**MINUTES OF THE PUBLIC HEALTH COUNCIL**

**Meeting of February 12, 2020**

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**PUBLIC HEALTH COUNCIL**

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**Henry I. Bowditch Public Health Council Room, 2nd Floor**

**250 Washington Street, Boston MA**

**Docket: Wednesday, February 12, 2020 - 9:00 AM**

1. **ROUTINE ITEMS**
	1. Introductions
	2. Updates from Commissioner Monica Bharel, MD, MPH.
		* Release of Opioid-related Overdose Death Data, 4th Quarter 2019
	3. Record of the Public Health Council January 15, 2020 Meeting. **(Vote)**
2. **DETERMINATION OF NEED**
	1. Request by Partners HealthCare System, Inc. for substantial change in service to add three MRI units. **(Vote)**
3. **FINAL REGULATIONS**
	1. Requset to approve for final promulgation regulation 105 CMR 665.000, *Minimum Standards for Retail Sale of Tobacco and Electronic Nicotine Delivery Systems.* **(Vote).**
4. **PRESENTATIONS**
	1. Developing a Public Health Awareness Campaign.

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

**Public Health Council**

Attendance and Summary of Votes:

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

**Date of Meeting:** January 15, 2020

**Start Time:** 9:16AM **Ending Time:** 11:46AM

| **Board Member** | **Attended** | **First Order: Approval of January 12, 2020 Meeting Minutes (Vote)** | **Second Order:**  **Partners HealthCare System DoN Application (Vote)** | **Third Order: Approval of Final Regulations 105 CMR 665.000 (Vote)** |
| --- | --- | --- | --- | --- |
| Commissioner Monica Bharel | Yes | Yes | Yes | Yes |
| Edward Bernstein  | Yes | Abstained | Yes | Yes |
| Lissette Blondet | Absent | Absent | Absent | Absent |
| Derek Brindisi | Yes | Abstained | No | Yes |
| Kathleen Carey | Yes | Yes | Yes | Yes |
| Secretary Elizabeth Chen | Yes | Yes | Yes | Yes |
| Harold Cox | Yes | Yes | No | Yes |
| John Cunningham | Yes | Yes | Yes | Yes |
| Michele David | Absent | Absent | Absent | Absent |
| Michael Kneeland | Yes | Yes | Yes | Yes |
| Keith Hovan | Yes | Yes | Yes | Yes |
| Joanna Lambert | Yes | Yes | Yes | Yes |
| Lucilia Prates-Ramos | Yes | Yes  | Yes | Yes |
| Secretary Francisco Ureña | Yes | Yes | Yes | Yes |
| **Summary** | **12 members present, 2 members absent** | **10 members approved, 2 members absent, 2 members abstained** | **10 members approved, 2 members oppose, 2 members absent** | **12 members approved, 2 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, February 12, 2020 at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108.

Members present were: Edward Bernstein, MD; Monica Bharel, MD, MPH; Derek Brindisi; Kathleen Carey, PhD; Secretary Elizabeth Chen, PhD, MPH, MBA; John Cunningham, PhD; Michael Kneeland, MD; Keith Hovan; Joanna Lambert; and Lucilia Prates-Ramos.

Members arriving late: Harold Cox (9:18); Secretary Francisco Ureña (9:20).

Absent members were: Lissette Blondet; Michelle David, MD.

Also in attendance was Margret Cooke, General Counsel at the Massachusetts Department of Public Health.

Commissioner Bharel called the meeting to order at 9:16AM and made opening remarks before reviewing the agenda.

**1. ROUTINE ITEMS**

**b. Updates from Commissioner Monica Bharel, MD, MPH**

Commissioner Bharel stated before the Council reviews and votes on minutes from the December Public Health Council meeting, she wanted to share a few highlights regarding recent public health work taking place at the Department and across the state.

*Coronavirus*

Commissioner Bharel stated she wanted to start by giving the Council an update on novel coronavirus, which was first identified in Wuhan, China in late December. The World Health Organization has declared the 2019 novel coronavirus a Public Health Emergency of International Concern. And U.S. Health and Human Services Secretary Alex Azar declared a public health emergency for the United States to aid the healthcare community in responding. As reported by the CDC on Monday, there are over 40,000 cases and over 800 deaths, with 99% of all cases in China. As of Monday, the U.S. has 12 confirmed cases, including 1 in Massachusetts. While person-to-person spread among close contacts has been detected with this virus, the virus is NOT currently spreading in the community in the U.S.. DPH’s key message to the public is that the risk to Massachusetts residents remains low at this time. Commissioner Bharel emphasized that DPH is experienced in public health emergencies. DPH has been working very closely with CDC, other federal agencies, and our local boards of health and clinical partners to educate the public about this novel virus, investigate suspected cases, and isolate and support the one confirmed case of coronavirus in Massachusetts. DPH has implemented its emergency incident command structure, and through daily meetings, DPH continues its disease surveillance and coordination, as DPH continues to provide the most updated guidance to communities, local boards of health, hospitals and health systems, colleges and universities, EMS, and its legislative partners. The most up-to-date information on this evolving public health issue can be found at DPH’s new website at www.mass.gov/2019coronavirus. As DPH continues its efforts, Commissioner Bharel wanted to remind everyone that while Massachusetts has a single confirmed case of novel coronavirus, Massachusetts has tens of thousands of influenza cases. The prevention message is the same and DPH asks people to continue with precautions as with any virus: wash hands often with soap and water for at least 20 seconds, cover your coughs and sneezes, and stay home if you are sick.

