**MINUTES OF THE PUBLIC HEALTH COUNCIL**

**Meeting of December 10, 2014**

**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: Wednesday, December 10, 2014 9:00 AM**

1. **ROUTINE ITEMS:**
   1. Introductions
   2. Record of the Public Health Council Meeting November 12, 2014 **(Vote)**
2. **DETERMINATION OF NEED**

a. Steward St. Anne’s Hospital Corporation Request for Approval of Significant Change Amendments to Previously Approved Project #5-3C08- Southcoast Hospitals Group’s Response to the Staff Recommendation Issued November 19, 2014. **(Vote)**

1. **FINAL REGULATION**

Request for Approval to Promulgate Final Regulations: 105 CMR 222.000: *Massachusetts Immunization Information System* **(Vote)**

1. **FINAL REGULATION**

Request for Approval to Promulgate Final Regulations: 105 CMR 158.000: *Licensure of Adult Day Health Programs*. **(Vote)**

1. **PRESENTATION**

a. Prevention and Wellness: Innovation and Success

*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**

Presented below is a summary of the meeting, including time-keeping, attendance and votes cast.

**Date of Meeting:** Wednesday, December 10, 2014

**Beginning Time:** 09:00 AM

**Ending Time:** 11:45 AM

**Attendance and Summary of Votes:**

| **Board Member** | **Attended** | **Item 1b** | **Item 2** | **Item 3** | **Item 4** |
| --- | --- | --- | --- | --- | --- |
|  |  | Record of the Public Health Council Meeting November 12, 2014 | Steward St. Anne’s Hospital Corporation Request for Approval of Significant Change Amendments to Previously Approved Project #5-3C08- Southcoast Hospitals Group’s Response to the Staff Recommendation Issued November 19, 2014.  *Motion was made by Meredith Rosenthal to table the DoN until further information could be provided by DPH, within the next 6 months. The Vote was made on this motion.* | Request for Approval to Promulgate Final Regulations: 105 CMR 222.000: *Massachusetts Immunization Information System* | Request for Approval to Promulgate Final Regulations: 105 CMR 158.000: *Licensure of Adult Day Health Programs*. |
| Cheryl Bartlett | Yes | Yes | Yes | Yes | Yes |
| Edward Bernstein | Yes | Yes | Yes | Yes | Yes |
| Derek Brindisi | Yes | Yes | Yes | Yes | Yes |
| Harold Cox | Absent | Absent | Absent | Absent | Absent |
| John Cunningham | Yes | Yes | Yes | Yes | Yes |
| Michele David | Absent | Absent | Absent | Absent | Absent |
| Meg Doherty | Yes | Yes | Yes | Yes | Yes |
| Michael Kneeland | Yes | Yes | Yes | Yes | Yes |
| Paul Lanzikos | Yes | Yes | Yes | Yes | Yes |
| Denis Leary | Yes | Yes | Yes | Yes | Yes |
| Lucilia Prates-Ramos | Yes | Yes | Yes | Yes | Yes |
| Jose Rafael Rivera | Absent | Absent | Absent | Absent | Absent |
| Meredith Rosenthal | Yes | Yes | Yes | Yes | Yes |
| Alan Woodward | Yes | Yes | Yes | Yes | Yes |
| Michael Wong | Yes | Yes | Yes | Yes | Yes |
| **Summary** | **12**  **Members attended** | **12**  **Approved with votes** | **12**  **Approved with Votes** | **12**  **Approved with votes** | **12**  **Approved with votes** |

**PROCEEDINGS**

A regular meeting of the Massachusetts Department of Public Health’s Public Health Council (M.G.L. C17, §§ 1, 3) was held on Wednesday, December 10, 2014 at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108.

Members present were: Department of Public Health Commissioner Cheryl Bartlett (chair), Dr. Edward Bernstein, Mr. Derek Brindisi, Dr. Michael Kneeland, Ms. Lucilia Prates-Ramos, Dr. John Cunningham, Dr. Alan Woodward, Dr. Michael Wong, Mr. Paul Lanzikos, Mr. Dennis Leary, Ms. Meg Doherty, Dr. Meredith Rosenthal

Absent member(s) were: Mr. Harold Cox, Dr. Michele David and Mr. Jose Rafael Rivera

Also in attendance was Attorney Tom O’Brien, General Counsel at the Massachusetts Department of Public Health.

Commissioner Bartlett called the meeting to order at 9:13 AM and reviewed the agenda.

