MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of August 14, 2024

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 14, 2024 – 9:00AM**

***Note: The August 14 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:

Join by Web:

<https://zoom.us/j/96708938293?pwd=strcRDlhYb7lWsCBdlp3cU0XyvRl2O.1>

Dial in Telephone Number: 929-436-2866 Webinar ID: 967 0893 8293

Passcode: 725107

1. **ROUTINE ITEMS**
	1. Introductions.
	2. Updates from Commissioner Robert Goldstein.
	3. Record of the Public Health Council Meeting held July 17, 2024 **(Vote)**.
2. **INFORMATIONAL PRESENTATIONS**
	1. Connecting Massachusetts Students to Behavioral Health Services: The Impact of School Health Services Funding.
	2. Massachusetts Healthcare Personnel COVID-19 and Influenza Vaccination in Health Care Facilities, 2023-2024.
3. **DISCUSSION**
	1. Roundtable and Q&A on health care personnel COVID-19 and influenza vaccination uptake.

*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 14, 2024 - Start Time: 9:00 am. Ending Time: 11:11 am.

| **Board Member** | **Attended** | **First Order:****Approval of****July 17, 2024 Minutes (Vote)** |
| --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes |
| **Edward Bernstein** | Yes | Yes |
| **Lissette Blondet** | Yes | Yes |
| **Kathleen Carey** | Yes | Yes |
| **Emily Cooper** | Yes | Abstain |
| **Harold Cox** | No | Absent |
| **Alba Cruz-Davis** | Yes |  Abstain |
| **Michele David** | Yes | Abstain |
| **Robert Engell** | No | Absent |
| **Elizabeth Evans** | Yes | Yes |
| **Eduardo Haddad** | Yes | Yes |
| **Joanna Lambert** | Yes | Yes |
| **Stewart Landers** | Yes | Yes |
| **Mary Moscato** | Yes | Abstain |
| **Gregory Volturo** | Yes | Yes |
| **Summary** | 13 Members Present;2 Members Absent | 9 Members Approved;2 Members Absent;4 Members Abstained |

**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 14, 2024, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Commissioner Robert Goldstein; Edward Bernstein, MD; Lissette Blondet; Kathleen Carey; Emily Cooper; Alba Cruz-Davis; Michele David, MD; Elizabeth Evans; Eduardo Haddad, MD; Joanna Lambert; Stewart Landers; Mary Moscato; 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 9:00 am and made opening remarks before reviewing the docket.

**1. ROUTINE ITEMS**

*b. Updates from Commissioner Robert Goldstein*

Commissioner Goldstein stated that he was attending the meeting from Sturdy Memorial Hospital in Attleboro and proceeded to update the Council on the following:

**Welcome, Emily!**

Commissioner Goldstein welcomed Emily Cooper, the newest member to the Public Health Council. Ms. Cooper is the Chief Housing Officer at the Massachusetts Executive Office of Elder Affairs (EOEA) and serves as a Special Advisor on Housing to MassHealth. She is a nationally recognized expert with 30 years of experience designing housing and services policies and programs to meet the needs of special populations. At EOEA and MassHealth, she is responsible for designing agency policy around preserving and expanding housing opportunities, including developing strategies for connecting housing and healthcare. Emily works collaboratively with state and local housing agencies, Continuums of Care, and communities to create innovative solutions to address housing instability and prevent homelessness. Prior to joining EOEA and MassHealth, Emily was the Director of Housing Practice for the Technical Assistance Collaborative, a non-profit supportive housing consulting firm. She also worked at the Massachusetts Department of Housing and Community Development administering rental assistance programs for homeless households and people with special needs.

**Mosquitoes – West Nile and Triple E**

Commissioner Goldstein said as expected in late summer, we are starting to see an increase in mosquitoes that test positive for West Nile virus and Eastern equine encephalitis across Massachusetts. Last week, DPH announced this year’s first human case of West Nile disease and first animal case of Eastern equine encephalitis in the state. The first West Nile case was exposed in Hampden County, the EEE infection was diagnosed in a horse in Plymouth. Mosquito samples collected in Dedham last week also tested positive for EEE. These findings raise the EEE risk level to high in Plymouth and to low in Dedham. Two other communities – Carver and Middleborough – had also been at high risk for EEE. In the past three years, there have been no human cases of EEE, which often causes more serious disease than West Nile virus, although both diseases can be fatal. The populations of mosquitoes that can carry and spread both EEE and West Nile are large this year, and we continue to see increases in the number of EEE and WNV-positive mosquito samples throughout the state. The Department is using its arbovirus dashboard, press releases, health marketing campaign, and social media to update the public about the risks of these mosquito-borne diseases. We are also reminding people to take action to avoid mosquito bites by using mosquito repellent with an EPA-registered active ingredient; wearing long sleeves, long pants, and socks when outside to reduce exposed skin; avoiding outdoor activities that occur during the evening or early morning; draining standing water; and using tight-fitting screens on windows.