*Vaping Update*

Commissioner Bharel stated, in December, the Council approved an emergency regulation implementing several key pieces of last year’s tobacco law addressing vaping and flavored tobacco. And today DPH hopes to finalize that regulation so we all can turn to implementing those parts of the law that take effect in June 2020, such as restricting use and sale of all flavored tobacco products to smoking bars only. Commissioner Bharel added, as the Council knows, these measures came out of the Administration’s response to the vaping public health emergency. Since mandating clinicians report all suspected cases of unexplained lung illness associated with vaping, known as EVALI, DPH has reported 37 confirmed cases and 75 probable cases of EVALI to the CDC. Unfortunately, there have been four deaths attributed to EVALI in Massachusetts since DPH began collecting the data. DPH continues its cessation programming and focus on reducing use among youth in particular. Commissioner Bharel then referred to slide 1 in the powerpoint, noting that these tobacco cessation efforts are part of a long history in Massachusetts of passing progressive, high-impact policies that raise the price of tobacco, prevent underage sales, restrict product availability in the retail environment, and de-normalize tobacco use in public spaces. However, in the past decade, the expedient proliferation of flavored tobacco products, including vape products, has undermined decades of progress. Commissioner Bharel then referred to slide 2, noting in implementing last year’s tobacco and vaping law, DPH is trying to reverse this trend by implementing the nation’s most significant restrictions and protections on vaping and flavored tobacco. She noted that Council members can see from the data on the screen vaping is still a significant issue among Massachusetts youth. 2019 data shows that half of Massachusetts high school students said they had used vape products and one third said they had used vape products in the past month. Commissioner Bharel concluded that she wanted the Council members to see this data today because for her, it drove home yet again just how important the work we are doing in Massachusetts and as a Council. Through the 2019 law and the regulatory process, the Commissioner stated we will drastically reduce the availability of flavored tobacco products and vape products for sale by local retailers to reduce exposure, access, and use of these dangerous, deadly products by youth.

*Budget Overview*

The Commissioner stated since the Council last met, Governor Baker filed his proposal for the fiscal year 2021 budget, or H.2, which includes $699M in funding for the Department, as well as a supplemental budget for FY20. Each of these includes critical funding and policies impacting the Department the Commissioner would like to review with the Council.

*FY21 Budget*

Vaping Epidemic: H.2 dedicates $4M to support addressing the vaping epidemic across a public health continuum of prevention, intervention and awareness. Funds will support numerous initiatives including a multi-media vaping awareness campaign, cessation support through expansion of the Quitline capacity, and funds to municipalities for required enforcement activities such as retail surveillance and community education.

Vital Records: The budget proposal invests an additional $880,000 in the operations of vital records to modernize, secure, and eliminate risk for the Registry of vital Records. This investment is accompanied by a $6.6M capital investment request in FY21. H.2 also updates the laws governing the registry – laws that have not been significantly updated since the 1930s. DPH wants registration of births, deaths, and marriages to align with national best practices for the protection of personally identifiable data and confidential health information.

PFAS Testing: H.2 includes $1.2M in funding for DPH’s Bureau of Environmental Health to support inspections, laboratory testing, and toxicology analysis related to PFAS and other emerging contaminants at over 2,500 food and bottled water facilities and other buildings.

Family Planning Services: The Governor’s FY21 budget proposal includes $13.7M to continue the state’s strong investment in and support of family planning services, including funding to continue services previously funded federally in light of Title X program changes at the Federal level. This funding will allow DPH to continue to support 65,600 patients annually.

Lead Poisoning Prevention: H.2 level-funds the Childhood Lead Poisoning Prevention Program at $2.7M to continue supporting critical initiatives to investigate children or facilities with lead exposures and implementing wide-scale childhood lead prevention efforts among populations most vulnerable to lead exposure. These funds are critical to DPH’s implementation of the strong regulatory reforms the Council was instrumental in finalizing and adopting.

Nuclear Power Plant Assessment: The Governor’s FY21 proposal would authorize DPH to assess the operators of nuclear reactors that are in the process of being decommissioned (e.g. Pilgrim) for associated required radiation monitoring and emergency planning costs.

*FY20 Supplemental Budget*

EEE Prevention and Awareness: After a very active EEE season and in planning for summer 2020, the Governor’s supplemental budget request includes $1.8M for the State Laboratory and Communicable Disease Control Services for EEE prevention and awareness.