**1: MINUTES**

b. Record of the Public Health Council Meetings of November 12, 2014

Commissioner Bartlett asked for a motion to approve the minutes from November 12, 2014. Dr. Wong made a motion to approve the minutes, and Dr. Kneeland seconded the motion. Dr. Woodward asked for one change to be made to the minutes. All voted in favor of this change.

Before moving on in the agenda, Commissioner Bartlett took a moment to recognize Dr. Bernstein and Boston Medical Center for their 20 years of work with Project Asserts. Dr. Bernstein stated that “ Project Assert began as a BSAS supported  critical populations grant from SAMHSA to BCH/BMC and recruited health promotion advocates from the community who were concerned about addiction and brought them into the ER to do in- reach to educate the staff and support the patients, and facilitate access to primary care, opioid education and Naloxone and  treatment. We appreciate the collaboration that we have.”

**ITEM 2: DETERMINATION OF NEED**

Steward St. Anne’s Hospital Corporation Request for Approval of Significant Change Amendments to Previously Approved Project #5-3C08.

Bernie Plovnick, director for the DoN program presented the staff recommendation on the St. Anne’s Hospital request for a significant change to build out 11,476 gross square feet of shell space on the hospital’s ground floor for a diagnostic-only cardiac catheterization (cardiac cath) service as well as outpatient cardiology services.

Following the presentation, Commissioner Bartlett opened the floor to discussion.

Dr. Woodward asked what motivated the change in policy in July which had prohibited the establishment of any new cardiac cath services located within a 30 minute ambulance trip from an existing hospital with interventional cardiac services.

Dr. Biondolillo stated that this was one of the policy changes enumerated in a circular letter from HCQ and Office of Policy and Planning. When there are changes in the health care delivery system, staff continually scan regulations and guidance to evaluate if an update is needed. The timing of the circular letter had to do with several factors: the end of a large, controlled trial within the industry, which was a complex, multi-facility study. We made no big policy changes during the trial, because we didn’t want to destabilize the process of the trial but we knew that at the end we would need to re-look at issues, because of the trial and because quite a lot of time had gone by since the policies were last reviewed. So the circular letter is based on our learning through the trial and within the time that had passed since we last evaluated these policies.

Commissioner Bartlett stated that health care reform under Chapter 224 requires us to review the systems of care and to undertake a comprehensive state health plan. While we couldn’t review every service at this time, cardiac cath is one where the Office of Health Planning is beginning to focus.

Dr. Woodward asked for confirmation that this service would be for elective diagnostic procedures only and not provide services on a 24/7 basis.

Dr. Biondolillo stated that the circular letter articulated a number of mandates that DPH issued to encourage best practices. This letter speaks explicitly to volume minimums, effectively reminds facilities of these minimums and that they must be adhered to as a condition of operating a cath lab. But in addition, consistent with Chapter 224, this was determined to be an opportunity to allow health provider systems that had made an investment in health reform principles the ability to provide better continuity of care for patients within the network and to move an existing cardiac cath service from a facility that is not meeting volume minimums.

Dr. Woodward asked if, in the original DoN application, Steward was seeking to close their cath lab at Quincy that was operating below the minimum volume.

Dr. Biondolillo responded that this type of decision would not likely appear a DoN application but more likely to result from DPH discussions with facilities making applications.

Dr. Woodward inquired as to what hours the St. Anne’s service plans to operate and whether they would be taking acute patients from the ED to their cath lab?

Dr. Biondolillo stated that the current regulations will apply with regard to hours of operation and OEMS transport protocols.

Dr. Cunningham asked if DPH concluded that this is the best care for patients? At the new facility rather than at one that already exists?

Dr. Biondolillo stated that DoN is responsible for ensuring that the care to be provided will not result in unnecessary duplication of services. The licensure requirements will be overseen by HCSQ per usual and it appears from the interface between DoN and HCSQ that the proposed service will not bring other parties’ facilities below the required volume minimums. HCSQ looks more at quality of care than does DoN but in this case, quality standards do not seem to be negatively impacted.

Dr. Rosenthal expressed concern that “the ACO tail may be wagging the fee for service dog.” The rationale for the exception makes sense in two circumstances: First, if the patients that are going to use this service are part of their ACO. The second is that the ACO has sufficient need for this service to make it cost effective. You don’t want to send patients to other facilities if it is more cost effective to keep the diagnostic services in-house. She asked about the extent to which these services will be used by patients of the ACO and how much use will be by patients with primary care providers in the ACO?

