said it could be more in the current crisis. He wanted to know their thoughts on how they are preparing to handle capacity.

Dr. Churchwell thanked Dr. Bernstein for identifying the issue so well and answered that capacity is an important part of their planning that they will bring back to the Council. There is a capacity problem that they are working with the state in terms of different hospitals and organizations that take care of kids that are increasing their capacity. Cambridge Health Alliance, he said, is a great example but will still not solve the problem. The problem is not just capacity from an inpatient standpoint, but also from an outpatient evaluation standpoint; how do we improve that; how do we improve that continuum of care that starts with the family, that goes to the community-based programs, that goes to our school system and then goes to the hospitals and to the clinics. He continued, how do we actually collaborate and integrate is the opportunity that Dr. Mitchell had talked about. He stated that their plan is to move that forward as part of this planning exercise.

Dr. Bernstein added as an example, children with asthma. He said that to address that question one must speak of the inequities of communities where asthma is triggered environmentally. He said there are all sorts of examples, and we can’t just talk about education and schools, we must talk about the social determinants also. How do we improve the environment that these kids go back to? He asked them to address this as part of their capacity problem.

Dr. Churchwell replied that these considerations must be part of the continuum of care. He said we have a great community health system in this state, but how do we activate and support their work in this continuum that we’re building in terms of solution sets. It is our opportunity to go across all our neighborhoods, look at all of our socio-economic issues, our health equity issues in dealing with this and creating that solution set. He said they are doing that by bringing everyone to the table in this discussion. He believed that is going to be where those solutions will organically develop, and those collaborations will be developed for the issues that Dr. Bernstein just described.

Dr. Mitchell added that 60 % of the kids at Franciscan are on MassHealth, and one in three have had some form of involvement with the Department of Children and Families (DCF). He said they have robust wraparound services for children and families who are dealing with complex medical and behavioral needs. They are linked with the community organizations and public agencies to receive the social determinants support that they need. He said that their philosophy goes far beyond the four walls of their hospital and into the community.

Dr. Bernstein cited a California model called PEARLS, which measures pediatric adverse childhood events and recognizes the child’s social determinants. They screen for possible parents with addiction and mental health problems, whether they have parents in prison, etc. He asked if this type of model will be built or is already built into their system. He stated that screening alone is not beneficial if the screening is not acted upon.

Dr. Mitchell said he was not aware of that specific program, but as he stated earlier, they have a very strong social work organization that works with families to coordinate the care, not just when the child is at Franciscans, but also when they’re home. A big focus of theirs is to get children home to a safe environment where their parents can care for them. He said about 60% of their patients are on mechanical ventilators and they have a very strong program to provide training, support, supplies, financial support, transportation and anything else, so these families, often in lower socio-economic status can go home with their child, even if that child has high medical complexity.

Dr. Churchwell added that this program is being talked about on a national level of children’s hospitals, but he asked how they can do a better job. They are looking at social determinates of health, identifying them and then addressing them.

With no further questions, Commissioner Cooke asked if there was a motion to approve Children’s Medical Center Corporation’s request for transfer of ownership.

Dr. Bernstein made the motion which was seconded by Secretary Chen. All present members approved.

**3. PRESENTATIONS**

*a. Overview of Serious Reportable Events in Healthcare Facilities.*

Commissioner Cooke welcomed back Katherine Saunders, Manager of Data Analysis and Integrity in the Bureau of Health Care Safety and Quality, and Dr. Katherine Fillo, Director of Clinical Quality Improvement for the Bureau, to provide their annual overview of serious reportable events (SREs) in healthcare facilities for 2021.

Upon conclusion of the presentation, Commissioner Cooke asked the council members if there are any questions or comments.

Dr. Bernstein asked if it was worthwhile to break down the statistics by academic centers versus community hospitals. He said it would be interesting to break down the topic of assaults whether it is the patient or staff to learn more about intervention and implications.

Ms. Saunders agreed that they could look into that breakdown for next year’s report. She said that this report is shared on the website as required by statute and they provide a breakout of events by hospital, so the general public is able to look at events by individual provider.

Dr. Bernstein thanked them for their responses and said this is an example of why Massachusetts leads the nation in healthcare and received the top ten award because we hold hospitals accountable in defining parameters and the metrics while using a preventative approach rather than a punitive approach to solve these problems and looking at systems rather than individual error.

