MINUTES OF PUBLIC HEALTH COUNCIL

MEETING OF AUGUST 11, 2010

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

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

Updated Docket: Wednesday, August 11, 2010, 9:00 AM

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1. ROUTINE ITEMS: No Floor Discussion

a. Compliance with Massachusetts General Laws, Chapter 30A **(No Vote)**

b. Record of the Public Health Council Meeting of July 14, 2010 **(Approved with minor corrections)**

2. REGULATIONS: No Floor Discussion

Request for Final Promulgation of Amendments to Regulations Implementing the Controlled Substances Act, 105 CMR 700.000, Concerning the Prescription Monitoring Program **(Approved with minor amendments)**

Determination of Need Program:

3. Category 1 Applications:

a. **Project Application No. 4-4936 of South Shore Endoscopy Center, Inc. –** Transfer of ownership of South Shore Endoscopy Center, Inc in Braintree, a single specialty (gastrointestinal) ambulatory surgery center to Harbor Medical Associates, P.C. **(Approved)**

b. **Project Application No. 4-3B85 of Children's Hospital –** Construction of a 10-floor addition to main inpatient facility and associated renovations for expansion of emergency services, recovery room, inpatient, imaging and other ancillary services **(Approved)**

4. PRESENTATION: No Vote/Information Only

"Update on EEE"

The Commissioner and the Public Health Council are defined by law as constituting the Department of Public Health. The Council has one regular meeting per month. These meetings are open to public attendance except when the Council meets in Executive Session. The Council's meetings are not hearings, nor do members of the public have a right to speak or address the Council. The docket will indicate whether or not floor discussions are anticipated. For purposes of fairness since the regular meeting is not a hearing and is not advertised as such, presentations from the floor may require delaying a decision until a subsequent meeting.

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council (M.G.L. c17,§§ 1,3) was held on August 11, 2010, 9:10 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair, Mr. John Auerbach, Commissioner, Department of Public Health, Dr. John Cunningham, Dr. Michèle David, Mr. Paul Lanzikos, Mr. Denis Leary, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Mr. Albert Sherman, Dr. Michael Wong, and Dr. Alan Woodward. Absent members were: Ms. Helen Caulton-Harris, Dr. Muriel Gillick, Dr. Meredith Rosenthal, and Dr. Barry Zuckerman. There is one vacancy. Also in attendance was Attorney Donna Levin, 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. He summarized the agenda of the day.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF JULY 14, 2010:

Mr. Albert Sherman moved approval of the minutes of July 14, 2010. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **minutes of July 14, 2010** with two minor amendments by Dr. Woodward. The amendments follow on page 3, last paragraph, line two, Dr. "David" is deleted and replaced with "Dr. Davis" and on page 8, second paragraph, insert the words "a net reduction" in the following sentence: "When the project is completed in January 2013, the current number of licensed adult and pediatric rehabilitation beds will be reduced from 295 to 132, a total "net reduction" of 163 beds."

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO REGULATIONS IMPLEMENTING THE CONTROLLED SUBSTANCES ACT, 105 CMR 700.000, CONCERNING THE PRESCRIPTION MONITORING PROGRAM:

Dr. Alice Bonner, Director, Bureau of Health Care Safety and Quality, presented the amendments to 105 CMR 700.000 to the Council. Dr. Bonner was accompanied by Dr. Grant Carrow, Director, Prescription Monitoring Program, and Attorney Howard Saxner, Deputy General Counsel.

Dr. Bonner noted that the proposed amendments had been brought before the Council on April 14, 2010. She further noted that House 4879 was signed into law on August 9, 2010, establishing the PMP in statute for the first time with an effective date of January 2011. Dr. Bonner stated that the statute is very similar to the amendments being proposed. She said in part, "Our goal is to decrease morbidity and mortality from prescription drug misuse and abuse." Staff's memorandum to the Council, dated August 11, 2010 explains, "The proposed amendments build upon regulatory provisions promulgated by DPH and the Board of Registration in Pharmacy in 2008 that authorized the PMP to provide prescribing practitioners and pharmacies with prescription histories for clinical assessment and harm reduction. The regulatory proposal would build upon and clarify the 2008 amendments to enhance clinical use of the PMP information by:

- Making it more complete by expanding the Schedules of drugs collected from Schedule II to Schedules II-V
- making it a more effective deterrent to prescription fraud by similarly expanding the corresponding customer ID requirements
- making it more complete by requiring reporting by out-of-state (mail order) pharmacies
- making it more current through increasing the frequency of pharmacy data reporting from monthly to weekly
- clarifying the requirements for providing reports in response to prescriber requests for PMP information

- clarifying the authority to facilitate interstate exchange of essential information
- streamlining the process of reporting to law enforcement and regulatory agencies concerning ongoing investigations into prescription drug diversion and fraud."

It was noted that the proposed amendments would set forth the requirements for clinic and hospital outpatient pharmacies with respect to pharmacy reporting requirements. The Board of Registration in Pharmacy will be working on companion amendments to set forth the same reporting requirements for community pharmacies. A public hearing on the proposed amendments was held on May 25, 2010 and written comments accepted through May 28th. For the record, the final proposed amendments for promulgation were presented as Attachment A, the proposed revisions to the April 14, 2010 version were presented as Attachment B, and a list of parties who provided testimony and a detailed summary of testimony and staff's responses were presented as Attachment C to the August 11, 2010 memorandum to the Council.

Public testimony was summarized in the memorandum which stated in part, "Most testimony, including that from medical and pharmacy providers, state and federal agencies, a legislator, patients and advocates and those affected by prescription drug abuse, was highly supportive of the proposed amendments. In particular, health care providers spoke to the significant amount of non-clinical time spent trying to obtain prescription histories and determining if patients are receiving multiple narcotic prescriptions. They pointed out that unsuspecting providers can be a source of prescription drug misuse and spoke to the burden of drug diversion and abuse on their patients, their communities and themselves. Providers pointed to the value of having an online PMP system to practice safe prescribing by screening for and preventing the dispensing of duplicate prescriptions from multiple sources. Testimony was supportive of more complete and timely information for providers. They further spoke to Massachusetts' leadership role in health care in general and the need to render the PMP consistent with the Commonwealth's high standards. Prevention of drug misuse and abuse benefits individuals

and society. Testimony was also presented by individuals who told stories of the pain from drug addiction suffered by their families and communities."

Dr. Bonner went over the proposed changes to the amendments. Staff is recommending some technical changes, as well as additional steps to mitigate the potential impact of the requirement on pharmacies and consumers.

These include:

- Increasing reporting frequency from monthly to weekly while giving pharmacies 3 more days to clean-up data before reporting
- No delegated users will be permitted until after the pilot period
- Allowing sharing with the commonwealths, districts and territories in addition to states…
- Inclusion of a waiver provision to eliminate the need for pharmacies to collect IDs for refills, which would reduce the number of new IDs collected by approximately 44%;
- Inclusion of a waiver provision to eliminate the need for pharmacies to collect IDs for deliveries, thereby addressing a particularly problematic workload issue; Permitting the U.S. Immigration and Naturalization Service ID (i.e., Permanent Resident Card or 'green card') as an acceptable form of ID, thereby addressing the needs of a large, underserved population and another workload issue for pharmacies;
- Encouraging public education, including signage at the pharmacy, to increase public cooperation and readiness to present IDs for narcotics and other controlled substances;
- Encouraging the adoption of ID scanning technology to reduce manual data collection.

Chair Auerbach applauded staff's work on the PMP, he said in part, "…Dr. Bonner, I just want to applaud your determination and skill in pulling together all of the interested parties who have different concerns and raise different issues, some of them at variants with each other, and creating a process where people could work through those differences and really come to a point where I think now we

have a consensus from a wide variety of different interested parties and they include public safety, clinicians, patient advocates, the AGs office, people in the Legislature. It has been a very inclusive process and I think, as you have indicated, there have been very thoughtful compromises, in some cases, or solutions to problems have been identified as we got through this process and it has brought people to the point where they are feeling very enthusiastic about this as indicated by the Legislature's passage of legislation to actually endorse this effort and make sure that your efforts are supported in statute…Thank you very much for your leadership as well as Dr. Carrow, and Attorney Saxner for their leadership and flexibility in adapting this and coming up with good solutions to the issues that were raised. It has really been an excellent process."