Dr. Biondolillo replied that the analysis assumed that patients who will use this service will be coming from within the Steward system. She stated that the objective is that there be assurance of high quality services at all facilities and ensuring that all facilities that are operational meet the minimums. The transition from fee for service to accountable care will take time. The process is an evolution and DPH is part of the evolution.

Dr. Wong acknowledged the relationship between minimum volumes and quality. He expressed concern that in settings where the number of individuals needing the service is limited, providers will need to attract more patients to maintain sufficient volume. If there are existing facilities that have established their expertise in providing high quality services, are new facilities for cardiac cath services really necessary?

Dr. Biondolillo responded that we are balancing relying upon known quality standards while trying to make sure that our policy decisions don’t prevent health reform from moving forward. The circular letter does speak to the issue of small point of service providers. A new facility has a glide-path to get up to speed with the minimums, and if they can do that, then they will be deemed able to provide the services. DoN looks at unnecessary duplication of services and does not limit a service to one single provider in an area. In this case, it did not appear that a new service will unduly affect other providers.

Mr. Plovnick stated that in table 2 of page 4 of the memo, DPH reproduced data from the applicant that showing the number of cardiac catheterizations currently performed on Steward patients in the area, and it is projected that some, but not all, of the diagnostic procedures will be performed at St. Anne’s.

Dr. Woodward mentioned that if this wasn’t an ACO issue, then we would say that it makes no sense to duplicate services. On the quality of care, we want to ensure that this is strictly diagnostic and not about acute patients. If a patient is determined to need an intervention, where are those patients going, two miles down the road or to one of Steward’s other facilities?

Linda Bodenmann, Executive Vice President and Chief Operating Officer of SouthCoast and Dr. Margaret Ferrell, Physician-in-Chief for Cardiovascular Services, addressed the Council: This matter is much more than a DoN. Approval of the post-DoN application would be based on bad policy. In 2008, DPH implemented a moratorium on establishment of new diagnostic cath labs within 30 miles of an existing lab. This barred Steward’s cath lab because Southcoast has primary angioplasty and is less than two miles from St. Anne’s. But on August 13, 2013, Steward filed this application. At that time, DoN staff questioned whether it could be licensed due to the moratorium and no action was taken by the Department. Then in 2014, the Department created an exception. SouthCoast is also an ACO, also committed to health reform. The rule change affected Department regulations and should have gone through the regulatory process. There were concerns about the number of diagnostic cath labs that were below minimum volumes, and the circular letter allows establishment of a new cath lab within two miles of a program with primary, 24/7 access. The DoN standard is duplication, not unnecessary duplication. 86% of the population statewide has access to a PCI program, there is no need for an additional PCI program and 9 out of 12 existing diagnostic-only cardiac cath services in MA are operating below minimum thresholds, so that this recommendation is in contradiction to the recommendation regarding minimum volumes. We can continue to treat these patients rather than create expensive diagnostic services that aren’t necessary. 210 of the cases at St. Luke’s were done by physicians affiliated with Steward. If those physicians take 210 patients to St. Anne’s, St. Luke’s will be below volume minimums.

Craig Jesiolowski, President, St. Anne’s Hospital, Dr. Mark Girard, Steward Hospital Group, and Andy Levine, Counsel for St. Anne’s, came before the Council. As an ACO, we are committed to achieving the highest quality care while reducing total medical expense. Have determined that heart disease is prevalent among a significant group of patients, and many of these patients have 4-6 co-morbidities and they see multiple providers with much medical information that needs to follow these patients.

Dr. Rosenthal asked how many of the 379 patients projected by St. Anne’s come from their primary care population?

[St. Anne’s] All patients will be coming from the PCP, all are part of the ACO

Dr. Rosenthal- So these are all Medicare patients?

[St. Anne’s] We don’t define ACO as only Medicare patients. We don’t define patients according to their insurance, we apply ACO management to everyone. We treat patients according to disease management, delivery of care, not insurance.

Dr. Woodward asked if it the service will be limited to 7 AM-3 PM, is all elective, and if the projection includes only patients from MA?

[St. Anne’s] Patients are coming from Fall River and New Bedford and it would also serve our Taunton area patients, as there are no cardiac cath services in that area.

