MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of December 11, 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, December 11, 2024 – 9:00AM**

***Note: The December 11 Public Health Council meeting will be held remotely as a video conference consistent with St. 2021, c. 20, s. 20, which provides for certain modifications to the Massachusetts Open Meeting Law.***

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

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Passcode: 777774

1. **ROUTINE ITEMS**
	1. Introductions.
	2. Updates from Commissioner Robert Goldstein.
	3. Record of the Public Health Council Meeting held November 13, 2024 **(Vote)**.
2. **DETERMINATION OF NEED**
	1. Request by Beth Israel Lahey Health, Inc. for a Substantial Capital Expenditure **(Vote).**
3. **INFORMATIONAL PRESENTATION**
	1. 2024 Updates on Priorities to Advance Comprehensive Perinatal Health Systems of Care​.

*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: December 11, 2024

Start Time: 9:03 am. Ending Time: 11:08 am.

| **Board Member** | **Attended** | **First Order:****Approval of****November 13, 2024 Minutes (Vote)** | **DON****Request by Beth Israel Lahey Heal, Inc. for a Substantial Capital Expenditure (Vote)** |
| --- | --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes | Yes |
| **Edward Bernstein** | Yes | Yes | Yes |
| **Lissette Blondet** | Yes | Yes | Yes |
| **Kathleen Carey** | Yes | Yes | Yes |
| **Emily Cooper** | Yes | Abstain | Yes |
| **Harold Cox** | No | Absent | Absent |
| **Alba Cruz-Davis** | Yes | Yes | Yes |
| **Michele David** | Yes | Abstain | Yes |
| **Robert Engell** | Yes | Yes | Yes |
| **Elizabeth Evans** | Yes | Abstain | Yes |
| **Eduardo Haddad** | Yes | Yes | Yes |
| **Joanna Lambert** | Yes | Yes | Yes |
| **Stewart Landers** | No | Absent | Absent |
| **Mary Moscato** | Yes | Yes | Yes |
| **Gregory Volturo** | Yes | Yes | Yes |
| **Summary** | 13 Members Present;2 Members Absent | 10 Members Approved;2 Members Absent;3 Members Abstained | 13 Members Approved2 Members Absent |

**PROCEEDINGS**

A regular meeting of the Massachusetts Department of Public Health’s Public Health Council (M.G.L. c. 17, §§ 1, 3) was held on Wednesday, December 11, 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; Robert Engell; Liz Evans; Eduardo Haddad, MD; Joanna Lambert; 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 9:03 am and made opening remarks before reviewing the docket.

**1. ROUTINE ITEMS**

*b. Updates from Commissioner Robert Goldstein*

**Public Health Legislation**

Commissioner Goldstein said last month, Governor Healey signed the Mass Leads Act, an economic development bill that included two key measures to advance public health. The first is the Commonwealth joining the Nurse Licensure Compact, which will make it easier for nurses who are licensed in other compact states to work in Massachusetts. This will alleviate cumbersome reciprocal licensing procedures with a number of states and help to reduce staffing shortages. The second is passing the Statewide Accelerated Public Health for Every Community, or SAPHE 2.0 Act, which will strengthen local public health service delivery. SAPHE 2.0 promotes service sharing, establishes a statewide data collection system, and requires local boards of health to meet certain performance standards, all to support a more equitable public health system throughout the state. SAPHE 2.0 is a catalyst for the kind of change that can improve public health in all municipalities for generations to come, and we applaud its passage.

**Wildfires**

Commissioner Goldstein reported last month that the 2024 fire season in Massachusetts has been unusually severe, with more than 4,200 acres burned as of late November, which is significantly more than in previous years. This increase in wildfires has been attributed to drought conditions and unusually warm weather patterns, likely an effect of climate change. Massachusetts did receive some rain around the Thanksgiving holiday which was a welcome help for controlling wildfires. Several of these fires continue to burn quite deeply underground, so it will take more rain and cold weather to extinguish them completely. But the smokiness in the air that has been a respiratory risk for some in Metro Boston has improved significantly, and the fire activity level at all sites in Massachusetts has been downgraded to minimal.