**Commonwealth Fund Scorecard**

Commissioner Goldstein announced that Massachusetts ranked #1 as the best-performing state for women’s health overall in the Commonwealth Fund’s 2024 State Scorecard on Women’s Health and Reproductive Care. The Commonwealth also received the top score in health and reproductive care outcomes as well as in health care quality and prevention. He said it’s important to note that the State Scorecard did not provide disaggregated data by race and ethnicity. We must continue our important work to eliminate racial inequities and improve health equity in maternal care; a need highlighted in last year’s DPH Data Brief assessing severe maternal morbidity in Massachusetts between 2011 and 2020. He said we must also continue to take action on our commitment to increased access to comprehensive reproductive care options for all people in the Commonwealth, regardless of where they live.

**Hospital Capacity Dashboard**

Commissioner Goldstein mentioned last month that DPH was about to launch a publicly accessible Health Care Capacity Dashboard- this dashboard is now live. This powerful tool provides people throughout the Commonwealth with detailed information they can use to understand health care access in their communities and make informed decisions about their care. The dashboard features easy to navigate data on emergency department wait times, hospital services, staffing levels, and filled patient beds at any given hospital, and the ability to compare select variables with other hospitals within a 30-minute drivetime. This enables people to choose facilities that are convenient, have the services they need, and may be less capacity strained.

**Urgent Care Dashboard**

Commissioner Goldstein said DPH also created an interactive dashboard that maps urgent care and retail clinics in Massachusetts, with options to filter by location, services, insurance accepted, and more, this is a perfect complement to the Health Care Capacity Dashboard. Together, these tools help people throughout the Commonwealth understand and have access to the information they need to make use of a range of options and services available for caring for their health needs. He thanked the Office of Health Care Strategy and Planning for their swift work in developing and implementing these tools in record time.

**End of Legislative Session**

Commissioner Goldstein said July 31 marked the end of the 2-year legislative session and thanked DPH staff from every bureau and office for their tireless work. He said that while many of the public health priority bills did not make it through last-minute conference negotiations, including comprehensive Maternal Health and Substance Use Disorder Bills, he is confident that the work done to foster greater understanding and acceptance on issues such as Overdose Prevention Centers, workforce supports for Certified Professional Midwives and Recovery Coaches, and the possibility for a non-punitive pathway for Substance Exposed Newborns, putting the Department in a strong position to move these issues forward.

Two bills of note that were signed by Governor Healey are a comprehensive Gun Violence Prevention bill and the Parentage Equity Act. The Gun Violence Prevention bill does much to strengthen public safety tools to combat things like ghost guns and wins for public health including updating Emergency Risk Protection Order Laws, or red flag laws, to include medical providers as reporters and establishing a task force to study funding for violence prevention efforts. The Parentage Equity Act clarifies methods of establishing parentage that were lacking in current statute, most notably for LGBTQ+ families, people using assisted reproductive technologies, and those employing surrogates to establish families. Prior to this important bill, Massachusetts statutes had not kept pace with modern science and the diversity of our families, leaving children vulnerable.

**Steward Update**

Commissioner Goldstein updated the Council about the ongoing Steward Health Care bankruptcy issue and the transition of the Steward hospitals. The state and DPH continue to navigate this fluid and complex situation that has significant implications for health care across the Commonwealth. DPH is holding a series of public hearings in conjunction with Steward’s decision in late July to close both the Carney Hospital in Dorchester and Nashoba Valley Medical Center in Ayer. He said he attended a hearing in Dorchester attended by community members affected by the closure of Carney, and that he had felt their pain and anger. Carney Hospital has been a cornerstone of the Dorchester Community for generations serving its dynamic and diverse community and will be missed. There will also be a hearing for Nashoba Valley Medical Center. Beyond the two hospital closures, the final determination regarding the other Steward hospitals is anticipated. He said the role of DPH is to continue to work with health care and community partners to protect the health and well-being of patients and communities as hospitals close and care shifts to new providers. DPH will safeguard access to critical medical care and services and support the health care workers who have persevered through these uncertain times.