Dr. Woodward- Where do you send the patients if they need intervention

[St. Anne’s]- elective intervention is according to provider and patient preferences. We think we achieve high quality and value of care if we keep it integrated within the system, but it is up to the patient. For the acute cases, then we will act in the best interest of the patient, and if time is of the essence they will be sent out of the network.

Mr. Lanzikos asked staff if they have a sense of how the capacity for this service compares in this service area as compared to others around state currently, and if this is approved, is it going to have more, less, or comparable capacity than others?

Dr. Biondolillo replied that we are in the process of doing health planning across 52 different service lines, and that PCI is under review. It will probably be a period of months before we will be able to answer more specifically. What we have done so far is to show that the rate of hospitalization and disease is quite high. We have not done an analysis of capacity yet.

Mr. Lanzikos asked in light of the analysis, why the matter is before the Council now, rather than waiting until completion of the health plan.

Dr. Biondolillo stated that we the timeframe for completion of the health plan is uncertain, but this application is before the Department and needs to be addressed in one way or another.

Mr. Lanzikos: what happens if this is postponed?

Dr. Biondolillo: We have to ask the applicant what happens.

Ms. Doherty asked Southcoast why the prevalence of CHD in the area is 74% higher than other parts of the state, and what is being done regarding disease prevention.

Dr. Biondolillo agreed with Ms. Doherty on the need for prevention with the high rate of disease.

Commissioner Bartlett asked if either party wished to comment.

Dr. Farrell: The rate of disease is incredibly high, and I think we all know the challenges of treating the population in New Bedford and Fall River due to various issues, but to say that opening a cath lab is the answer, as opposed to prevention services. Dr. Farrell questioned the idea of opening a new cath lab based on 2012 numbers.

Dr. Girard noted that prevention and wellness measures are an important part of the practice of population health management which is a core responsibility of an ACO.

Dr. Woodward asked if the Invasive Cardiac Services Advisory Committee (“ICSAC”) has been consulted on this DoN?

Dr. Biondolillo stated that the ICSAC has met continuously to advise DPH on Department policy, including this issue currently being discussed as well as the circular letter, which is an extension of previous regulation and guidance. The ICSAC did not discuss the circumstances of this specific DoN.

Dr. Cunningham asked what is the role of the Council in procedures for updating policies.

Carol Balulescu, Deputy General Counsel stated that the matter before the Council is the DoN for the build out of shell space and about what the shell space is going to be used for. Approval of a cardiac cath service is a licensing issue, which is the authority of HCSQ. Denial of the DoN today would say that St. Anne’s could not build out shell space for a cath lab, but not that St. Anne’s cannot have a cath lab. The licensure regulations establish standards. It was a sub-regulatory letter in 2008 that put the brakes on the regs, establishing a moratorium on new cardiac cath services, but the regulatory standards remain in place. It is only because St. Anne’s wants to build out shell space, which was part of a previously approved DoN that they are before Council with this matter.

Dr. Cunningham asked what was the Council’s role during the adoption of the previous circular letter about the moratorium.

Attorney Balulescu stated that circular letters or advisories generally do not come before Council.

Dr. Rosenthal asked if it was within the power of Council to table this motion and if so how, if the Council can request a hearing on the circular letter, and if Council can wait until the Health Planning Council has completed its review of cardiac cath services.

Attorney Balulescu stated that it is within Council’s authority to approve or disapprove a DoN action and if Council determines that it lacks sufficient information, it has the ability to table and ask for additional information.

Dr. Wong stated that safety and quality trump health reform. In this situation, safety and quality may be at odds with the health reform act. He asked if, with respect to the 9 out of 12 diagnostic-only cardiac cath programs operating below the minimum volume threshold, does DPH have regulatory authority over them?

Dr. Biondolillo stated that the Department reviews data that the facilities are required to submit. If they are not meeting the volume minimum, they must submit a correction plan. If the plan that they submit is not sufficient, then the circular letter gives them 30 days to respond. This process is actively ongoing with HCSQ.

Dr. Wong asked if higher complication rates have been observed for those facilities that are not meeting the volume minimum.

Dr. Biondolillo stated that this has not been observed and that in cath labs in Massachusetts, such rates are extremely low.

Mr. Lanzikos stated that he does not understand the consequences, particularly to SouthCoast, of approving the DoN. He asked to see more information including the consequences to Southcoast if approved and more analysis of the impact to the existing program in comparison to the one proposed.

Dr. Biondolillo stated that the health planning process is more regionally focused and not intended to focus upon individual facilities.

