PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Tuesday, December 19, 2006, 10:00 a.m., at the John W. McCormack Building, One Ashburton Place, 21st Floor Conference Rooms, Boston, Massachusetts. Members present were: Chair Paul J. Cote, Jr., Commissioner, Department of Public Health, Atty. Michael C. Hanson , Soo J. Kim, Atty. Jennifer A. Nassour, Ms. Maureen Pompeo, Mr. Albert Sherman, Gaylord B.Thayer, Jr., and Martin J. Williams., M.D.; absent was Clifford Askinazi, M.D. Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chair Cote announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Brunilda Torres, Director, Office of Multicultural Health; Mr. James West, Chief Demographer & Epidemiologist, Center for Health Information, Statistics, Research & Evaluation; Mr. Pejman Talebian, Operations Director, Division of Epidemiology and Immunization; Mr. Steven Hughes, Director, Community Sanitation Program, Center for Environmental Health; Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control; Ms. Joan Gorga, Director, Mr. Bernard Plovnick, Consultant Analyst, and Mr. Jere Page, Senior Analyst, Determination of Need Program; Associate Commissioner Alfred DeMaria, M.D., Center for Communicable Disease Control and Acting Director, State Laboratory Institute; and Atty. James Ballin, Deputy General Counsel, Office of the General Counsel of the Department of Public Health.

STAFF PRESENTATIONS:

"Implementing New Race, Ethnicity, and Language Data Collection Standards: An Overview", by Brunilda Torres, Director, Office of Multicultural Health

Excerpts from the presentation follow:

"…Bruce Cohen and I have been working on developing standards around race, ethnicity and language, and most recently have worked with the hospitals on implementing the Division of Health Care Finance and Policy's standards, and we wanted to apprise the Council of what we were doing, and other folks, in terms of the importance of the collection of race, ethnicity and language."

"Briefly", she said, "I am just going to cover these topics:

- The history
- Why we need more detailed information
- Identifiers to define some of our principles
- Basic concepts: What is race and ethnicity?"

"Race: Referring to a group or groups that an individual identifies with because there is a shared quality, either physical characteristics or social and geographic origins. Ethnicity is a person's background, heritage, culture, ancestry, and where they were born, or their parents were born, or their grandparents were born."

"In the 1990s, we developed detailed ethnicity and perinatal reports. At the end of the last century, we had our three population perinatal reports: births to mothers, Black mothers, births to Latinas, and births to Asian mothers, and really looked at what those populations were…"

"In 2000, with federal dollars, we started to look at all our databases – there were sixty-five (65) databases at that time and we looked at how the different programs collected race and ethnicity information and all that was collected was Hispanic ethnicity and race…"

"In 2001, the implementation of the Emergency Room Interpreter's Law required, through regulations, the collection of race and ethnicity and language data"

In 2002, we began meeting internally with all those managing the sixty-five databases to see what our standards looked like."

In 2005, collaboration with the Boston Public Health Commission's effort on eliminating disparities by looking at standards/regulations for collecting race and detailed ethnicity data"

"In 2006, working with Division of Health Care Finance and Policy, reviewing their case mix data regulations"

"…Birth data is the cleanest data that we have and where we collected detailed ethnicity information. If we look at the mother's race, just by racial categories, it doesn't look very busy. It doesn't provide us with many of the details that we might need for targeting interventions to eliminate infant mortality disparities. When we look at the mother's ancestry as looking at ethnicity, we see a much more rich and detailed information data about who are the mothers that are delivering babies in this state, who are residing in this state, and we have a very different picture."

As an example, Ms. Torres noted that under the Asian Race category, Japanese, Asian Indian, Vietnamese, Laotian, and Cambodian would be in one Asian Race category and it would be difficult to target any interventions to a particular ethnic population. Materials targeted to the Japanese population would be very different than material targeted to the Vietnamese, Laotian, and Cambodian populations which have less education.

"What are our principles?", stated Ms. Torres, "We are encouraging self-report by patient, by client, allowing for the selection of multiple categories; detailed ethnicity groups we are collecting, as well as broad racial groups. We are incorporating language preference as a basic sociodemographic characteristic, and we are maintaining consistency with the Federal Office for Management and Budget (OMB) standards."

"What are our proposed standards?", said Ms. Torres, "We have a five question format that defines a minimum set of categories. Should programs have populations that are represented on that minimum set of categories? We are allowing for expansion to meet the local needs. We also have some please specify categories for free text, and maintaining consistency with Federal standards."

The five questions are:

1. It is the Hispanic identifier (required by Federal funders). It's a yes/no question. Are you Hispanic/Latino/Spanish?

2. What is your ethnicity? (You can specify one or more)

3. What is your race? (You can specify one or more)

4. In what language do you prefer to discuss your health-related concerns?

5. In what language do you prefer to read health-related materials?

Ms. Torres noted, "Studies have shown that if one has two race categories and two ethnicity categories, one can capture 95% of the populations. If we add on a third choice, then we would capture 98% of the populations." Ms. Torres said that they would like to have a question around literacy but they haven't worked out the standard yet.

Ms. Torres said further, "…If you collect ethnicity data, we sort of get a better understanding of who people are because we tend to be whoever we are in whatever context we are in. Therefore, it is less context dependent. It absolutely helps us in terms of targeting programs and developing programs, and it improves our sensitivity to what are the linguistic needs, and to be able to identify what interpreter services we may need or how we will serve those and it provides just an added insight into acculturation."

It was noted that this data collection tool has been implemented in Massachusetts' hospitals. This data collection tool has also been field tested on about 9,000 patients, primarily at Massachusetts General Hospital and at their Chelsea clinic, and on 1,200 WIC participants. DPH provided training to about 200 registrars.

Ms. Torres said, "We are trying to help the respondents understand the importance of the information. Research has shown that people are not reticent to provide the information. They provide it more, and feel more comfortable providing it when we talk about how we will use the data, and indicate what the quality improvements are that the information will help us make."