Commissioner Goldstein asked if any of the Council members had questions.

Dr. Bernstein asked if in the future the Council could be informed about the opioid settlement grants. He would like to know how the money is being distributed and suggested DPH could pilot and support overdose prevention centers.

Commissioner Goldstein clarified that there are two parts to the opioid settlement, one that is controlled by the state, and the part controlled by the municipalities. He said the Council may have seen press releases about some grants that DPH put out related to opioid settlement funds. He agreed that the Bureau of Substance Addiction Services’ team could potentially pull together a presentation to highlight the distinction between the two programs.

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

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

*c. July 17, 2024 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the July 17, 2024, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the July 17, 2024, minutes.

Dr. Haddad made the motion, which was seconded by Dr. Volturo. Ms. Cooper, Dr. Cruz-Davis, Dr. David, and Ms. Moscato abstained. All other present members voted to approve the minutes.

**2. INFORMATIONAL PRESENTATIONS**

*a. Connecting Massachusetts Students to Behavioral Health Services: The Impact of School Health Services Funding.*

Commissioner Goldstein invited Avery Brien, Manager of Behavioral Health Initiatives for the Bureau of Community Health and Prevention, to give an update on Behavioral Health Services in Schools. Avery was joined by Karen Robitaille, Director of School Health Services, and Mairead Day Lopes, Director of School Based Health Center Program.

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

Ms. Moscato asked about vacancies of school nurses and if they are experiencing the same staffing constraints as nurses in the hospitals and healthcare centers.

Ms. Robitaille said they are experiencing large numbers of vacancies that are difficult to fill. Pay equity is an issue because school nurses are paid far less than their counterparts.

Ms. Moscato asked if the distribution of programs and grants are distributed equally throughout the state or are they distributed more in urban or rural settings.

Ms. Robitaille specified that the question referred to comprehensive school health services grants and said that in recent years they have tried to be more equitable in their distribution. There is a funding gap between Eastern Massachusetts and Western Massachusetts with those being funded more in Eastern or Central Massachusetts. Western Mass tends to be very well organized while traditionally supporting each other. They now fund a regional school nurse consultant for Franklin and Berkshire counties and another for Hampden and Hampshire counties.

Ms. Moscato asked if the 33 school based health centers are distributed evenly across the state.

Ms. Day Lopes said there are 40 school based health centers currently funded under the School Based Health Center Program at DPH, and a total of at least 65 school based health center programs in the state, demonstrating that not all school based health centers are funded through DPH. She said they were able to accept new sites two years ago and were able to fund startups for the first time in the program’s history, allowing them to expand into Southeastern Massachusetts where traditionally there was funding gap. They now have funded school based health centers in all the OHS regions of the Commonwealth.

Dr. Evans asked how the program supports teachers who are the frontline to noticing behavioral changes in their students, and what their role is. And not only the teachers, but how are the families of the students involved?

Ms. Robitaille said specifically around substance use education, rolling out SBIRT (Screening, Brief Intervention and Referral to Treatment)is seen as a prevention and early intervention exercise. They often talk to nurses and caregivers and teachers about how the importance is not necessarily just on identifying problem substance abuse, but more about opening lines of communication within the community, between students and their teachers or caregivers and other trusted adults so that students understand they can talk about these issues and there are adults that are equipped to listen to them.

Ms. Day Lopes added that the MOUs (memorandums of understanding) for school based health centers are between the school and the SBHCs sponsoring agency which may be a community health center, hospital or public health agency. The SBHCs may also support and provide care to the staff in the school, which has been a benefit for the schools that have an SBHC with this capacity, which is generally based upon the credentialing of the nurse practitioner (the medical provider) and what their comfort level is in providing care for adult patients. Another thing about school based health centers is that some have an external door, which can allow for community access. SBHCs are positioned differently in different schools and are sometimes within the same school building or on the same campus. When they are tucked deep within the school, it can prevent the opportunity to open it to family members during the day, for security reasons based on the school protocols.