Mr. Lanzikos requested additional staff analysis on this specific application, in this service area, on the population’s morbidity and mortality, and a better understanding of what would happen to the existing program if this program were realized. Would it be mutually beneficial?

Mr. Plovnick reminded Council that there is another process that is still pending with HCSQ for approval of the cardiac cath service. In 1997, DPH ended DoN regulation of cardiac cath as a substantial change of service. The impact of numbers will be addressed in the HCSQ process.

Dr. Cunningham said that he would like better clarity on what is happening in 2014 for prevention as compared to 2012 and asked how long it would take to look at this?

Dr. Biondolillo stated that the Health Planning Council had decided to conduct a “level 3” analysis on cardiac cath with a more in depth focus on policy issues. Part of the reason why the process takes longer is because of the statewide focus.

Commissioner Bartlett asked Southcoast and St. Anne’s to make a closing statement.

Dr. Farrell stated that 460 is the number of diagnostic caths at St. Luke’s facility in 2014 annualized to the fiscal year. Also some confusion here regarding the Masscomm trials, they were PCI trials, and have little or no bearing on diagnostic catheterization. Commissioner Bartlett clarified that the trials were brought up in regards to timing of the circular letter, only.

Counsellor Levine spoke on behalf of St. Anne’s. Regarding the circular letter: the applicant embraces the requirements in that letter. Mr. Levine also noted that the requirement that hospitals with cath labs report and are monitored by the Department are also contained within that circular letter. So it’s a very comprehensive circular letter. In addition, Mr. Levine noted that the reason St. Anne’s was before the Council that day was because of the decision to place the cath lab in that particular shell space. The circular letter gives other ACOs the right to open cath labs and were it not for the choice of using shell space, we would not be here.

Dr. Woodward asked if there could be an accommodation that ACO physicians can perform cardiac cath procedure in one location or another and that they can get the health records from each hospital sent to a lab that is two miles away.

Dr. Rosenthal moved to table the DoN pending further information from health planning, further clarification regarding the circular letter, and an assessment of the potential impact on public health based upon projections in this area.

Dr. Wong asked to make a friendly amendment that would require staff to come back to PHC in a time frame not to exceed 6 months.

Mr. Lanzikos moved to table the DoN, Ms. Prates- Ramos seconded the motion. All approved.

**ITEM 3: FINAL REGULATION**

Request for Approval to Promulgate Final Regulations: 105 CMR 222.000: *Massachusetts Immunization Information System*

Following the presentation, Commissioner Bartlett opened the floor for discussion.

Dr. Woodward stated that there has been a 20% increase of usage since September with 500 providers.

Mr. Cranston stated that the ultimate goal is to have all providers who administer vaccines to be submitting immunization data to the MIIS. Mr. Talebian confirmed that the total number of providers that will eventually be submitting date is approximately 3,000. Some provider sites are reporting as a group instead of individuals.

Dr. Woodward asked for DPH to clarify the comments submitted by local health departments saying it is unfair for DPH to require local boards of health to comply. Mr. Cranston responded that there is a perception that local boards are being held to more stringent standards, which is not the case. The law and the proposed regulations would apply equally to all providers who give immunizations.

Dr. Woodward inquired about the one complaint about the system freezing and whether there is pattern of complaints about this issue. Mr. Talebian stated that the vast majority of the times, the issues are at the end user side. It is often related to the internet bandwidth or other IT infrastructure at the provider office.

Mr. Brindisi commented that DPH used the term over immunizing for flu and if we have data? Mr. Talebian stated that there is no hard data, but we know covered rates are lower than they need to be. Our system that quantifies this information is primarily a national phone-based survey. . Once the MIIS has more complete information, we can better qualify this. Mr. Brindisi stated that for local boards of health to set up a system for entering flu immunization data real time during a flu clinic is difficult; typically they take the forms back to their offices and enter the data after the clinic. So if we really need the flu data in real time in order to prevent over immunization then we need to ensure it is a real issue. Mr. Cranston stated that real time data is also important for emergency planning purposes as individuals have a hard time knowing if they were up to date on vaccinations which is important especially in outbreak situations.

Mr. Lanzikos asked for chain pharmacies, what entity is registered? Is it the individual pharmacy or the chain? Mr. Talebian stated that the whole chain is registered as one entity and typically reports data to us in aggregate but the data can be identified down to the individual site location. Chains have been very cooperative, Walgreens was a very early adopter of the system and several other chains are coming on board in the near future.