Discussion followed by the Council. Please see the verbatim transcript for the entire discussion. Dr. Alan Woodward recommended that biometrics (maybe by swiping a finger) be used to get into the system, which would be safer than a password system. In addition, he made the following suggested changes to the regulations:

- Add the word situation/activities instead of just the word 'activity' to page 16 first sentence on the top and page 19 at the bottom. (redline version)

- Page 17 D1 (f) remove the word 'state agency' and say "agency in another state, district, commonwealth, territory or country"

- Eliminate 105 CMR 700.012 A (6) which states: "A pharmacy that reports data from 25 or more prescriptions in any given month must provide the required information electronically in accordance with 105 CMR 700.012 (A) (4)(a)."

During discussion, Mr. Josè Rafael Rivera noted that transgender individuals who may not match their ID picture should be included in the exceptions to the ID requirement. Mr. Lanzikos concurred.

Dr. Alan Woodward made the motion to approve the PMP amendments with his three changes noted above. After consideration, upon motion made and duly seconded, it was voted unanimously (Albert Sherman not present to vote) to approve the Request for **Final Promulgation of Amendments to Regulations Implementing the Controlled Substances Act, 105 CMR 700.000, Concerning the Prescription Monitoring Program** with Dr. Woodward's amendments as noted above. The approved amendments including staff's memorandum dated August 11, 2010 and supporting Attachments A, B and C, are attached and made a part of this record as **Exhibit No. 14,952.**

DETERMINATION OF NEED PROGRAM:

CATEGORY 1 APPLICATIONS: PROJECT APPLICATION NO. 4-4936 OF SOUTH SHORE ENDOSCOPY CENTER, INC.: TRANSFER OF OWNERSHIP TO HARBOR MEDICAL ASSOCIATES, P.C.:

For the record, Albert Sherman returned to the meeting during Mr. Page's presentation on this project.

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the South Shore Endoscopy Center application to the Council. Mr. Page noted in part, "…The applicant has requested a transfer of ownership and original licensure of South Shore Endoscopy Center, Inc. (SSEC), a physician-owned Massachusetts corporation and single specialty (gastrointestinal) ambulatory surgery center located at 659 Washington Street in Braintree. SSEC reports that it has operated the 6,000 square foot free-standing ambulatory surgery center at the above site since August 1997. The Center has four operating/procedure rooms. The proposed change of ownership will be effected by a transaction whereby certain shares of SSEC will be transferred to Harbor Medical Associates, P.C. (Harbor). Specifically, the proposed transaction will allow Harbor to acquire no less than 70% of the outstanding shares of SSEC and up to a total of 100% of the shares, at Harbor's option, from the SSEC shareholders. The aggregate price to be paid by Harbor to the SSEC shareholders

for 100% of the outstanding stock is $1,350,000. Following the proposed transaction, the South Shore Endoscopy Center ASC will continue to be operated by SSEC. There is no capital expenditure associated with this transfer and the Center will remain at its current site in Braintree."

Mr. Page further indicated that the application satisfies the requirements for the Alternate Process for Change of Ownership found in DoN Regulations 105 CMR 100.600 et seq. and that SSEC satisfies the standards applied under 100.602 A-D. "Staff recommends approval of Project No. 4-4936 of South Shore Endoscopy Center, Inc., Braintree, based upon staff's analysis."

Discussion followed by the Council. Please see the verbatim transcript for full discussion. In response to questions by Dr. Alan Woodward, Attorney Regina Rockefeller explained, "The new shareholder of South Shore Endoscopy will be Harbor Medical Associates. The current shareholders are four gastroenterologists. Harbor Medical is a multi-disciplinary group practice that includes gastroenterologists and purchasing 100% of the stock due to the stock laws. Dr. Sarah Reddy, Harbor Medical Associates explained further, "…We feel there are several advantages of us acquiring this center long term. Ownership by Harbor would be preferable to ownership by the current four stockholders and would assure long term survival and continuity of the center. Secondly, it would provide our patients, and we currently take care of sixty thousand patients actively on the South Shore, with a cost effective alternative to obtaining endoscopic procedures and screening colonoscopies, as opposed to other alternatives offered by local area hospitals or Boston hospitals. A third consideration is that Harbor Medical Associates has the financial resources to provide necessary capital investment in the center to upgrade equipment and to expand services to better serve the patients on the South Shore."