In closing, Ms. Torres stated, "…The training for data collectors is crucial and concentrating on the purpose and the strategies, reaching out to our community partners, is also essential. Implementation in hospital settings would not have been possible if we had not reached out to our hospital

partners. The same thing as we are implementing them in our DPH programs, we are going to be reaching out to our community partners, and there is a need to bring IT into the process because it has major implications for how the data system is set-up."

NO VOTE/INFORMATION ONLY

"Lessons Learned from the MDPH Native American Health Status Report", by James West, Chief Demographer & Epidemiologist, Center for Health Information, Statistics, Research & Evaluation

Mr. West presented the Native American report to the Council. In his introduction he said, "We released this historic report in November 2006 at the Diversity Council's American Indian Month Presentation. I have to give a little background on this report. It made history and is making history. Nationally, it is the first comprehensive report on Native Americans Health by any state. In Massachusetts, it was the first statewide report on Native Americans by the Department…" Some excerpts from the report follow:

According to the U.S. Census 2000:

- The per capita income for American Indians in Massachusetts is 60% of the state per capita income.

- The proportion of American Indian families living below 100% of the poverty level is three times that of the state average.

- The proportion of American Indians who have less than a high school education is almost twice that of the state average.

Poor education and poverty are associated with poorer health outcomes, and the findings for American Indians in Massachusetts are no exception.

- According to data from the Massachusetts Behavioral Risk Factor Survey, more than 29% of American Indians reported being in poor or fair health as compared with about 13% for the state overall.

- According to Massachusetts birth data, the proportion of American Indian mothers who reported smoking during pregnancy is three times

that of all mothers.

American Indians have less access to health care than Massachusetts residents overall. For example, the proportion of American Indians who reported having no health insurance on the Behavioral Risk Factor Surveillance System was 2.3 times greater than that of the state as a whole, and the proportion of those who reported being unable to see a doctor due to cost was over twice that of Massachusetts overall.

American Indian youth also experience poorer outcomes when compared with all Massachusetts high school students.

- The proportion of American Indian high school students who reported being involved in gangs is over three times that of all other students.

- American Indians were 32% less likely to go to a 4-year public college and almost twice more likely to work after graduating from high school than all students.

- The proportion of American Indian high school students who reported attempting suicide is more than 2.5 times that of all other students.

Mr. West stated, "The lessons learned from producing this report, it shows about ability to focus on specific groups. There is no group, there is no other state which has this report. And then, we were enriched, particularly in the births, by having the ethnicity component. The mortality rates are unnaturally low. And in this report, having used fourteen data sets, which we can't exactly compare, we can't compare death results with birth results in terms of population because they are collected by different standards. We need one standard and we need ethnicity to be part of that, and language. This report forms a baseline by which we can judge subsequent outcomes for Native Americans…"

Chair Cote, Commissioner of Public Health, added, "…Those were very valuable reports, and I think they underscore the potential of the initiative in terms of our new data collection activities. I think the problems that we ran into, albeit problems that I think are still minimal compared to the, actually publishing of the report of Health Status of Indians within Massachusetts. As we become successful in implementing these new data collection standards, we really will be able to have a much more robust population to

analyze and I think that obviously the key thing is not just the analysis itself, it is how we can actually target our efforts to correct any problems with particular interventions for these population groups. I think this is very valuable."

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF OCTOBER 24, 2006 AND NOVEMBER 14, 2006:

Records of the Public Health Council Meetings of October 24, 2006 and November 14, 2006 were presented to the Council for approval. Council Member Sherman moved approval. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Records of Public Health Council Meetings of October 24, 2006 and November 14, 2006 with a correction to the Minutes of November 14, 2006: On page 12, the typo "usual" should be changed to "unusual" for Dr. DeMaria's statement.

PROPOSED REGULATION:

INFORMATIONAL BRIEFING ON AMENDMENTS TO 105 CMR 220.700: MENINGOCOCCAL VACCINE REQUIREMENTS FOR STUDENTS AND 105 CMR 221.300: DISSEMINATION OF INFORMATION ABOUT MENINGOCOCCAL DISEASE AND VACCINE:

Mr. Pejman Talebian, Operations Director, Division of Epidemiology and Immunization, gave the informational briefing on Amendments to 105 CMR 220.700 and 105 CMR 221.300 to the Council. Mr. Talebian indicated that the statute was amended (MGLc.76§15D) that now limits the meningococcal vaccination requirement to newly enrolled full-time students attending a secondary school or postsecondary institution who will be living in a dormitory or comparable congregate living arrangement licensed or approved by the institution. [The previous statute also applied to non-residential students attending a secondary or postsecondary institution.] In addition, this new amendment allows students to register without a certificate of immunization, provided that proof of the required immunization is provided within 30 days of registration (this is consistent with other college immunization requirements). [The previous statute required a certificate of immunization two weeks prior to the beginning of

classes].

Staff is proposing to amend two related sets of regulations (1) Meningococcal Vaccine Requirements for Students at Secondary Schools and Postsecondary Schools that Provide or License Housing (105 CMR 220.700); and (2) the Dissemination of Information about Meningococcal Disease and Vaccine (105 CMR 221.300).

The proposed amendments are summarized below in bold:

1. Definitions

- **Students:** For the purposes of 105 CMR 220.700, students shall mean:

  (a) full-time students newly enrolled at a secondary school who will be **living in a dormitory or comparable congregate living arrangement** licensed or approved by the secondary school; or

  (b) full-time undergraduate or graduate students newly enrolled in a degree granting program at a postsecondary institution who will be **living in a dormitory or comparable congregate living arrangement** licensed or approved by the postsecondary institution.