Dr. Evans added that she believed it was an informative report and so important to monitor SREs, because it’s only with that information can we take measures to prevent them. She continued that it was mentioned that Massachusetts is one of only a few states in the nation even doing this. She said in a future report it might be interesting to see how Massachusetts compares to data from those other states, just to see some benchmark or some sense of how Massachusetts compares. She said she was also interested separation of patient data from staff data, especially after COVID. She believed that staff probably were more likely to be the victim of these events in healthcare settings, stating that perhaps we do not focus on this so much without the data to shine the light on the challenges that they are facing. She then said she was curious about the SRE indicators that are selected and why. She asked what other SREs could potentially be tracked and because of her work, she focuses on the opioid epidemic and wondered if inappropriate opioid prescribing could be looked at in the future as an SRE, and how that data might vary by healthcare setting and change over time. She said she would be interested in hearing their thoughts and ideas.

Ms. Saunders replied that the SREs that they capture are those that are defined by regulation to capture from facilities. She deferred to Dr. Fillo to respond to other questions.

Dr. Fillo said there are many patient safety indicators that are tracked, some are required by CMS for hospitals and ambulatory surgical centers. She said this is one particular subset that focuses on largely preventable events, with the aim of transparency. She said they want to work closely with all their hospitals to ensure accurate reporting and learn from it with the goal of reducing these events to zero. She said they track other events too, like ambulatory sensitive indicators so when people go to emergency departments for things that could potentially be seen as outpatient settings. She continued that they will be sharing some of their healthcare associated infection related events as well, which tracks infections post-surgery. Because there are no benchmarks, she said they look at other states for their data, which like Massachusetts, show that pressure injuries and ulcers and falls are the top events. She addressed the questions of assaults and said that throughout COVID-19, they have seen an unprecedented burden on healthcare and front-line workers regarding assaults. She said assaults are mostly patient-on-patient, followed by patient-on-staff, which leads to missed days at work. She continued that most hospitals have instituted training programs to move away from a punitive system to a more emotionally informed one, even in the most volatile environments like emergency departments where security guards and other non-clinical staff are trained to diffuse situations, and she said they are continuing to follow and track the impact of it.

Dr. Bernstein asked if there are any punitive follow up and if so, he suggested that this may factor into future DoN requests, implying that a request may not be looked upon favorably if the institution has not limited the number of SREs.

Dr. Fillo said that her team works closely with the Determination of Need team and has many metrics for monitoring quality that are related to a project. And though it may not be apparent to the Council she said, there are conversations around this that they address.

Dr. Carey thanked Ms. Saunders for the very comprehensive report and noted that the two events that rose dramatically during the COVID period were the ones there were affected most by staffing shortages, which were pressure ulcers and assault, and providers have had to manage it in the context of these most recent challenges.

Dr. Cruz-Davis thanked the team for the report and stated that that the work is important particularly in the context of COVID and the impact that it has had on the healthcare system.

**3. PRESENTATIONS**

*b. Update from the COVID-19 Community Impact Survey (CCIS): Older Adults*

Commissioner Cooke invited the Bureau of Community Health and Prevention to share new findings from the COVID-19 Community Impact Survey, focused on older adults. Presenting was Caroline Stack, epidemiologist in the Office of Statistics and Evaluation.

Upon conclusion of the presentation, Commissioner Cooke asked the council members if there are any questions or comments.

Dr. David thanked the team for the informative presentation and asked how the data has informed programming and resource allocation to date.

Ms. Stack said that this was the first data collection of 2020, and they are actively planning and developing the second iteration. She said they are hoping to use the feedback that they hear from these presentations and the Council to prepare the second iteration. She said they also learned that there were some gaps and some people that they didn’t reach because of technology. They are planning on improving upon this in the second iteration. She said though that they have been using the data that they collected in the first survey to inform policy and program work and on their website, there is a great presentation about the CCIS impacts on multiple groups work. She said internally they have used it to help allocate funding into identified groups’ that really needed additional funding or geographic areas. It also helped inform vaccine equity work.