Mr. Denis Leary moved approval of the application. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-4936 of South Shore Endoscopy Center, Inc.** As approved, the

application provides for Transfer of ownership of South Shore Endoscopy Center, Inc. in Braintree, a single specialty (gastrointestinal) ambulatory surgery center to Harbor Medical Associates, P.C. There are no capital expenditure and incremental operating costs associated with this project. A staff summary dated August 11, 2010 is attached and made a part of this record as **Exhibit No. 14,953.**

Tribute to Public Health Council Member: Mr. Albert Sherman:

Mr. Paul Lanzikos made a motion that the Council thanks Mr. Sherman for his 50 years of service as a pharmacist, this being his 50th anniversary as a pharmacist. He said, "I would like to move that the Massachusetts Public Health Council formally recognize and thank our colleague, Albie Sherman, for fifty years of professional services as a pharmacist to the citizens of the Commonwealth." After consideration, upon the motion made and duly seconded it was voted unanimously to acknowledge Mr. Albert Sherman for his 50 years of professional services as a pharmacist to the citizens of the Commonwealth.

PROJECT APPLICATION NO. 4-3B85 OF CHILDREN'S HOSPITAL: for construction of a 10-floor addition to the main inpatient facility and associated renovations for expansion of emergency services, recovery room, inpatient, imaging and other ancillary services

Mr. Bernard Plovnick, Senior Program Analyst, Determination of Need Program, presented Project Application No. 4-3B85 of Children's Hospital to the Council for consideration. He stated in part, "As proposed, the project would encompass the construction of a new 10-story, 117,345 gross square foot (GSF) inpatient tower and associated renovation of 9,295 GSF of existing space….Children's main campus in the Longwood Medical area currently encompasses 461,386 GSF of space. Children's also operates satellite campuses in Jamaica Plain (Martha Eliot Community Health Center), Waltham,

Lexington, and Peabody. The Waltham facility includes 11 acute surgical beds and multiple specialty care services…"

The staff summary presented to the Council further explains, "The proposed project would expand the main clinical facility originally opened in 1988. In 2005, Children's Hospital added Main South, an 11-story addition that accommodates two intensive care units as well as ambulatory and ancillary services. The current expansion plan proposed in this application would create approximately 11,000 additional gross square feet per floor to provide additional space for emergency, imaging, surgical, inpatient and other ancillary and support services. While the project will not increase Children's licensed bed capacity, Children's anticipates that it will help to accommodate the significant growth experienced and projected in the utilization of inpatient and other services in the following manner: construction of 44 new private patient rooms, facilitating the conversion of two-bed rooms to private rooms, will increase the supply of private rooms by 77, significantly increasing the availability of inpatient beds without increasing licensed bed capacity; addition of 8 observation rooms in the emergency department; addition of 12 short stay beds in the post-anesthesia care unit (PACU); and expansion space for radiology, pharmacy, and future MRI services."

The staff summary further explains that "the project seeks to address the following existing physical plant deficiencies: replace existing emergency fuel storage tank; replace fire pumps and provide underground emergency water storage tanks; provide new domestic water pumps and filters; improve gas cylinder storage capacity; and provide appropriately sized data closets."

Mr. Plovnick noted that project completion is anticipated in the fall of 2013 and the estimated maximum capital expenditure (MCE) is $124,781,361 (February 2010 dollars) and that Children's has documented a trend of significant growth in the demand for its services…Staff finds that the project, as proposed, will provide sufficient capacity to adequately address Children's rising demand as well as the health care requirements of its service area without necessary duplication…He noted that the staff recommends approval

with five conditions listed on page 13 of the staff summary and agrees to contribute $44,781,361 in equity to the project and to contribute $6,239,068 (February 2010 dollars) or $891,295 per year for a period of seven years to fund the community health services initiatives."