**Respiratory Illness Season/Vaccination**

Commissioner Goldstein said we are now in respiratory illness season—a time when illnesses like COVID-19, influenza, and RSV become more common. Although cases of these three pathogens are currently low, we are anticipating increasing case numbers in the upcoming weeks. Now is the time to protect ourselves and those around us by getting vaccinated, before case counts start to rise. Vaccines are our best defense against severe illness, hospitalization, and complications from respiratory pathogens. Vaccines not only protect the health of the individual but also help to safeguard vulnerable populations and keep workplaces and schools safe and healthy. Influenza and COVID-19 vaccines are recommended for everyone aged 6 months and older and RSV immunizations are recommended for eligible adults and infants. A second dose of the 2024-2025 COVID-19 vaccine is recommended after 6 months for those 65 and older. Vaccines are widely available at pharmacies, clinics, and healthcare providers across Massachusetts. It’s also important to remember other ways to keep ourselves, our friends and loved ones, and our communities healthy. Stay home when sick, cover your coughs, and use good hand hygiene. We continue to observe relatively high numbers of two bacterial respiratory illnesses -- pertussis (also known as whooping cough) and mycoplasma pneumonia. Both infections are primarily affecting children and adolescents. Pertussis illness begins with mild upper respiratory tract symptoms and can progress to severe paroxysms of cough, often with a characteristic respiratory whoop, which may be followed by vomiting. Symptoms of mycoplasma pneumonia often include persistent cough, fever, and fatigue, though symptoms are often mild, and patients do not require hospitalization. At this time, DPH continues to recommend that clinicians and families be alert for symptoms of both pertussis and mycoplasma pneumonia. Antibiotic treatment is recommended for both conditions to reduce symptoms and limit spread of infection. Vaccines are available to prevent pertussis. We encourage eligible patients to stay updated on pertussis vaccinations, particularly infants and young children.

**Steward Health Care**

Commissioner Goldstein said the Steward Health Care situation in Massachusetts has entered a new phase. On November 14, DPH stood down the Incident Command structure we had activated seven months ago to manage the myriad details involved with preserving and protecting health care access and safety in Massachusetts in the midst of Steward’s financial crisis and bankruptcy declaration. This deactivation of Incident Command symbolized, at least for DPH, a welcome shift toward stabilization in our health care environment after a period of intense monitoring, managing, oversight, and concern. Even though Steward now has largely exited Massachusetts, there remain some issues that need to be resolved. For example, Norwood Hospital’s future remains uncertain, TRACO, Steward’s malpractice insurance company, awaits an important January bankruptcy court decision about coverage for physicians who worked at Steward, and the Regional Working Groups continue to meet to assess the impact of the closures of Carney Hospital and Nashoba Valley Medical Center on the communities that had counted on these facilities. These Working Groups are identifying gaps in care and services and will make recommendations as to how those gaps could be addressed. On a positive note, the five former Steward hospitals that are now operating under new high-quality, and well-known health care organizations continue to adapt well. Staff who worked in the former Steward hospitals are now employed by reliable health care systems and have the stability and support they deserve. And most important, quality patient care is being delivered every day in these facilities. As we look forward at a future without Steward, we also must look back and learn from the experience we just went through. Winston Churchill, in the darkest days of World War II, famously and wisely remarked, “Never let a good crisis go to waste.” This Steward crisis has been challenging, but it has provided invaluable insights that can drive meaningful and systemic improvements. We must take these lessons to heart and leverage them as we continue to strengthen and evolve the Massachusetts health care landscape for the future.

Commissioner Goldstein asked if there were any questions.

Dr. Haddad asked what the principal lessons were from the Steward Health Care crisis.

Commissioner Goldstein said it may be too early to answer that question, but it is the responsibility of DPH to do the analysis that’s necessary.

Dr. Bernstein asked what we are learning about incorporating private equity into the healthcare system.

Commissioner Goldstein said we learned a lot about private equity in healthcare in the past year. That has to be part of the analysis that we do and an understanding of how we move forward. There is pending legislation that is sitting in a conference committee, but he believes many are thinking about the role of private equity in healthcare and what role it should play in hospital management and medical practice management, as you mentioned, ambulatory surgical centers.

Dr. Bernstein said at the last meeting, the Commissioner had mentioned the impact of the elections on public health and is there a planning process in place to give us some information on how we're preparing for the administration change?