2. Student Requirements

- **Vaccine Type:** No newly enrolled full-time student attending a secondary school or postsecondary institution who will be living in a dormitory or comparable congregate living arrangement licensed or approved by the secondary school of postsecondary institution may be registered without a certificate of immunization documenting that the student has received a dose of meningococcal **polysaccharide** vaccine within the last 5 years (**or a dose of meningococcal conjugate vaccine at any time in the past**). No student shall begin classes without this certificate, except

as provided in 105 CMR 220.700 (C).

- **Timing of Immunization:** Whenever possible, the required immunization is to be obtained prior to registration. However, a student subject to 105 CMR 220.700 may be registered without a certificate of immunization provided that the student supplies a certificate of immunization **within thirty (30) days of registration** and provided, further, that the secondary school or postsecondary institution has policies and procedures for ascertaining which students have failed to provide the required certification within 30 days and for taking appropriate follow-up action to ensure compliance with 105 CMR 220.700.

Amendments to 105 CMR 221.300

Chapter 111, §219 requires public and private secondary schools, colleges, universities, day care centers, and youth camps to provide to a parent or guardian, or to a student 18 years of age or older, information approved or provided by the Department regarding the risk of meningococcal disease and the availability, effectiveness and risks of meningococcal vaccine. This requirement is reflected in existing DPH regulations (105 CMR 221.300).

Chapter 219 of the Acts of 2006 and the proposed regulatory amendments above, however, specifically address issues of meningococcal vaccine immunizations for newly enrolled full-time students at secondary and postsecondary schools living in a dormitory or comparable congregate living arrangement licensed or approved by the school. Accordingly, with respect to students attending postsecondary institutions and secondary schools, it is proposed to amend 105 CMR 221.300 to require provision of DPH approved information about meningococcal disease and vaccine only to those new students who are **not** living in a dormitory or comparable congregate living arrangements licensed or approved by the postsecondary institution or secondary school.

NO VOTE/INFORMATION ONLY

REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENT TO LONG TERM CARE REGULATIONS 105 CMR 150.000: NURSING HOME SATISFACTION SURVEY:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented the request for final approval of the nursing home satisfaction survey to the Council. Dr. Dreyer informed the Council that a voluntary survey was conducted in 2005 as was required by the legislature [c.184 of the Acts of 2002]. Staff's memorandum to the Council dated December 19, 2006 further explained, "Sixty-six percent of the eligible facilities participated and 64% of eligible responsible parties returned surveys. After further screening, 14,886 surveys or 58% of returned surveys were determined to be usable." "Essentially," stated Dr. Dreyer, "the surveys were sent to all long-term care facilities in the Commonwealth. The facilities provided a list of names of family members to DPH. What this amendment does today, is make this survey participation mandatory instead of voluntary. Mandatory participation means that all eligible long-term care facilities would send lists of residents with stays of four weeks or longer and the names of those responsible for their care to the Department. We expect that mandatory participation would produce at least 22,000 usable surveys (an increase of slightly over 7,000 from the 2005 process)." Dr. Dreyer indicated that a public hearing was held (October 31, 2006) in which written testimony was received from the Coalition of Organizations to Reform Eldercare, which was in support of the survey and the amendment.

Staff's memorandum, notes the satisfaction measures in the survey which are: (1) staff and administration; (2) physical environment; (3) activities; (4) personal care; (5) food and meals; and (6) personal rights.

Council Member Sherman made the motion to approve the amendment. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Request for Final Promulgation of Amendments to Long Term Care Regulations 105 CMR 150.000: Nursing Home Satisfaction Survey**; that a copy of the amended regulations be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14, 870**.

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 410.000: MINIMUM STANDARDS OF FITNESS FOR HUMAN HABITATION (STATE SANITARY CODE, CHAPTER II):

Mr. Steven Hughes, Director, Community Sanitation Program, accompanied by Attorney James Ballin, Deputy General Counsel, Office of the General Counsel, Department of Public Health, presented the request for final promulgation of amendments to 105 CMR 410.000.

Staff's memorandum to the Council, dated December 19, 2006, states the following: "That the amendments are to implement the requirements of Chapter 123 of the Acts of 2005, *An Act Relative to the Installation of Carbon Monoxide Alarms and Smoke Detectors in Residential Buildings* (the act is also referred to as Nicole's Law). The act took effect on March 31, 2006. It requires that all residential housing that contains fossil fuel burning equipment or an attached garage contain carbon monoxide (CO) alarms. Primary jurisdiction for implementation and enforcement of this new law is with the Board of Fire Prevention. The Board of Fire Prevention has promulgated regulations at 527 CMR 31.00, *Carbon Monoxide Alarms*, which specify the requirements for CO alarms in residential dwellings in MA. Section 4 (f) of the Act states that: 'The department of public health shall promulgate such rules and regulations as may be necessary to effectuate subsection (a) into the state sanitary code as established under section 127A of chapter 111.' Therefore, the Department of Public Health is proposing to amend the Housing Code in order to satisfy the statutory requirements set forth in section 4(f) of the Act…These proposed amendments incorporate these requirements in the Housing Code by reference to the appropriate Code of Massachusetts Regulations (CMR) citation. The amendments also refer to regulations issued by the Board of Examiners of Plumbers and Gas Fitters relating to CO alarms as well as regulations by the State Board of Building Regulations and Standards, which is expected to promulgate regulations relating to CO alarms in new construction."

The Department held a public hearing on November 28, 2006. Three people attended but none of them submitted any oral or written testimony. No

additional written testimony was received during the comment period subsequent to the public hearing.