Regarding the community initiatives, approval condition #4, Mr. Plovnick stated further, "…The planned uses of this funding are provided in a memorandum from Cathy O'Connor, Director of the Department's Office of Healthy Communities, which is included in Attachment 3 of the staff summary…"

Discussion followed by the Council, please see the verbatim transcript of the meeting for full discussion. Dr. John Cunningham asked why not have the community health initiative monies be spent statewide since the applicant's service area is statewide. Regarding Dr. Cunningham's question on the community health initiatives, Chair Auerbach said in part, "…The process of making that determination is largely delegated by the Determination of Need Program to the Office of Local Communities and that Ms. Kristin Golden, Director of Policy and Planning, Commissioner's Office would telephone the Director, Mr. Geoff Wilkerson for his comment. Chair Auerbach noted further that Mr. Cunningham's question on distribution of the community initiative funds was a good policy consideration to review for the future. Mr. Plovnick noted that the local Community Health Network Agency (CHNA) also has a say on where the funds will be spend and further that it probably wouldn't be practical if the applicant would have to deal with all the CHNAs in the state. Mr. Josè Rafael Rivera added that there have been projects where the community benefits have had a broader impact than just on the local community in which it resides.

Ms. Eileen Sporing, Senior Vice President for Patient Care Services and Mr. David Peck, Director of Facility Planning, Children's Hospital answered questions on the project for the Council. In response to Chair Auerbach's question on ER utilization, Ms. Sporing replied in part, "This project will enable us to take care of our current population in a more cost effective manner. When we have demand

in our emergency department and insufficient examining rooms, we have no place to monitor patients that are on a trajectory of illness that is not predictable, whether they require inpatient care or will recover after a certain amount of treatment, and this will enable us to keep more of those patients in the emergency room, avoiding a hand-off to inpatient care and an inpatient hospitalization. This is really improving our own emergency department capability as opposed to anticipating continued increases in volume." She further noted that "…all children's hospitals in the United States that are building new, are totally replacing their facility with all single rooms… due to space considerations, infection control issues, the widening age rage of patients, gender issues and new technology." Mr. Sherman asked Mr. Peck, to insure him that policemen will be used to direct the traffic on Binney Street during construction of the project, and not use just flaggers. Mr. Peck agreed to that request. Ms. Kristin Golden, Director, Policy and Planning, Commissioner's Office approached the table and informed that Council they she spoke to Geoff Wilkinson on the telephone regarding Dr. Cunningham's question on the community initiatives and he indicated the following: "The way the community health initiatives are typically determined are to look at the primary catchment area for the patient population. Even though Children's considers its patient draw to come from the whole state, most of their patients come from the Boston area – that is in line with past practice, how we have looked at community health initiatives, and how we have determined that past practice was continued with this particular application."

Chair Auerbach responded that, Mr. Paul Lanzikos suggested that we should invite Mr. Wilkinson back to the Public Health Council to give an update on the community initiatives projects and the accomplishment of the goals established within those, and where are we with the prioritization of different health issues, the issues we would concentrate on in terms of DoN and thirdly, where we are considering hospitals, other than community hospitals – is it appropriate for us to be thinking of the catchment area as going beyond the immediate community or communities? We will have that fuller discussion." Mr. Lanzikos asked when the community health initiatives money would begin to flow into the community. Ms.

Joan Gorga, Director, Determination of need Program replied, "There are two ways this is usually done – one is upon approval and the other is upon implementation. Upon implementation will take several years but, in this case, it is upon approval." Mr. Lanzikos responded, "The implication there is that once the operation plan is devised and accepted by the end of the year that sometime in early 2011, there will start to be a flow of funds." Mr. Gorga replied, "Yes".

Dr. Alan Woodward moved approval of the application. Drs. Michèle David and Michael Wong recused themselves from the vote and discussion of this project. After consideration upon motion made and duly seconded, it was voted unanimously [except Drs. David and Wong] to approve **Project Application No. 4-3B85 of Children's Hospital, Boston,** based on staff findings, with a maximum capital expenditure of $124,781,361 (February 2010 dollars) and first year incremental operating costs of $21,261,000 (February 2010 dollars). As approved, the project provides for construction of a 10-floor addition and associated renovations to the main inpatient facility to provide additional space for emergency services, recovery room, inpatient, imaging and other ancillary services at the Children's campus located at 300 Longwood Avenue, Boston, MA. Please see the staff summary, dated August 11, 2010 for the conditions associated with this approval, which is attached and made a part of this record as **Exhibit No. 14,954**.