Commissioner Goldstein said the word that he’s been using over the past month has been “uncertainty,” and he thinks there is significant uncertainty of what might happen at the federal level as the Trump administration comes in at the end of January. We are certainly doing the work within the Department of Public Health to understand the impact of a transition in administration. We do this every time there is a transition in administration. We are benefiting this time from the fact that there was a prior Trump administration, and we know some of the actions that they took during those four years. We know the response that we had as a department and as public health to those actions. And we are looking at what we need to do to make sure that we can continue to fulfill our mission, we can provide care and services to individuals all across Massachusetts. It’s a process that mirrors what we would do with any transition of presidential administration.

Dr. Bernstein said he was encouraged by the remark that the Governor is committed to not invest any of our state's resources in the mass immigration policies of the next administration.

Ms. Blondet said we know how those policies may affect some of our most vulnerable neighbors. In the past, when there has been insecurity for immigrants, whether they have the paperwork or not, it has had a very significant impact on primary care. People do not go to their appointment for fear of being arrested. She said she is aware of this through community health workers who are constantly brainstorming ways of getting people to care. She asked if there are any plans for proactive interventions or strategies to prepare for this.

Commissioner Goldstein said we are exploring all opportunities that exist, and we are doing the work that is necessary to prepare. There isn’t anything that is specific that we are going to roll out over the next four weeks, because we need to treat this as all transitions of presidential administrations, making sure that we're doing the work and we're analyzing what might happen. We are taking into account what we know from the prior Trump administration, and we should also be cognizant of many things that were put in place during the first Trump administration here in Massachusetts to protect individuals, to make sure they have access to care. Massachusetts is a state that has protected access to primary care, to healthcare all across the state and has used every tool that we have to get people to engage in care.

Dr. Bernstein wanted to go on record as condemning the comments since the last Public Health Council meeting, made by the “Immigration Czar” to-be that threatened our Mayor in Boston and indirectly the Governor to “get out of the way, or else.”

Dr. Cruz-Davis said her concern, in addition to what everyone else has voiced, is the issue around vaccination and prevention, particularly for children and vulnerable populations. Although there is considerable anti-vaccine thinking, there should always be access to vaccines.

Commissioner Goldstein said there are two big issues for us to address when it comes to vaccines and Dr. Cruz-Davis hit on both of them. One is the misinformation and disinformation that exists around vaccine safety. He said he could use the help of this council to make sure that they are addressing mis and disinformation wherever they see it, making sure that they are standing up for the evidence and the data around vaccines. Vaccines have been one of the best public health interventions that we've had in 100 years. In regard to access, he commends Massachusetts for being a state that has done so much to improve access to vaccines. We have a pediatric vaccine trust in this state that provides vaccine access to everyone 17 and under in the state. It makes sure that anyone, regardless of insurance coverage, regardless of geography, regardless of race and ethnicity, regardless of wealth and income status, has access to childhood vaccines. Because of that, we have some of the highest rates of childhood vaccination in the country. He wants to expand that making Massachusetts a model for the rest of the country.

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

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

*c. November 13, 2024 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the November 13, 2024, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the November 13, 2024 minutes.

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

**2. DETERMINATION OF NEED**

*a. Request by Beth Israel Lahey Health, Inc. for a Substantial Capital Expenditure* ***(Vote)***

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

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

Dr. Carey offered a few quick calculations on the slide that had the wait times and in length of stay that showed the increase in length of stay over the 2020 to 2023 was entirely due to the increased wait time to be seen. She asked: regarding bed capacity and specifically, staffed beds, what is the plan for increasing staffing, considering the workforce challenges?

Kevin Coughlin, President of Beth Israel Deaconess, Plymouth, answered that they are constantly recruiting and training and trying to bring more folks into the organization. In their emergency department, they have all BID Plymouth-employed nursing staff. They do not have any travel staff or outside staff currently in our emergency department. That is based upon some significant work that has been done on part of the leadership in the ED and our Chief Nursing Officer, Donna Doherty, to retain staff and also attract staff in the community to our organization. They also do a lot of work with the educational facilities in their community in Southeastern Massachusetts to both help train staff and also attract them to their organization.