Council Member Sherman moved for approval. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Request for Final Promulgation of Amendments to 105 CMR 410.000: Minimum Standards of Fitness for Human Habitation (State Sanitary Code, Chapter II)**; that a copy of the amendments be forwarded to the Secretary of the Commonwealth; and that a copy of the amendments be attached and made a part of this record as **Exhibit No. 14,871.** As approved, the Carbon Monoxide Alarm Amendments to 105 CMR 410.000 is as follows:

410.351: Owners Installation and Maintenance Responsibilities

The owner shall install in accordance with accepted plumbing, gasfitting and electrical wiring standards, and shall maintain free from leaks, obstructions or other defects, the following:

(A) All facilities and equipment which the owner is or may be required to provide including, but not limited to, all sinks, washbasins, bathtubs, showers, toilets, waterheating facilities, gas pipes, heating equipment water pipes, owner installed stoves and ovens, catch basins, drains, vents and other similar supplied fixtures; the connections to water, sewer and gas lines; the subsurface sewage disposal system, if any, all electrical fixtures, outlets and wiring, smoke detectors and carbon monoxide alarms, and all heating and ventilating equipment and appurtenances thereto; and

410.482: Smoke Detectors and Carbon Monoxide Alarms

(A) Owners shall provide, install, and maintain in operable condition smoke detectors and carbon monoxide alarms in every dwelling that is required to be equipped with smoke detectors and carbon monoxide alarms in accordance with any provision of the Massachusetts General Laws and any applicable regulations of the State Board of Fire Prevention (527 CMR), State Board of Building Regulations and Standards (780 CMR), or the Board of Examiners of Plumbers

and Gas Fitters (248 CMR).

(B) The board of health shall immediately notify the chief of the local fire department of any violation of 105 CMR 410.482 which is observed during an inspection of any dwelling.

(C) If any dwelling is found by the local fire department to be adequately equipped with smoke detectors and carbon monoxide alarms, the board of health shall not be authorized by 105 CMR 410.482 to impose any additional or differing smoke detector or carbon monoxide alarm requirement beyond that which has been found sufficient by the local fire department.

410.750: Conditions Deemed to Endanger or Impair Health or Safety

The following conditions, when found to exist in residential premises, shall be deemed conditions which may endanger or impair the health, or safety and well-being of a person or persons occupying the premises. This listing is composed of those items which are deemed to always have the potential to endanger or materially impair the health or safety, and well-being of the occupants or the public. Because, 105 CMR 410.100 through 410.620 state minimum requirements of fitness for human habitation, any other violation has the potential to fall within this category in any given specific situation but may not do so in every case and therefore is not included in this listing. Failure to include shall in no way be construed as a determination that other violations or conditions may not be found to fall within this category. Nor shall failure to include affect the duty of the local health official to order repair or correction of such violations pursuant to 105 CMR 410.830 through 410.833 nor shall failure to include affect the legal obligation of the person to whom the order is issued to comply with such order.

(N) Failure to provide a smoke detector or carbon monoxide alarm required by 105 CMR 410.482.

DETERMINATION OF NEED PROGRAM:

CATEGORY 1 APPLICATION:

PROJECT APPLICATION NO. 4-3A90 OF CHILDREN'S HOSPITAL, BOSTON:

Mr. Bernard Plovnick, Consulting Analyst, Determination of Need Program, said in part, "… Children's Hospital, the applicant, is seeking a Determination of Need for substantial change in service, to add four beds to its Neonatal Intensive Care Unit. If approved, the capacity of the existing unit, located on the seventh floor of the Children's Hospital inpatient tower at 300 Longwood Avenue, Boston, would be expanded to a total complement of twenty-four (24) beds. This application was filed subsequent to the Department's granting of an exemption to the standard DoN process on December 31, 2003, pursuant to Section 100.308 of the DoN regulations. The new beds have been operational since 2004, and there is no capital expenditure associated with this project. Unlike other Massachusetts hospitals currently operating Neonatal Intensive Care Units, Children's does not operate in obstetrical service. Thus, 100% of its NICU patients are transported from other facilities."

Mr. Plovnick continued, "Children's Neonatal Transport Program, operating through a network of affiliations and transfer protocols, bring critically ill newborns from area community hospitals to Children's NICU for care. In addition, a significant number of Children's NICU admissions are patients brought from other Boston area academic medical centers, from hospitals throughout New England, and from international sites, for advanced medical or surgical therapies not available at that birth institution. Children's thus serves as a regional referral hospital for newborns requiring quaternary procedures."

Mr. Plovnick said further, "During the five years prior to its application, Children's operated its NICU at three different levels of bed capacity, as a twenty-six (26), twenty-four (24) and twenty (20) bed unit. Operating as a twenty bed NICU, Children's indicated that it was turning away a growing

number of ICU transports and had experienced a shortage of beds during the respiratory illness season in winter. Recent experience has led Children's Hospital to conclude that the optimal NICU size for the present and foreseeable future is twenty-four beds…It is widely believed that an occupancy rate of between 85% to 90% is considered optimal, given the unpredictability of demand and the need to ensure a high probability of bed availability for an emergency."

In conclusion, Mr. Plovnick stated, "Failure to approve this application would result in the reversion of Children's to a 20 bed NICU service. By virtue of Children's consistently high census, and its role as a regional referral center for quaternary level services to ill newborns, the case for expanding its NICU unit by four beds is extremely compelling. Staff recommends approval of this project with one condition. This condition, recommended by the Office of Multicultural Health, is limited to specific language access improvements to be implemented by the hospital, and the applicant is in full agreement with staff recommendation."

Council Member Sherman asked if somebody could answer his question about the whooping cough situation at Children's Hospital. Dr. Alfred DeMaria, Associate Commissioner, Communicable Disease Control, and Acting Director, State Laboratory, replied that the Department was still in the investigatory phase of what the outbreak was. He said in part, "At the present time, it appears that it was not Pertussis or Whooping Cough. We are examining this further in collaboration with the Boston Public Health Commission, and the Centers for Disease Control (CDC) and trying to determine what happened with this respiratory illness at Children's Hospital…"

Discussion continued and Council Member Sherman stated further, "In the interest of full disclosure, the reason I ask is that, I think most of us glean most of our information from not only our professional background but also from our personal background. Children's Hospital had a couple of incidents several years ago where one child died as a result of whatever the case may be. I don't remember the investigation exactly. And the other child lived. I am the grandfather of the child who lived. Until today, I have not said anything to the Council about it. I feel that a hospital that from my perspective and those with whom I have spoken, has an extraordinary aura of arrogance about it can come in and ask for four more beds and has a condition running around the place, and nobody can lay their hand on it yet.