Mr. Landers credited the team with addressing the concept of rural vs. urban equity and asked if they also look at racial equity issues in the lens of access to the large pool of behavioral health providers of color and similarly for linguistic minorities who may need access. He followed up by saying that often students present with headaches or stomach aches, and it is, in actuality, behavioral health issues and asked how these cases are tracked.

Ms. Robitaille addressed the second part of his question saying that most of their school health services in the Commonwealth utilize an electronic health record like any other clinical setting. Therefore, the health professional can enter the presenting symptom and modify later when the symptom is different. They require monthly and annual reporting from their grantees. They track mental health issues and when able, they track race and ethnicity. In this way they can see trends. It has been illuminating for school nurses, who, according to demographic data collected by the Department of Elementary and Secondary Education, are often white, middle-aged women. They have focused training around issues of racial equity and institutional racism as it applies to educational and healthcare systems, to build the capacity of school nurses to look at the data critically and to ask hard questions of themselves that they may not have before.

Avery Brien said for their school behavioral health and workforce expansion grant, health equity was a significant focus of the application questions for that funding. They sought grantees that understood the inequities that existed among their student population and in hiring additional providers they made sure that they were considering how to meet the cultural and linguistic needs of their students. If the potential grantee could not meet that need, they looked for grantees who were thinking creatively about partnering with community based organizations that were more equipped to provide culturally specific services to those students.

Ms. Day Lopes pointed out that for school based health centers, they have priority populations which is what determined their funding prioritization – these populations include youth of color, youth who are refugees and immigrants, youth who live in poverty, youth who live rurally, and youth who identify as LGBTQIA+. That was a determining factor as to where they were able to provide funding to school based health centers, given the demographics that they’re serving within those schools with a focus at serving those young people, their families and communities where they live. She added that school based health centers are birthed as a health equity initiative, knowing that some populations and young people can’t access pediatric care or adolescent care within the traditional infrastructure.

Dr. Cruz-Davis asked if there was any collaboration with the BEST team, which works with the police to respond to non-criminal emergencies around mental health or social issues and serve to de-escalate a situation.

Avery Brien said the BEST team is a youth mobile crisis intervention service that supports schools in responding to de-escalate crisis situations. They are part of the behavioral road map and one of the entities with which they promote partnership between schools and youth mobile crisis intervention. Teams like the BEST team exist across the state. Part of the focus - of their collaboration with the Department of Elementary and Secondary Education (DESE) and during the process of updating the medical and behavioral health emergency response plans and guidance that they provided to schools - was to make sure that they were uplifting alternatives to traditional responses within schools that have historically relied on School Resource Officers (SRO’s) and law enforcement referrals. Even 911 is not always the best response to a behavioral health incident. They are trying to collaborate with other state agencies to lift up alternatives to de-escalate situations appropriately, have behavioral health providers who are trained to respond to behavioral health related incidents, and making sure that there are connections to adequate care and support.

Ms. Robitaille worked in schools when SRO’s started working in schools, and she is pleased to see how they have evolved into a different role. Without outside resources , schools were compelled to rely on emergency services out of lack of options. The behavioral health road map and the extra services that are now available has shown a shift away from utilizing EMS and the SRO’s to address behavioral health crises.

Dr. Cruz-Davis shared that her experience has shown when a school or family calls the BEST team, they often do not respond on time and the police respond instead, with outcomes that may not have been necessary. She suggested in future iterations of their program, that they work with the BEST team so they can decrease their response time and to make the community more aware of the implications of calling 911.

Ms. Day Lopes agreed with the importance of quick response when there is a high acuity situation. Where they see their influence in school based health centers related to mobile crisis response is to build trusted adult relationships where students feel they can walk in and see their behavioral health provider, while providing preventative care and give behavioral health support prior to a high acuity event.

Dr. Bernstein commented on the comprehensive nature of the program and its attention to social determinants of health and issues of discrimination. He asked how social determinants, and the impact of discrimination are thought of in the implementation of the program and if SBIRT has broader public health implications in just identifying people with substance abuse and mental health problems.

Ms. Day Lopes said regarding social determinants of health, the model for the school based health center program changed to include a full time community health worker to look at the social determinants of health and to connect them to other supports as needed.

Ms. Robitaille said that they have been involved with a study regarding SBIRT that is training near peers, so that young adults that have lived experience can conduct the screening. The results are positive in the forming connections with young people, particularly young people of color or young people who identify along the spectrum of gender identity and sexual orientation, that may not have felt as connected or heard by the school clinician conducting the same screening.