Dean Cox expanded on Dr. David’s question and said that he is not surprised that the issues of availability of information regarding the elderly community, social isolation, and use of technology stand out as major issues among this population. He asked if the Council could hear a presentation specific to ways that DPH works with other elderly organizations around the state to address some of the issues that are being discussed here. He continued saying that Dr. David asked about resources and how those are allocated. He hoped to see a presentation that would focus on the needs of the elderly and how the Department works jointly with other agencies to address some of those issues that have been identified, especially around social isolation, lack of information, referral, and technology usage.

Commissioner Cooke responded that she would reach out to Secretary Chen to see if she would like to coordinate such a presentation with DPH. She stated that many bureaus and programs within the Department touch this work.

Dean Cox replied that would be helpful because listening to the data and recognizing that there is a vulnerable population, we see areas that have been identified that really don’t surprise anyone. Older individuals, he said, are going to have difficulty in all those areas, and perhaps some others as well.

Secretary Chen said she will be happy to work on something to bring back to the council, but she would also like to make a few points. She continued by pointing out that the presentation is data collected from 2020 and that is not a normal time. She said that data should not be used to project what the current state is or was prior to 2020. That is a very important piece, saying that older adults were more isolated in 2020 compared to others. As a gerontologist, she speaks of this often and at the Executive Office of Elder Affairs, they take care of people from age 60 to beyond 100. That is a 40 plus lifespan and a lot happens in that time. She said that access to internet or technology is not necessarily age based, it is also location based. We have parts of this state that you can’t even use a cell phone. She believed that the inability to drive to certain locations for testing or for vaccination is not just an older, adult issue, but that it is an equity issue also. She cautioned everyone to not think of this as an elder issue because older adults are not different from anybody else. Social isolation, she said, is an issue for a lot of different populations and there are some things they have done at Elder Affairs to improve that. Councils on Aging have been conducting exercise classes using a hybrid format with the result of more attendance. There are 350 Councils on Aging in 351 towns. She said that over the past two years, Councils of Aging have been visiting people’s homes to help them understand Zoom and pass out tablets to be connected to services. She cautioned that the Council not interpret 2020 data, a very extraordinary time, to project that to where we are today.

Dean Cox appreciated the comments from Secretary Chen but stated that many of the things that were discussed did exist pre-COVID. Issues like social isolation for those who are by themselves, individuals that don’t have access, or don’t want to learn about a computer.

Secretary Chen agreed and said perhaps some things are better since COVID, because of interventions that have been put in place because of it. She used her example of Zoom exercise classes and how more people attend because of the hybrid model. Also, she said there have been improvements to social isolation. One of the most important programs is the senior nutrition program with 10 million meals being delivered last year to people who are not able to leave their home, and sometimes the person that delivers the food is the only contact that homebound person has. We have learned to use that as a wellness check. She said that continued physical isolation has not been good on the aging population. We see more rapid physical and cognitive decline due to pandemic constraints.

Mr. Landers complimented the work on the presentation and the valuable discussion. He asked about a ranking in the presentation that said three out of five elders say that they had household needs and he asked how “household needs” were defined.

Ms. Stack said it was a broad definition but that it did included items like paper goods, cleaning supplies, groceries. She said at the time the question was asked was during the worst of the supply chain issues.

Dr. Bernstein echoed Secretary Chen’s comments about the Zoom exercise because he said he did it for two years and it helped with socializing with other people. He continued that he felt there were many things that Elder Affairs does that are excellent. He said that the lessons learned from COVID should be shared between bureaus and departments and wanted to know if our learned information has ended up in the hands of our state representatives and executives so they can see what the lay of the land is. He closed by stating that seeing the data of 91% of deaths was the percentage of 60-year-old and over that died from COVID is inequity and didn’t have to happen. He continued that you may see numbers like this in a natural disaster, but this is a human disaster from incompetence in policy and governance. \*

Commissioner Cooke stated that this presentation concluded the final agenda item for the day and reminded the council that the next meeting of the Public Health Council is September 14, 2022 at 9:00 AM.

Commissioner Cooke asked if there was a motion to adjourn. A motion was made by Stewart Landers and seconded by Dr. David. Lisette Blondet abstained, and all other members present approved.

The meeting was adjourned at 11:09am.

At the September 14, 2022 Public Health Committee, Dr. Bernstein mentioned the deletion of this paragraph from the August minutes. It has been added.