And if you can't, then frankly, I don't think anybody can…that's a backwards compliment but that is how I feel about it. I am reluctant to vote up front about replacing those four beds and nobody can tell me why everybody is coughing in the place. You tell me that it is twenty-nine (29) cases of Whooping Cough. It is my understanding, from what I hear on the street, that there are a lot more people coughing at Children's Hospital than 29 patients…I don't know if it is the same condition, but there's an awful lot of people coughing there. Now, until they tell me that have got their act together. I wish Nancy Ridley was here….She would tell me, this is the story. I would like to know what the story is."

Discussion continued and Dr. DeMaria said further, "The investigation is still ongoing. We have gotten full cooperation. They [Children's Hospital] were acting on our test results. We do know, with the investigation done by the Boston Public Health Commission and the Department, that there did not seem to be any ongoing transmission of any respiratory ailments, whatever that might have been. We think everything is under control now. It is just a matter of finding out what the illness was and we are working with the Centers for Disease Control and Prevention (CDC) because some other states have had similar situations. It is too early to say right now what it was. Right now, there does not appear to be any problem going on and they have been fully cooperating."

Council Member Sherman asked Dr. DeMaria again if Children's Hospital was really cooperating with the investigation and really trying to find the cause. Dr. DeMaria replied, "Yes".

Further discussion continued. Council Member Thayer inquired, "If the four beds are already operating why we are meeting then?"

Mr. Plovnick explained, "This particular request is eligible for a 105 CMR 100.308 exemption, under which the regulations require that the applicant submit a full application a year later, so that it can be examined and reviewed more closely. If the Council were to deny this application, Children's Hospital would have to remove the beds from service." Council Member Pompeo added, "The .308 was granted because they demonstrated need at that time." Mr. Plovnick and Chair Cote agreed. Mr. Plovnick further added, "It was several years ago and they have submitted information for the last five years, showing the beds are being used pretty fully."

Ms. Joan Gorga, Director, Determination of Need Program, clarified, "Regulation 100.308 allows the Department to put in place a request from an applicant if it is an innovative program or if it is an emergency action, etc. They obviously were having problems treating all the patients that needed their services and their census shows that, that for the last three years their census has been over twenty. They could not have treated all the patients with twenty beds because their census has been in addition to twenty. They are a referral center for neonatal care from hospitals around the state and because that kind of referral service cannot be scheduled, they need to have a bed in place when a baby from an outlying hospital needs it. So that's why, for example, their occupancy probably will never be very much above 85%. They are a small unit, but they need to have that in place. That bed cannot be scheduled for that patient. They came to us and said we were wrong to cut back. They originally did have more beds. They cut back, and they felt that they did need the beds, and that is why they asked us for them. We gave them a .308. They handed in the application, which is required of an applicant of a .308 and today we are acting on their application."

Council Member Soo Kim asked about the unmet need of about 17 beds statewide for neonatal services, even if the four Children's beds are approved. Ms. Gorga said in part, "…In the new perinatal regulations, hospitals may be able to do some more in the way of high tech under another level of care without calling it NICU. So I think, we may want to reduce that need in the future because the need can be met by a level slightly less than NICU."

Council Member Pompeo made the motion to approve the application**.** After consideration upon motion made and duly seconded, it was voted: (Chair Cote, Atty.Hanson, Ms. Kim, Atty. Nassour, Ms. Pompeo, Mr. Thayer and Dr. Williams in favor; and Mr. Sherman abstaining [Mr. Askinazi was absent] to approve **Project No 4-3A90 of Children's Hospital,** based on staff findings, with a maximum capital expenditure of $0 and estimated first year incremental operating costs of $1,641,454 (October 2004 dollars). A staff summary is attached and made a part of this record as **Exhibit No. 14, 872**. As approved, the application provides for the addition of 4 beds to its existing neonatal intensive care unit, located at the applicant's main campus at 300 Longwood Avenue, Boston, MA 02115, to increase the unit to 24 beds. This Determination is subject to the following condition:

1. Children's Hospital shall have in place the following missing elements of a professional medical interpreter services:

    - Policies and procedures that ensure availability and assure quality of interpreter services at its affiliated practices and centers;

    - Ongoing training for all hospital clinical staff on the appropriate use of interpreter services;

    - A comprehensive strategy to inform LEP community members and agencies identified in the HSA IV area of the availability of interpreter services;

    - An annual Language Needs Assessment utilizing external sources as well as internal sources of data, and involving community-based organizations in this process,

    - Inclusion of the Interpreter Services Manager in any decision-making that would affect people with LEP including, but not limited to, appropriate methodologies for collection of race and ethnicity data;

    - Inclusion of Interpreter Services Manager as a support to registration and admission departments as they implement the new regulations for the collection of race, ethnicity and language; and

    - Adherence to recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care.

    Also, Children's Hospital shall:

    - Notify OMH of any substantial changes to its Interpreter Services Program;

- Submit to OMH, within 120 days of DoN approval, a plan for improvement addressing the above items; and

- Provide to OMH an annual progress report on the anniversary date of DoN approval.

Staff's recommendation was based on the following findings:

1. Children's Hospital, the applicant, is proposing to add 4 Neonatal Intensive Care Unit ("NICU") beds to its existing 20-bed unit for a total of 24 NICU beds.