PRESENTATION: "UPDATE ON EEE", by Dr. Catherine (Katie) Brown, DVM, MSc, MPH, State Public Health Veterinarian, Massachusetts Department of Public Health:

For the record, Mr. Denis Leary and Mr. Albert Sherman left the meeting just prior to this presentation which began at 11:00 a.m.

Dr. Catherine Brown stated in part, "…Eastern Equine Encephalitis, affectionately know as Triple E by those of us in the field… has been known as a disease in horses since 1831 and the virus itself identified in 1933 and the first recognized outbreak in humans occurred right here in Massachusetts in 1938 and 1939 with 35 cases and in the last four and half decades or so, only Florida has reported more human

cases of Triple E than in Massachusetts. It clearly remains a problem here."

Dr. Brown continued, "Passerine or perching songbirds are the natural reservoir of this virus and it is transmitted between them through a bird biting mosquito, primarily culiseta melanura here ad the summer environment amplifies the virus up to the point where you start to see more generalist mosquitos, mosquitos that feed on both birds and mammals, they start to pick it up, as well, and once that has happened, then we see the potential for spillover into dead end hosts, such as horses and humans. They are called dead end hosts because they don't actually serve to further infect anybody."

"Just as a reminder", she said, "this is an extremely serious disease. While the number of cases may actually appear small, it is extremely serious and the mortality rate nationally is between thirty and fifty percent. In Massachusetts, in the different outbreaks, we have seen between thirty-three and seventy-one percent mortality and eighty percent of survivors are left with very severe neurologic deficits. The case burden is primarily located down in the southeast Massachusetts, Plymouth, Bristol and Norfolk counties because that is where the primary enzootic mosquito vector's best place to live."

Dr. Brown said further, "The mainstays of EEE surveillance here in Massachusetts is through mosquito trapping and surveillance. DPH actually maintains long term trap sites, which have been in existence for decades. The traps are kept in the same place every year and those mosquitos are brought into the state lab for testing. The advantage to this is it enables us to do some year-to-year comparisons. In addition, there are nine mosquito control projects in Massachusetts. Three of them operate in the current area of concern, in Plymouth, Bristol and Norfolk County. Over the years, we have a decent, although not perfect, correlation between identification of virus in mosquito isolates, and the presence of human cases….Most of the time there is a good correlation. However, we have also been able to identify other criteria that we can use for risk assessment, and some of the ones that we really look are significant EEE activity in the preceding year, mild winters that

allow the larval mosquitos to survive, exceptionally wet springs, and we have had several of those recently, and then, early identification of the virus in mosquitos, and then continuing when we see large numbers of positive isolates, and the early appearance of a horse or human case. Those are all indications that the potential for human risk is increasing."

She continued, "In 2010, we saw many of those factors, and actually some additional ones. Last year, we didn't see a huge amount of EEE activity, although there were three animal cases. We did have a wet spring, ad then we have had some persistent heat, which accelerates the mosquito development, thus allowing for greater amplification of the virus. In addition, the fact that it was initially very wet, but then very dry, means that the swamps where these birds and mosquitos live together have sort of contracted a little bit, and the mosquitos and birds are now living in a higher concentration, in a smaller area, thus again also increasing the capability for amplification of the virus."

Dr. Brown indicated that the infection rate in mosquitos has skyrocketed for 2010 in a way that is not expected this early in the season. "We have never seen this number of positives in July before and in addition 40% of the isolates in July were in mammal-biting mosquitos, not only in the bird-biting enzootic vector."

Dr. Brown noted further that historically the majority of human cases occur in August. The area in Southeastern Massachusetts with the greatest risk does not have a lot of roads so truck-based spraying of pesticides was not possible so aerial spraying was necessary. The aerial spraying done in 2006 successfully reduced the infection rate. There was some excluded areas such as public water supplies, coastal buffer zones, some certified organic farms, aquaculture areas, and a few endangered species habitats.