Dr. Volturo asked if there is any emphasis being placed on prevention of teen suicide due to social media.

Ms. Robitaille said much of that work ends up with the educators they work with, but her program supports comprehensive health education that includes social media training for young people to help identify a dangerous online situation. Although they haven’t done a lot with social media, they support health education and other means to educate students.

Avery Brien mentioned the school tele behavioral health pilot program, which is not funded through the school health services line, but provides training and technical assistance to both school based staff and behavioral health providers around the impact of social media on mental health outcomes. They hope to bring this to the group of grantees this year through training and technical assistance opportunities. Within the Bureau there is also another program focused on suicide prevention, and they often collaborate together.

Ms. Day Lopes said suicide prevention was a key topic for school based health centers. There are lots of questions from providers and school based health centers around suicide prevention. They talk a lot about resiliency building and becoming trusted adults. They encourage community health centers and hospitals that sponsor school based health centers and receive funding from DPH to hire those that are representative and reflective of the community in which they’re serving. She said the resilience aspect and opportunity to connect with a trusted adult that has the shared lived experiences is one of the greatest suicide prevention strategies they employ.

Ms. Blondet asked about any opportunities for Community Health Workers (CHWs) to collaborate with the school based health centers.

Ms. Day Lopes said that the school based health centers that are funded by DPH can support full time community health workers. They have drop in and technical assistance sessions geared toward the CHW that works in school based health centers. They work closely with the Office of Community Health Workers and often speak about how the initiatives they’re doing intersect with each other.

Dr. Bernstein asked about barriers they have or are experiencing to implement these programs.

Ms. Robitaille answered that diversity of the workforce is a challenge. Currently, many parts in the Commonwealth don’t have a workforce that reflects the population of their students.

Avery Brien said there are significant challenges and barriers. Building school environments that promote belonging among all students challenging, and it requires addressing anti-LGBTQ bias, racism, and several other social conditions that are difficult to address. Avery said they have started to build partnerships with organizations who have already been doing that work and thinking through how they can provide support to not just their behavioral health providers, but to school districts.

Ms. Day Lopes said funding of school based health centers is always a barrier regarding startup costs or to build out a clinic if one does not exist and then to sustain it. Another barrier is space around placement of a school based health center and ensuring that access is meaningful in the space they can dedicate. The third barrier she mentioned is education and awareness around school based health centers, making clear the difference between school based health centers and school nurses.

Ms. Robitaille added the we are expecting our schools to be social safety nets, but they are not being supported in that work properly. They need to be fiscally and programmatically supported if we wish them to do that work.

Dr. Cruz-Davis emphasized the importance of the need in Boston to diversify its workforce for health professionals by providing students with educational opportunities.

With no further questions, Commissioner Goldstein moved on to the next docket item.

*b. Massachusetts Healthcare Personnel COVID-19 and Influenza Vaccination in Health Care Facilities, 2023-2024.*

Commissioner Goldstein mentioned that August is National Immunization Awareness Month, highlighting the importance of vaccination for people of all ages. He then invited Dr. Katherine Fillo, Director of the Office of Healthcare Strategy and Planning, Fareesa Hassan, epidemiologist, and Eileen McHale, Healthcare Associated Infection Coordinator, to give an update on Massachusetts healthcare personnel (HCP) COVID-19 and influenza vaccination in healthcare facilities and emergency medical services for the 2023-2024 season.

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

Dr. Carey asked about the percentage of HCP vaccinated each year for each provider – which is the total who received the vaccine over the total number of HCP at the facility. She assumed the denominator excludes people with religious exemption and mentioned her concern that the exemption can be used to get around vaccinations. She then mentioned the slides showing “unknowns” in the data and asked how they were accounted for in the calculation. She was concerned that the numbers for some of the facilities may overrepresent how well public health is doing.

Ms. Hassan said there were no exemptions used in the denominator and the figure represents the total number of staff working on site. They no longer collect the religious exemption metric. The federal reporting has metrics for medical and unknown declinations, but not religious exemptions.

Dr. Evans pointed out that people who work or live in jails and prisons aren’t included in this data. She believed that this is critical data.

Dr. Fillo responded that the data that is collected is through required clinical and hospital regulations. The Bureau of Climate Environmental Health does work with the jails and prisons with inspections, technical assistance, and education around vaccinations through the pandemic. She said they do not regulate the prisons and therefore the regulated data does not extend to them.