2. On December 31, 2003, the Department granted an exemption under Section 100.308 of the DoN Regulations to permit Children's to add 4 NICU beds.

3. The health planning process for this project was satisfactory.

4. Consistent with the 2002 Revisions to Determination of Need Guidelines for Neonatal Intensive Care Units, the Applicant has demonstrated need for the 4 NICU beds, as discussed under the health care requirements factor of the Staff Summary.

5. The project meets the operational objectives factor of the 2002 Guidelines.

6. The project meets the requirements of Factor 4 of the DoN Regulations.

7. No capital expenditure is associated with this project.

8. The recommended incremental operating costs of $1,641,454 (October 2004 dollars) are reasonable based on similar, previously approved projects.

9. The project is financially feasible and within the financial capability of the Applicant.

10. The project meets the relative merit requirements of the Guidelines.

11. The requirements under Factor 9 of the DoN Regulations do not apply to this project because there is no associated capital expenditure.

ALTERNATIVE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATIONS:

Mr. Bernard Plovnick, Consulting Analyst for the Determination of Need Program, noted for the record a correction to the docket. He said that the word "The" should be inserted in the 12/19/2006 docket so that the sole corporate member's name is "The Massachusetts General Hospital" on both transfer of ownership applications (docket item 5a Martha's Vineyard Hospital, Inc.) and docket item 5b (Nantucket Cottage Hospital).

PROJECT APPLICATION NO. 5-3B29 OF MARTHA'S VINEYARD HOSPITAL, INC. – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF MARTHA'S VINEYARD HOSPITAL RESULTING FROM A CHANGE OF CONTROL WHEREBY THE MASSACHUSETTS GENERAL HOSPITAL WILL BECOME THE HOSPITAL'S SOLE CORPORATE MEMBER:

Mr. Bernard Plovnick, Consulting Analyst, Determination of Need Program, presented Project Application No. 5-3B29 to the Council. Mr. Plovnick said, "Martha's Vineyard Hospital (MVH) is seeking the Council's approval today of a transfer of ownership resulting from a change in its control, whereby The Massachusetts General Hospital would become MVH's sole corporate member. MVH is located at 1 Hospital Road in Oak Bluffs. MVH is a Massachusetts Not-for-Profit Corporation, and consistent with the provisions of DoN Regulation 105 CMR 100.020, a change in the membership of a non- Profit Corporation is considered a transfer of ownership. MVH operates Martha's Vineyard Hospital, a geographically isolated, 19-bed acute care hospital, which is federally designated as a critical access hospital…The hospital serves a population of 15,000 year-round residents, plus an additional 90,000 residents and visitors. MVH also operates WNR, Inc., doing business as Windemere Nursing and Rehabilitation Center, a 61-bed skilled nursing facility. Located on the hospital campus, Windemere is organized as a subsidiary of the hospital."

Mr. Plovnick clarified, "The Massachusetts General Hospital is the sole member of the General Hospital Corporation, Inc. which, as I indicated, operates Massachusetts General Hospital. It is also the sole member of the Massachusetts General Physicians Organizations, Inc., The McLean Hospital Corporation, The MGH Institute for Health Professions, Inc., and the North End Community Health Center, Inc. The Massachusetts General Hospital and its subsidiaries are all part of the Partners Health Care System, Inc., an integrated health care network founded in 1994 by the MGH, and Brigham and Women's Hospital."

Mr. Plovnick said further, "Based on our review of the application, including agreements signed by all parties, staff has determined that the proposed change in control of MVH satisfies the following five standards set forth under the DoN regulations regarding a hospital change of ownership:

1. Individuals residing in the hospital's service area will continue to comprise the majority of individuals responsible for decisions concerning borrowings, changes in service and capital and operating budgets. The hospital's Board of Trustees in the future will be composed of 80% island residents and 20% MGH or Partners representatives.

2. The Applicant and staff consulted with the Executive Office of Health and Human Services (EOHHS) concerning the access of Medicaid recipients to medical services at Martha's Vineyard Hospital. In written comments, that you will find attached to the staff Summary, EOHHS found no existing access problems for medical services for Medicaid recipients in the MVH primary service area and MVH will continue to make access to health care services for Medicaid recipients a priority

3. The Department's Division of Health Care Quality found that neither the Applicant nor any of its affiliates have engaged in a pattern or practice in violation of the provisions of Massachusetts General Laws relative to discrimination against Medicare recipients in discharge planning.

4. The Department, in recognition of Chapter 58 of the Acts of 2006, an Act Providing Access to Affordable Quality Accountable Health Care, is not imposing a specific free care condition with the expectation that

the Applicant will not change its free care policy, in a way that would result in a loss of benefits to individuals who would have been eligible for free care.

5. The Applicant applying for the transfer of ownership is an acute care hospital licensed by the Department.

Mr. Plovnick further explained, "There were no parties of record registered with this application, nor did anyone request a public hearing. This project has no capital expenditure associated with it. Upon implementation of this transfer of ownership, The MGH has agreed to transfer five million dollars to MVH, to fund unspecified future capital improvements at the hospital campus. That expenditure was not subject to review as part of this application."

In conclusion, Mr. Plovnick stated, "Staff recommends approval of this application with one condition as indicated on pages three and four of the Staff Summary. The condition, recommended by the Office of Multicultural Health, is limited to specific language access improvements to be implemented at the hospital. The applicant is in full agreement with staff recommendation…"

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Senator Robert O'Leary, representing Cape Cod and the Islands, addressed the Council on the Martha's Vineyard Hospital and Nantucket Cottage Hospital applications. Senator O'Leary said in part, "…I have been involved in this over the last several months. I participated in a public forum on the Vineyard some weeks ago and I have been in contact with my constituents on Nantucket, both in the community, at the political level, and the hospital, and there is nearly universal support for this. There is a real recognition on both islands that, because they are islands, and because they are isolated, and because they are aging, as the community, health care is an enormous concern, and because it is becoming more sophisticated and more complicated, access and a relationship with an entity like Partners is something that is highly desirable, and they feel that there is a real community of interest here, and a real public benefit..."