Dr. Carey mentioned the broad public health movement in recent years has resulted in increases in the number of urgent care centers, which has taken many of the cases of out of the ED’s. She asked if there are urgent care opportunities and growth for those facilities in in the Plymouth area.

Mr. Coughlin said they have had a number of urgent care providers, some funded by private equity, move into their community. They are doing a great job of offloading the less acute patients from the emergency department. So even though in that data you saw an increasing trend of patients coming in, what we're seeing is an increase in the acuity of the average patients that come into the emergency department, and appropriately so. Patients that are not severely ill are being seen in the urgent care facilities in our community. They just opened an urgent care facility in Middleborough. When Compass Medical went bankrupt and closed their facility in Middleborough, Massachusetts, he signed a lease for that 30,000 square foot property and have repopulated that with the primary care, many of the same primary care physicians that were there before and some specialty physicians.

Ms. Blondet asked what percentage of additional beds will be dedicated to child and adult behavioral health. She also asked for date of ED visits based on zip code and insurance type.

Mr. Coughlin said they currently have 17 behavioral health beds as part of their emergency room. They’re proposing to increase that to 16 making it a 100% increase. They have a significant number of adolescents and children that come into the emergency room in crisis. In those circumstances we tend use the seven bed behavioral health unit driving the adult behavioral health patients which are usually higher in number out into the regular emergency department. It is a small facility with curtained stretchers with about a foot between each patient and a curtain between them. It’s possible to have a behavioral health patient in crisis right next to a regular emergency department patient there. It’s stressful for the patients and difficult for the staff. This expansion will help eliminate those problems by more than doubling the size of the of the unit.

Donna Doherty, Senior Vice-President of Patient Care Services and Chief Nursing Officer for Beth Israel Deaconess Plymouth, addressed Ms. Blondet’s question concerning the split of child and adult behavioral beds. She corrected Mr. Coughlin’s numbers stating that he incorrectly said there are currently 17 beds. There are seven. They will increase behavioral beds by 9 making a total of 16. The design of that new unit is going to be such that there's dividers or doors that can have the unit broken out. They tend to cohort by age groups, to make sure that their mix is appropriate for the patients who are in our locked 7 bed unit presently. There's often beds with curtains in between them. There are 4 private beds and 3 curtained beds. The appropriate patients, whether it be adolescent, children, elderly or adult will be able to close those areas so that they can cohort the appropriate behavioral patients and prevent the mix.

Mr. Renaud answered Ms. Blondet’s question regarding insurance and zip code, saying in FY23, emergency room visits by payer mix, Medicaid was 23%, Medicare was 36% and commercial payers were 34%. He will look into a breakdown of zip code.

Ms. Blondet said that partnerships with other potential emergency departments in the area, is critical, mainly Cape Cod Healthcare. She assumes Cape residents are having the same issues of overflow in the Cape and though these partnerships are not required within the DoN application, she would like to know how partnerships with other emergency departments are created, encouraged, and maintained for the sake of patients especially for the publicly insured, Medicare or Medicaid.

Mr. Coughlin said particularly with the closing of Good Samaritan in Brockton, the local hospitals with facilitation from DPH, work closely to find opportunities to transfer patients to another local facility when needed. Both Hyannis and Falmouth have undergone significant expansion with their emergency departments, which has significantly increased their capacity.

Ms. Doherty added with the help of the Department of Public Health and regional coordination for Region 5, significantly with the issues that were faced based on the signature closure, they had members of the senior team and clinicians on calls weekly so that they could determine where capacity constraints existed. Also, there were subgroups that were created to assist them (with DPH partnership) that addressed some of the constraints that were felt. Mobile Integrated Health was something where some of the facilities had partnerships. They partnered with Brewster, Brewster holding the license, but other facilities also reaching out to one another. They sought ways to deescalate capacity constraints both in the emergency department and inpatient and use the best practices across the region as well as the state to determine how to make sure that the patients in their region are getting the best quality care. Those partnerships solidified during the pandemic and the post pandemic crisis of capacity constraint.

Ms. Cooper asked for clarification on the CHI funding for this application. She also questioned the utilizing of many small grants to multiple agencies, saying sometimes that approach doesn’t have much of a public health impact. She encouraged BID Plymouth and their Community Board when they’re looking at CHI funds and to make some tough decisions about prioritization to not choose everything as a need.