With no further questions, Commissioner Goldstein introduced the next agenda item.

**3. DISCUSSION**

*a. Roundtable and Q&A on health care personnel COVID-19 and influenza vaccination update.*

Commissioner Goldstein opened the discussion and asked the panelists to introduce themselves. In order of introduction, they were:

* Candice Richardson, RN, Chief Clinical Operations Officer, Edward M. Kennedy Community Health Center;
* Paul Fu, MD, MBA, FACHE, Chief Medical Officer, Sturdy Health Medical Group;
* Timothy Birch, Deputy Fire Chief, EMS Section, Attleboro Fire Department;
* Deborah Barbeau, MD, PhD, MSPH, Medical Director for Employee Health, BIDMC/Medical Consultant for Employee Health, BILH;
* Chris Garofalo, MD, Mass Medical Society Representative, Family Physician, Family Medicine Associates of South Attleboro;
* Leigh Simons, MPH, Senior Director, Healthcare Policy, Massachusetts Health & Hospital Association;
* Harry Byrnes, Director of Infection Control and Prevention, Williamstown Commons Nursing & Rehabilitation Center.

Commissioner Goldstein asked the group: although nurses hold the highest position of trust in our society and their medical opinions are important, why does the data show that they themselves are not all getting vaccinated?

Mr. Byrnes said employee resistance to COVID-19 vaccination is because it is mandated, but the flu vaccine is recommended. He suggested perhaps the COVID-19 vaccine could also be recommended.

Dr. Fu said the availability of COVID tests has changed and the perception of the decrease in virulence of how sick people are getting. Employees feel they get sicker from the vaccine than from the illness.

Dr. Barbeau said the figure of 89% seemed low to her and her institution mandates flu vaccine. She has seen more religious and medical exemption requests for COVID-19. She feels the attitude toward COVID-19 may be bleeding over to perception of the flu vaccine, impacting vaccination rates. She questioned if the prior year had higher flu vaccination rates.

Dr. Fillo confirmed that last year, the flu vaccination rate for acute care hospital healthcare personnel was above 90%.

Dr. Garofalo said from the Massachusetts Medical Society perspective, there are concerns about mandates, but there is a belief in the ethical consideration for healthcare workers who are patient facing. He said the MMS believes there is an ethical duty to avail yourself of an immunization if available and they oppose any non-religious or non-medical exemption.

Ms. Richardson added that her community health center has had an employee health policy in place since 2020 for flu and COVID. She believes their high vaccination rates of 99% for flu and 96% for COVID are due to this. Also, senior leadership visit all the sites speaking to employees about the ethical duty of patient facing care and this is done out of concern for the patients and the organization. She said their biggest push back is the request to simply wear a mask.

Ms. Simons said from the hospital perspective, they have been working for many years to achieve their current rate of 90%. She wondered if the COVID vaccination push back is now affecting flu vaccination perception. She said the mandated COVID-19 vaccination affected the number of needed temporary workers during the pandemic, especially out of state workers, and wondered with decreased need of temporary workers, if the vaccination rates would increase. She hopes to see vaccination rates rise with the decrease in temporary workers.

Commissioner Goldstein mentioned that this was the first time that EMS was included in DPH regulations around vaccination and asked Mr. Birch for comment.

Mr. Birch said he saw push back with the mandated vaccination from his employees and they had a lot of questions. He has also noticed a type of “vaccine-fatigue” leading to fewer people getting vaccinated.

Commissioner Goldstein suggested that at the core of the comments that employees are making, there may still be a layer of misinformation within in the workforce. He said that it’s interesting that it’s the healthcare space that is struggling with misinformation and disinformation because these are the people that we want to go out and combat that misinformation. He asked the panel if there was something that DPH could do to help with education, or resources that could be provided to help counter this misinformation which is perhaps contributing to lower vaccination rates.

Dr. Fu believed that people accept the idea that they should get the flu vaccine yearly but have not come to terms that the COVID vaccine should also be taken yearly. He feels there should be greater awareness of understanding that this will now be a regular vaccination.

Ms. Simons says that there is confusion from the CDC to define what their term “up to date” meant. People were confused if the vaccines they already had were sufficient or was the CDC asking for newer vaccines. She hopes the messaging will become clearer.