He said further, "I am pleased to point out that Partners has expressed interest in becoming more involved in community-based health care issues

on both islands, as well, services that play outside the hospital and outside the institution. I think this is really a positive step." Senator O'Leary stated that he supports the applications.

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A brief discussion followed. One of the questions asked was by Council Member Pompeo who inquired about the composition of the new boards, as a result of the acquisitions. Mr. Timothy Walsh, President of the Martha's Vineyard Hospital answered the question. "80% of the Board will be island residents, and the other 20% will be from Mass. General Hospital and Partners Health Care. The 80%: island board members will nominate replacements for island residents to Partners, and Partners will nominate them to be the island trustees…The board term will be for three years and with a three-year term limit except for officers."

Ms. Joan Gorga, Director, Determination of Need Program, wanted to make a clarification. She said, "Bernie had mentioned that there was a contribution of five million dollars, which was not a capital expenditure. There were no capital expenditures. I want to clarify that this was a voluntary contribution. There are no capital expenditures, and that is why it is not subject to Determination of Need, and that is for both hospitals, five million dollars voluntary contribution from The Massachusetts General Hospital to both hospitals."

Council Member Soo Kim made the motion for approval. After consideration, upon motion made and duly seconded, it was voted unanimously [Attorney Nassour and Mr. Sherman* were not present during the vote; therefore they did not vote] to approve **Project Application No. 5-3B29 of Martha's Vineyard Hospital, Inc.**, based on staff findings, with a maximum capital expenditure of $0. *For the record, Council Member Sherman supports the approval of this application. A staff summary is attached and made a part of this record as **Exhibit No. 14, 873**. As approved, the application provides for the transfer of ownership and original licensure of Martha's Vineyard Hospital Inc. resulting from a change in its corporate membership whereby The Massachusetts General Hospital will become the Hospital's sole corporate member and assume control over Martha's Vineyard Hospital and its subsidiary, WNR, Inc. d/b/a Windemere Nursing and Rehabilitation Center. This Determination is subject to the following condition:

1. With regards to its interpreter service, the Applicant shall maintain its capacity to ensure the availability of timely and competent interpreter services and have in place the following missing elements of a professional medical interpreter service:

   1. Policies and procedures that include:

   - Use of trained interpreters, including hospital staff, to provide medical interpretation and/or logistical support;
   - Prohibition of the use of children as interpreters;
   - Use of telephonic services only as a last resort;
   - Inclusion of recently enacted operating procedures for accessing medical interpretation; and
   - Ongoing training for all hospital clinical staff on the appropriate use of interpreter services.

   b) Inclusion in the hospital data collection system of self-reported race, ethnicity and language information from patients as per the DPH Guidelines and Division of Health Care Finance and Policy case mix data requirements.

   c) Submission of a plan to the Office of Multicultural Health (OMH) describing how the Hospital will use the new data collected on race, ethnicity and language to improve care for all patients.

   d) Inclusion of the Interpreter Services Director in any decision-making that affects people with Limited English Proficiency (LEP) including appropriate methodologies for collecting race and ethnicity data.

   e) Continued posting of signage in the Emergency Department and at all key points of entry into the hospital as required by 105 CMR 130.1108. Signage must be available in the primary languages identified by the language needs assessment that

informs patients of the availability of interpreter services at no charge.

f) Continued outreach to the LEP communities in the Hospital's service area to ensure their knowledge of the Hospital's services.

g) Continuing assurance that established translation procedures and guidelines are followed for developing timely, accurate, competent, and culturally appropriate patient educational materials.

A plan to address these interpreter service elements shall be submitted to the Office of Multicultural Health within 120 days of the DoN approval, and the Applicant shall notify OMH of any substantial changes to its Interpreter Services Program. Also, the Applicant shall follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. In addition, the Applicant will provide annual progress reports to OMH on the anniversary date of the DoN approval.

PROJECT APPLICATION NO. 5-3B30 OF NANTUCKET COTTAGE HOSPITAL – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF NANTUCKET COTTAGE HOSPITAL RESULTING FROM A CHANGE OF CONTROL WHEREBY THE MASSACHUSETTS GENERAL HOSPITAL WILL BECOME THE HOSPITAL'S SOLE CORPORATE MEMBER:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented Project Application No. 5-3B30 to the Council. He said in part, "…This is very similar to the previous project, the transfer of Martha's Vineyard. The standards of review [for an Alternative Process Transfer of Ownership Application] we looked at were the same for both hospitals. The first standard, individuals residing in the hospital's service area will comprise the majority of the individuals responsible for decisions concerning borrowings, changes in service and capital and operating budgets. Two, the hospital consulted with the Executive Office of Health and Human Services (EOHHS) concerning the access of medical services to Medicaid recipients at the hospital, and EOHHS determined that no access problems exist for Medicaid

recipients in the Nantucket Cottage Hospital's primary service area. There has been no pattern of discrimination against Medicare recipients in discharge planning by the hospital and, in recognition of the Universal Health Care Bill, the Acts of 2006, the Department is not imposing a specific free care condition. The expectation is that Nantucket Cottage Hospital...will not make changes in the free care policy that would result in a loss of benefits to people who have been eligible for free care in the past…"

Council Member Pompeo inquired about the composition of the Hospital Board as she did for the prior application. Staff replied that the composition will be the same ratio as Martha's Vineyard Hospital (80% Islanders-20% MGH representative ratio).