Ms. Doherty commented on the question on over immunization. The problem is that you have an aging population with dementia, an elderly person may be offered a flu vaccination at their local council on aging, then again at the pharmacy clinic and at their PCP. This happens more than you think and access to information is key. Dr. Cunningham commented that it was suggested to him that he receive a double dose. Mr. Talebian mentioned that it is important that the clinicians have immunization information in a timely manner

At the conclusion of the presentation, Commissioner Bartlett asked for a motion to approve. Dr. Woodward made the motion and Dr. Bernstein seconded. All approved.

**ITEM 4: FINAL REGULATION**

Request for Approval to Promulgate Final Regulations: 105 CMR 158.000: *Licensure of Adult Day Health*

*Programs*

Following the presentation, Commissioner Bartlett opened the floor for discussion.

Dr. Bernstein asked for clarification regarding discharge criteria at the day center.

Ms. Nelson responded that there are very specific requirements for an Adult Day Health Program to initiate discharge of a participant, including behavioral or safety concerns, or in the instance when a participant has a health condition that requires more intensive medical oversight than a Program can provide.

Mr. Lanzikos asked that of the 50 or so that are operating without certification, how will they identify to come into compliance? Are they self-identifying or being sought out, and what do we do if they say they aren’t an adult day health program?

Ms. Nelson stated that the definition is clear and that we will be publishing sub-regulatory guidelines Lauren- definitions are quite clear, with sub-regulatory guidance and will plan on working with the community to ensure that they are all captured.

Mr. Lanzikos stated as far as RN staffing issues, is there a schedule with a bumper? If we schedule 24, 21 will show up. When determining ratios, will you be looking at scheduled participants or those that are anticipated.

Ms. Nelson stated that this will be staffed for the expectation for scheduled participants with the understanding that the number of participants fluctuate.

Ms. Allwes stated that Adult Day Health licensure and enforcement will be modeled after the licensure and enforcement mechanisms that the Department uses for similar facilities. DPH will be looking at the trend analysis based on the time of year and the week.

Ms. Doherty asked if anyone has considered the CPR requirement for bus service as many Programs offer bus services through Medicaid. Those who aren’t Medicaid payors, how are they paying; are they public payors, and do we know if other payors, or types of insurance are willing to pay?

Ms. Nelson answered that we are not aware of what these other facilities have as far as payment terms and will learn of those as we go. Complaints from consumers will be handled in the same manner as the Department handles complaints regarding other types of facilities.

After no further comments, Commissioner Bartlett asked for a motion to approve the regulations. Dr. Rosenthal moved for approval and Mr. Lanzikos seconded. All approved.

**ITEM 5: PRESENTATION**

Prevention and Wellness: Innovation and Success

Following the presentation, Commissioner Bartlett opened the floor for discussion.

Carlene Pavlos, Director, Bureau of Community Health and Prevention and Lea Susan Ojamaa discussed chronic disease initiatives and how Massachusetts has become a national model and how the department integrated 9 individual programs operating separately, and how they came together. Ms. Pavlos and Ms. Ojamaa will return early 2015 to continue to update the Council on these matters.

Before the Commissioner closed the meeting, Dr. Kneeland thanked the Commissioner for her service as Commissioner of Public Health. During his 14 months on the Council, he recognized the work of DPH staff and is thankful for them for setting high standards for the residents of the Commonwealth, under the Commissioners leadership and wishes her well in her next endeavor.

Commissioner Bartlett asked for a motion to adjourn. Dr. Wong made the motion and Mr. Lanzikos seconded.

The meeting adjourned at 11:45AM on a motion by and passed unanimously without discussion.

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

1. Docket of the meeting
2. Minutes of the Public Health Council meeting of November 12, 2014
3. Steward St. Anne’s Hospital Corporation Request for Approval of Significant Change Amendments to Previously Approved Project #5-3C08- Southcoast Hospitals Group’s Response to the Staff Recommendation Issued November 19, 2014.
4. Request for Approval to Promulgate Final Regulations: 105 CMR 222.000: *Massachusetts Immunization Information System*
5. Request for Approval to Promulgate Final Regulations: 105 CMR 158.000: *Licensure of Adult Day Health Programs*.
6. Copies of all power point presentations (emailed upon conclusion of the meeting)

Commissioner Cheryl Bartlett, Chair