She added that MassHealth is launching a new service in January called Homeless Medical Respite. It is to help hospitals free up space in the emergency rooms and their inpatient units for a place for people to go who are experiencing homelessness and they would be ready for discharge home, but they don't have a home to go to. It's up to BID Plymouth to find the partners in your community you want to work with. It needs to be a combination of a healthcare partner and a homeless provider agency that come together and find a location for this. It is a billable service and hope that hospitals take advantage of this because of capacity issues.

Jennica Allen, Manager of Community Engagement Practices for DPH, joined the panel.

Ms. Cooper noted that it looks like for the CHI investment, when you take out all the fees and the money that goes to the state for this, it's about $1.6 million. But she thought she read it was also going to be combined with a separate DoN that has been already approved, which had a CHI of about 500,000. So she said she was thinking of this as more about $2,000,000.

Jennica Allen confirmed that was correct.

Dr. Volturo commended BID Plymouth for building a modern emergency department without curtains and cubicles, critically important today with the infectious disease issues that we're dealing with on a regular basis. He asked if the behavioral health time in admitted and acute transfer in their total and median total length of stay time, is included, or is it separated out.

Ms. Doherty said it was included.

Dr. Volturo advised to separate out behavioral health, which is a reporting piece that allows you also to look at your admitted processes and looking at that number is important in terms of looking at some of your operations. He suggested if they want to show some improvement, to look at your total length of stay for discharged patients, because with the vertical unit that you're putting in there and some vertical beds, that should substantially reduce that. Your total “left without being seen” are not actually that far off from state or national averages right now. With a waiting time in terms of arrival to treatment space and looking at total length of stay for admitted patients he said he could tell that staff is working hard to do what they're doing, which is a good job. He suggested using the ED throughput steering committee. It's a good opportunity to work with them to help your ED succeed in terms of reducing consult times, laboratory time, wait times, and so forth. Another question he suggested they think about is any pediatric specialty rooms. He said they are running about 10 to 11% pediatrics, which is significant. Also the potential for some rooms that have specialty needs for the geriatric patients with different lighting and different flooring for those patients. He said not to be surprised about having some hallway patients when finished because he thinks their growth is going to be higher than they think in this ED.

Dr. Haddad mentioned published data of population growth for Plymouth, is less than 2% per year. Yet the applicant mentioned 3.5 percent growth, leading him to believe there is an influx of people outside Plymouth coming to the hospital. That population is likely to not have access in their area and be less insured. The cost of care in the emergency room is very high. We need to be cognizant of that and try to work with a different approach in regard to early access to care for those populations that may end up in an emergency, because they haven't had the access to the primary care.

Mr. Coughlin said when Compass closed in Middleboro, which is 18 miles away from the hospital, we saw a 20% increase in flow from that community into our emergency room almost immediately when that happened. It's part of the reason why we made the decision to repopulate that facility with primary care in an urgent care to try and take care of that population in the community that they live in and not put them in a situation where they had to come to the emergency room.

Ms. Moscato thanked the BID team for an excellent DoN application, noting that they addressed very important concerns for her and the council, workforce, adolescent care, their approach to geriatrics and the local community. She is happy to hear that there are no contract staff in the ED, and she hopes to see more behavioral staff hired.

Dr. Bernstein mentioned that data around people with substance use disorder, homelessness, or those with no primary care, and those leaving the ED before being seen, is not captured. He asked if they would address that. He then mentioned the framework that is the inputs, the throughputs and the outputs in any system. The system can't put all the burden on the local hospital, the public health system of the state and the governance of the state has to address some of those issues too. They have addressed this around insurance as much as they could. There are output issues creating a crisis within our state based on bed capacity, ED boarding, overcrowding, the COVID crisis, the Stewart crisis, the closing of hospitals, all of which we've been discussing. All this can’t be ignored as having an impact on what you're doing and planning for the future.