Council Member Thayer, Jr., asked if the hospitals were merging or what mechanism causes this to happen? Dr. Peter Slavin, President, Massachusetts General Hospital clarified that "The Massachusetts General Hospital Board will become the sole member of the Nantucket Cottage Hospital Board. We are not purchasing Nantucket Cottage Hospital." He also indicated that a legal agreement between the two hospitals subject to the Council's approval is the mechanism by which this occurs today. Ms. Lucille Giddings, President/CEO of Nantucket Cottage Hospital, added, "The Nantucket Cottage Hospital keeps its name and its core identity, and that was very important to the community, as well as to Massachusetts General Hospital – that we remain local and true to all of the aspects of health care on the island, and everyone was very supportive of that." Chair Cote added, "And that relationship is clearly spelled out within financial statements and other disclosures as well." Council Member Kim asked about any pending law suits – "…would MGH acquire those liabilities?" Ms. Giddings replied, "If you mean malpractice cases, as opposed to other law suits, there are three cases that are currently on the books and we [Nantucket Cottage Hospital] would still assume those responsibilities." Ms. Kim clarified, "So your entity stays in place. It just gets acquired to another holding company." Ms. Giddings agreed and stated, "Right, and that really speaks to the sustainability of the Nantucket Cottage Hospital, and that is why this is such a benefit to us, because of the ability to look at services that we may need to enhance, or build upon, or to create new, and also to be able to obtain some of the special bond ratings and things like that, that we can't currently; and for us, it is not

hundreds of thousands of dollars. It is nickels and dimes and dollars that we have to have to make sure to be able to support our institution."

Council Member Hanson made the motion for approval. After consideration, upon motion made and duly seconded, it was voted unanimously [Attorney Nassour and Mr. Sherman* were not present during the vote; therefore they did not vote] to approve **Project Application No. 5-3B30 of Nantucket Cottage Hospital,** based on staff findings, with a maximum capital expenditure of $0. *For the record, Council Member Sherman supports the approval of this application. A staff summary is attached and made a part of this record as **Exhibit No. 14,874**. As approved, the application provides for the transfer of ownership and original licensure of Nantucket Cottage Hospital resulting from a change of control whereby The Massachusetts General Hospital will become the Hospital's sole corporate member. This Determination is subject to the following condition:

With regards to its interpreter service, the Applicant shall establish policies and procedures that include:

- The use of only trained interpreters, including hospital staff, to provide medical interpretation and/or logistical support.

- The use of face to face interpreter services as the primary mechanism for providing medical interpretation.

- The inclusion of new Hospital operating changes in policies and procedures involved with medical interpretation.

- A reliable and valid system to track, monitor, and arrange for all interpreting sessions inclusive of the use of employees.

- Agreement to take no disciplinary action relating to the effects of an employee's provision of volunteer interpreter services while on duty on the employee's job performance.

- Signage posted on the availability of interpreter services at no cost in the Emergency Department and at all key points of entry

into the hospital as required by 105 CMR 130.1108.

- The provision of ongoing training for all the Hospital's clinical staff on the appropriate use of interpreter services and diversity/cultural competency training.

- Development of a comprehensive strategy to outreach and inform Limited English Proficiency ("LEP") community members and agencies identified in the Hospital's service area about availability of interpreter services.

- The submission to the Office of Multicultural Health (OMH) of an annual Language Needs Assessment as required by 105 CMR 130.1103 and utilizing external sources as well as internal sources of data, and involving community-based organizations in this process.

- The inclusion in the Hospital data collection system of self-reported race, ethnicity and language information from patients, as per DPH guidelines and Division of Health Care Finance and Policy case mix data requirements.

- The inclusion of the Interpreter Services Coordinator as a support to registration and admission departments for the collection of case mix data involving race, ethnicity and language.

- Submission of a plan to OMH detailing how the hospital will use data collected on race, ethnicity and language to improve care for all patients.

- Inclusion of the Interpreter Services Director in any decision-making that affects people with LEP, including appropriate methodologies for collecting race and ethnicity data.

- Establish a plan to ensure that freelance and/or per diem medical interpreters deliver competent and quality medical interpretation services.

A plan to address these interpreter service elements shall be submitted to the Office of Multicultural Health (OMH) within 120 days of the DoN approval, and the Applicant shall notify OMH of any substantial changes to its Interpreter Services Program. Also, the Applicant shall follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care. In addition, the Applicant will provide annual progress reports to OMH on the anniversary date of the DoN approval."

Staff's recommendation was based on the following findings:

Based upon a review of the application as submitted and clarification of issues by the Applicant, Staff finds the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. Staff also finds that the Applicant satisfies the standards applied under 100.602 as follows:

A) Individuals residing in Nantucket Cottage Hospital's health systems area comprise a majority of the individuals responsible for decisions concerning:

1. approval of borrowings in excess of $500,000;
2. additions or conversions which constitute substantial change in services;
3. approval of capital and operating budgets; and
4. approval of the filing of an application for Determination of Need.

Under the terms of the proposed transaction, 80% of the Hospital's trustees will be appointed by the Hospital, whose board of trustees has historically been represented by a majority of residents of the Hospital's primary service area.

B) The Applicant has consulted with EOHHS concerning the access of medical services to Medicaid recipients at Nantucket Cottage Hospital. Comments submitted indicate that EOHHS has determined that no access problems exist for Medicaid recipients in Nantucket Cottage Hospital's primary service area, and that EOHHS anticipates that the Hospital will continue to make access to Medicaid providers

and primary care for Medicaid patients a priority.

C) The Division of Health Care Quality has determined that the Applicant and any health care facility affiliates have not been found to have engaged in a pattern or practice in violation of the provisions of M.G.L.c.111, §51(D).

D) In recognition of Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care, the Department is not imposing a specific free care condition. The expectation is that the Applicant will not make changes in its free care policy that would result in a loss of benefits to people who would have been eligible for free care.

E) The Applicant is an acute care hospital licensed by the Department.

The meeting adjourned at 11:30 a.m.

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LMH/lmh Paul J. Cote, Chair