Dr. Brown said that the pesticide chosen is pyrethroid-based pesticide, the least toxic available and that the method of application was designed to minimize negative impacts on non-target insects because there is a broad-spectrum pesticide. In closing, she said,

"The mosquito population reductions we saw in 2006 ranged between about 57% and 88% and we are hoping to have achieved something similar to that this year."

Chair Auerbach noted that "an unprecedented level of collaboration with other state agencies and local health departments occurred and the use of daily conference calls, the internet and the Department's web site and another state agency's NEMA's 211 web site - those factors helped us to move beyond some of the 2006 indicators in terms of making sure the public really knew when to stay indoors and when their communities were going to be sprayed."

A discussion followed by the Council, please see the verbatim transcript for full discussion. Dr. Alan Woodward asked about the cost/benefit ration of aerial spraying versus educating the public about protecting themselves. Dr. Brown replied, "…Studies have shown that people, even when they know the risk, choose not to actually protect themselves and we saw enough indicators this year that there were not just going to be sporadic cases in humans, but that we might actually have an outbreak and balancing that with the fact that, even though there are personal things that people can do, we know that many of them won't do it, and that is sort of how the cost/benefit analysis went down." It was noted that it cost about $1.2 million dollars for the aerial spraying but one has to look at the cost of not spraying, a disease with a mortality rate of between 30 to 50 percent and survivors are left permanently neurologically impaired and the cost to care for them is substantial (several hundred thousand dollars per case).

Chair Auerbach stated in part, "…That in the 27 communities affected by the spraying, it was up to the local community to decide to take safety measures like canceling Little League games and other recreational and musical activities outside and some chose to do this but many did not and it was of great concern to the Department."

Discussion followed briefly on various public health topics under Dr. Brown's domain: salmonella in pet food, probably seeing increase due to more people feeding their pets raw food diets (uncooked

chicken and eggs); Lyme disease leveling off at Cape and Islands but increasing in Middlesex County and Worcester; West Nile Virus limited at this point with some isolated cases in urban areas; rabies is alive and well with about 128 animals testing positive last year. Most cases are in raccoons, skunks and bats. Domestic cats are of a concern to humans because of their low vaccination rates.

Chair Auerbach concluded, "We may want to look closer at the issue of Lyme disease because it is often under diagnosed due to people presenting with different symptoms…We will come back and talk about appropriate ways of addressing things that may not have been addressed…We all appreciate your work and thank you for your commitment, as well as your expertise, and we look forward to hearing the results of the impact of the spraying, both in terms of the human surveillance, and the mosquito surveillance. Maybe we will ask you to come back and give us an update on that."

NO VOTE/ INFORMATION ONLY

FOLLOW-UP ACTION STEPS:

- Invite Geoff Wilkinson back to the PHC for overview of DoN Community Initiatives, see page 14 of this document for issues to be discussed (Auerbach, Cunningham, Lanzikos)

- Follow-up on Lyme Disease (Auerbach to Brown)

- Invite Dr. Catherine Brown to return to PHC for results of EEE spraying (Auerbach to Brown)

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

- Docket of the meeting
- Docket item 1a: Copy of letters of meeting notice to A&F and Secretary of Commonwealth
- Docket item 1b: Draft minutes of July 14, 2010

- Docket item 2: Cover memorandum and Attachment A: a copy of amendments to Regulations Implementing the Controlled Substances Act, 105 CMR 700.000, Concerning the Prescription Monitoring Program, Attachment B: proposed revisions to the regulations, and Attachment C: a list of parties who provided testimony, overview of issues raised in testimony and recommended revisions and a detailed summary of the testimony with staff responses
- Docket item 3a: Staff Summary of Project Application No. 4-4936 of South Shore Endoscopy Center, Inc.
- Docket item 3b: Staff Summary of Project Application No. 4-3B85 of Children's Hospital
- Copy of PowerPoint slides on docket item #2 PMP Regulations
- Copy of Powerpoint slides on the "Update on EEE"

The meeting adjourned at 11:30 a.m.

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John Auerbach, Chair

LMH