Mr. Coughlin said substance use disorder, and behavioral health issues are a massive problem in this community. We, first as an organization, recognize this as something that we have to address here locally. We partnered with the state through the CHART grant program starting in about 2015 or 2016, and received about a $4 million grant to focus on doing a better job of managing the patients that were showing up in our emergency department with behavioral health and substance use disorder issues. Back then, the opiate crisis was really driving a large number of these patients. In the initial chart grant that we got, we built a lot of very good capabilities and had some significant successes with the way we were managing those patients. We reduced our chronic ED visitation patients by 26 or 28% over the course of that CHART grant by employing within the organization, significant behavioral health providers, while partnering in the community, including with the Police Department and the courts while managing these patients toward treatment facilities. Although that grant went away around the time of the pandemic, we have kept those capabilities within the organization and continue those today. Lately we’ve been able to partner with the Beth Israel Leahy behavioral health division and get additional resources to help us in our emergency department and have seen a significant improvement in our ability to place inpatient psychiatric patients through that BILH partnership in, facilities across the state. We are committed to staying invested heavily in psychiatry and social work here at the hospital.

Dr. Bernstein said somebody who injects drugs can be traced to getting an infection which spreads to their heart and may have endocarditis leading to getting admitted and they don't have a home because of the substance use, while the patient is hospitalized for 30 or more days getting his IV antibiotics. This is where early intervention is helpful. We need to have more help from the state and they've been working on that, but I'm not sure that the capacity problems have been solved. He asked if bed capacity at BID Plymouth was 95%.

Mr. Coughlin agreed.

Dr. Bernstein said back up into the emergency department is inevitable, along with scheduled surgeries, there needs to be adjustments. He noticed that they put in this multidisciplinary team, which would be part of this transition, but he imagined that this team has already been in place and asked what would now be different.

Mr. Coughlin said the space in which they’re in right now is not a good space to be managing unstable behavioral health or substance use disorder patients. It's not a calming space, it's dangerous for our staff. We have had not an insignificant number of injuries of our staff because of these unstable patients. Part of the reason for that is because they're in an open curtained emergency room and not in a locked safe facility. This new facility will offer many opportunities for us to manage those patients in a safer manner. And then as I stated, through Beth Israel Leahy Health having an entire division of behavioral health services with large numbers of psychiatrists and social workers with whom we can partner, the resources that we have available to us are significantly greater than they have been historically.

Dr, Bernstein said he was talking about the inpatient capacity regarding the inflow, the throughput and the outflow.

Mr. Coughlin said the average inpatient capacity is usually in the mid-90 percentile. They spend significant effort and resources trying to keep the length of stay at appropriate levels, as close to the metric being length of stay as we can and working with external facilities whether that’s skilled nursing facilities, long term care facilities, or the MIH program, getting people back to home. We spend a lot of time trying to get that throughput better and better, which we have been successful at doing.

With no further questions, Commissioner Goldstein asked if there was a motion to approve Beth Israel Lahey Health, Inc request for a Substantial Capital Expenditure.

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

**3. INFORMATIONAL PRESENTATION**

*a. 2024 Updates on Priorities to Advance Comprehensive Perinatal Health Systems of Care.*

Commissioner Goldstein said that the next item on the agenda will be to hear an update about the 2024 Priorities to Advance Comprehensive Perinatal Health Systems. He mentioned a few months ago, the Department has a long standing commitment to improving outcomes and maternal health, particularly as our data show a widening gap in outcomes for Black and brown birthing people relative to other racial and ethnic categories. This commitment to health equity, particularly to racial equity, is one of our foundational priorities and it's reflected in all we do at every level of our work.

For example, one of our six key initiatives of our strategy map is the implementation of levels of maternal care throughout Massachusetts. It's a process to evaluate the capacity of healthcare facilities and to inform the public about how to seek the appropriate provider for their labor and delivery.

Our commitment to equity in maternal health also includes our support and implementation of the recently passed Maternal Health Bill, which lays out a number of directives for the department in an effort to improve outcomes for birthing people, children and families across the state.

Just over a year ago, in the wake of the loss of the maternity ward at Health Alliance Leominster, Governor Healey tasked the Department of Public Health with delivering two reports, one on the state of essential services in Northern Worcester County and one assessing the state of availability and access to maternal health services across Massachusetts. At last month's Public Health Council meeting, we provided an update on the recommendations made in the Essential Services Report, and today we're going to share some of the work the Department has been engaged in over the past year related to the Maternal Health Report.