Commissioner Goldstein opened the roundtable up to the Council for questions.

Dr. Carey felt that religious exemptions should be eliminated. Unlike medical exemptions which require documentation, religious exemptions are as simple as checking a box. She added that there are three reasons why people don’t get vaccinated for COVID. 1) inertia – they simply don’t get around to it. 2) hesitancy – not sure of effectiveness or it makes you sick, and 3) vaccine resistance – don’t like the mandate or lack pressure to be vaccinated. She suggested that it would be good to understand which is dominant in their facilities, because strategies could be applied to overcome it.

Commissioner Goldstein touched upon religious exemptions noting that where religious exemptions are removed, vaccination rates increase.

Beth McLaughlin, DPH General Counsel, noted that there is Massachusetts law pertaining to vaccine exemptions, but the state of that law as it pertains to religious exemptions is currently in flux. She also explained that the regulation requires vaccination but does allow for opt-out, including for religious exemptions.

Commissioner Goldstein suggested that each panel member share briefly what they see as the biggest barrier to their employees’ vaccine uptake.

All the panelists answered that resistance to COVID vaccinations kept their rates down, but flu was not as troublesome. All reported that their flu rates were higher than their COVID rates. Unique comments were:

* Ms. Richardson, in a clinical community health center setting, felt that her workforce would respond better to no mandate. She cited a lot of resistance to mandates.
* Dr. Fu, in a hospital setting said the option for employees to decline the COVID vaccine due to an exemptions is proving challenging.
* Dr. Barbeau, in a healthcare setting, said exemptions have kept their vaccination levels lower and she is surprised to see the exemptions signed by a medical provider. She would like to know more from the health providers in the community about who is being asked to complete these exemptions.
* Dr. Garofalo, in his private practice, pushes for both his staff and patients to get vaccinated for flu and COVID but misinformation about COVID has made it difficult.
* Mr. Byrnes, in long term care, shared information regarding the National Healthcare Safety Network (NHSN) reporting. He said that if the reporter does not put in a declination date in the system, it defaults to unknown and said that is why the presentation by Dr. Fillo’s team showed so many unknowns.

Dr. Garofalo said that the MMS opposes any exemptions except for medical exemptions. Five states already have only medical exemptions.

Dr. Cruz-Davis said regarding the ethics of being vaccinated as a healthcare provider, patients don’t have a choice when they need care and therefore the ethics of the healthcare worker is in fact, an obligation to be vaccinated. She also said that to overcome resistance to COVID vaccination from healthcare workers and patients is a matter of education in making people understand that the vaccine is need every year because of the virus’ ability to mutate and create new variations, much like the flu where there isn’t an objection to a yearly vaccine.

Ms. Moscato asked if the panel would recommend to DPH or CMS to create a performance incentive either on their quality measure or on some type of their financial reimbursement measure related to vaccine percentages of their employees.

Ms. Simons said incentive for performance measures already exist around the flu and many hospitals participate, but not for COVID.

Dr. Fu said it would be interesting if there were an incentive but with everything hospitals are struggling through, the worst thing they could create is a penalty.

Mr. Birch said a good incentive would be if the state waived the recertification fee for paramedics.

Dr. Garofalo said the MMS would encourage incentives, understanding that it’s better than a mandate. To what type of incentive, the Medical Society doesn’t necessarily take a position.

Mr. Byrnes agreed.

Commissioner Goldstein said DPH could certainly look at this idea.

Ms. Richardson asked the panel about a point of confusion in the regulation and wondered if they had trouble explaining it to their staff. The confusion being that the regulation says it strongly recommends vaccinating for COVID, but it also says that it is a condition of licensure.

Mr. Birch agreed.

Dr. Bernstein said that it is very disturbing to know that the COVID vaccination rates among healthcare workers is so low, especially when there is such a high level of chronically ill elderly patients in acute care system. He understands there is resistance, but governance is critical. He said when the Council voted on the regulation and it sounded optional to get vaccinated, he felt the regulation wasn’t strong. He believes that this is an issue of communitarian value, not an area for individualism.

Upon the conclusion of the roundtable, Commissioner Goldstein thanked the panel, the team at Sturdy Health, and the PHC.

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 Wednesday, September 11, 2024, at 9 AM.

Commissioner Goldstein asked if there was a motion to adjourn.

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

The meeting was adjourned at 11:11 am.