It's important to note that our commitment to improving maternal health outcomes focused on racial equity did not start with our strategy map or the passage of a bill or the commissioning of a report. This work has been alive, ongoing and growing within the department for many years, and it's been championed by our Bureau of Family Health and Nutrition. The folks you're about to hear from are passionate, dedicated, lifelong advocates who've been working tirelessly in community with providers and advocates across the Commonwealth to improve outcomes in maternal health for many years.

Commissioner Goldstein invited Dr. Elaine Fitzgerald Lewis, Director of the Bureau of Health and Family Nutrition to provide an update on Priorities to Advance Comprehensive Perinatal Health Systems of Care. Joining her was Dr. Cristina Alonso Lord, Director for the Bureau’s Division of Pregnancy, Infancy, and Early Childhood.

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

Ms. Blondet said she feels that doulas, specializing in maternal health as community health workers specialize in broader public health issues, can benefit from the certification process and general work of community health workers.

Dr. Carey commented she and her colleagues at the BU School of Public Health with NIH support have five year funding to look at the importance of Medicaid accountable care organizations (ACOs). Working with this population is another way in which Massachusetts is a healthcare leader, and that Medicaid ACOs are very well developed. Looking at this for maternal health, we're finding some positive impacts, particularly with regard to engagement and care for those engaged in working with Medicaid ACOs.

Ms. Moscato commented on the dependency of staffing to run the programs noted in the presentation. She asked where Dr. Fitzgerald Lewis sees the workforce today and in the future.

Dr. Alonso Lord said one thing she wanted to highlight is that the strategy we're taking is really grounding it in community relationships and community involvement. And so with doulas, with midwives, and with community health workers, a lot of this work has to be driven by the people who are either already doing the work or want to do the work, but have already identified the barriers into entering the workforce. We spend a lot of time talking to groups and coalitions and associations and making sure that we're hearing the pulse of what is it that would make the workforce attractive. For those that are already in the profession, what would help them stay or what would help them come back? So, one of the things that we're thinking deeply about with the expansion of universal home visiting is how we can bring nurses back to be able to provide that service. We need at least 100 nurses to be able to expand. We've also heard from nurses that being able to go to a new family's home and provide direct nursing support, the real essence of nursing care, is very attractive. We’re trying to figure out how we can make those bridges happen.

Dr. Cruz-Davis commented that the work they’re doing, including looking at perinatal health, maternal mental health, and ensuring community involvement, is so key to the strategies that are needed to address these issues. She said it is inspiring to see the involvement and the work that's put in. She applauded the doula certification program and the visiting nurse strategy.

Dr. Bernstein noted one slide where there was a mention of the of change in the policies and social welfare around taking children away from mothers with substance use. He asked what the impact of that policy is.

Dr. Elaine Fitzgerald Lewis shared that the work they’re doing through DPH is possible because of their collaboration with DCF, recognizing the complex nature of not only supporting the birthing parent, but also the infant. And how do they ensure the safety and the protection of both while supporting them through their journey. They recognize that whether you're in early or later recovery, that parenting, especially a newborn or a newborn that may have additional needs, is very challenging while the supports you have, if you've gone through this journey, is that much more limited or constrained. So much of the work that they've been focusing on over the last year has really been to identify what are the barriers in the facilitators, where can they clarify so it can be easier for providers to make appropriate referrals, to whether it's services and or do the filings to DCF because that protection is needed. They're still in the midst of figuring out those policies and those regulations and that guidance.

Dr. Bernstein thinks it should be on an individual basis rather than automatic. He thinks that women in treatment need to have special care in this the application, because if you break that bond so early, holding the baby and being with the baby, even if it's just for a week when they're making an investigation, he thinks that would be a mistake.

Dr. Elaine Fitzgerald Lewis said in fact, they just had their fall PNQIN summit and the entire focus was on perinatal mental health, substance use, and the impact on the dyad, looking at separating the infant too early from their mother, it does have long term implications. These are all the conversations that they're having to date and thinking about how do they support and ensure the unification of the family and support successful health and development.

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 January 15, 2025 at 9:00 am.

Commissioner Goldstein asked if there was a motion to adjourn.

Dr. Cruz-Davis made the motion which was seconded by Dr. Volturo. All present members approved.

The meeting was adjourned at 11:08 am.