New Tobacco Law: The request includes $2M that will support enforcement by local boards of health and to provide technical assistance, continue media campaigns related to vaping, and evaluate public health issues related to vaping.

 Long-Term Care Facilities: The proposal ensures DPH has the ability to more fully evaluate suitability of nursing home applicants and licensees, and expands the Department’s enforcement options when rules are not followed by increasing fines and broadening authority to freeze admissions or suspend a license.

SANE Program: The FY20 supplemental budget would allow DPH to establish a cost-sharing mechanism with facilities, such as hospital emergency rooms, that participate in the Sexual Assault Nurse Examiner (SANE) program, in order to establish a stable funding model following the end of federal funding.

The Commissioner stated that she will bring more on these pieces as the budget process moves forward, and hopes the Council will join the Department in supporting these key initiatives.

*Quarterly Opioid Data Report*

The Commissioner stated that she wanted to present the new quarterly opioid overdose report being released today. As the Council knows, these reports help guide the Commonwealth’s response to the opioid epidemic. They are snapshots in time and provide the data that state and local communities need to assist us in responding more effectively. Referring to the powerpoint, the Commissioner presented the data. The rate of opioid-related overdose deaths fell an estimated 5% from its peak in 2016. This decrease is despite the growing presence of fentanyl, which DPH’s data show is a driver of opioid-related deaths. DPH also examined the trajectory of the opioid epidemic from the counts of opioid-related deaths in 2016 if the 2012-2016 rate of increase continued beyond 2016, as compared to the rate of increase DPH has actually seen. Thanks to public health interventions, the death rate has flattened instead of climbing. Providers continue to use MassPAT as a tool in their prescribing. Referring to the powerpoint, the large increase in searches is likely attributed to continued integration of the PMP into larger EHR systems. The Commissioner concluded that this data and report are a reminder that we all must continue to collectively address the current opioid epidemic and addiction overall with continued resources, a focus on highest risk populations, and working through a public health approach.

With no further questions or comments, the Commissioner proceeded with the docket.

**1. ROUTINE ITEMS**

**c. Record of the Public Health Council January 15, 2020 Meeting (Vote).**

Commissioner Bharel asked if any members have any changes to be included in the January 15, 2020 meeting minutes.

Commissioner Bharel asked for a motion to accept the minutes. Motion to accept minutes, Mr. Hovan made the motion and Secretary Chen seconded it. Dr. Bernstein and Mr. Brindisi abstained. All other present members approved.

**2. DETERMINATION OF NEED**

**a. Request by Partners HealthCare System, Inc. for substantial change in service to add three MRI units. (Vote).**

Commissioner Bharel invited Margo Michaels, Director of the Determination of Need (DoN) Program, and Rebecca Rodman, Deputy General Counsel, to review the DoN staff summary for Partners HealthCare’s request to add three MRIs. Commissioner Bharel stated that there is a representative present of the Melrose-Wakefield Ten Taxpayer Group (TTG) that formed related to this application here to speak. Mayor Joseph Curatone of Somerville is also here to address the Council. Additionally, there are representatives of the applicant at the meeting today, who are available to respond to questions after all groups have provided their remarks. The Commissioner asked the Council members to hold all questions for staff and the applicant until conclusion of all the presentations.

Before Ms. Michaels began, the Commissioner gave Mr. Hovan a moment to leave the room as he recused himself from participating in this determination of need application.

Upon conclusion of the presentation, the Commissioner invited Ryan Fuller and Charles Whipple of the Melrose-Wakefield Healthcare TTG to provide remarks regarding the application.

Mr. Fuller and Mr. Whipple expressed concerns with Partners HealthCare’s plans. While they are respectful of the DoN program’s review and staff recommendations, they believe that the applicant did not adequately satisfy the DoN factors related to patient-payer need; the proposed project will compete on the basis of price or total medical expense; and the applicant’s plans will not help the Commonwealth meet its cost containment goals. Mr. Fuller asserted there are substitute methods for meeting the patient panel needs and questioned whether the Applicant considered its system-wide MRI capacity when demonstrating need for the patient panel and instead only focused on a subset of the patient panel – MGPO and MGH. Mr. Fuller indicated this analysis did not give the Commonwealth a full picture of whether this project is actually needed or if there are alternatives that would the needs of the patient panel. Mr. Fuller stated that Partners could move existing resources between existing facilities to increase efficiency in existing capacity, and indicated approval of this project would result in a total of 55 MRIs in the Partners system, including other recently approved units not yet online. The TTG’s report estimates that each MRI would have 8,000 scans per machine; however, DPH staff’s report disagreed and cited a figure of 5,200-7,000 capacity per magnet. Using DPH’s lower estimate, Partners, through their 55 MRIs would screen 286-385K patients annually, 19% of the total patient panel annually or one out of every five of patients. Unfortunately, Partners did not provide MRI utilization for its system-wide patient panel; however, only 8.6% of the MGH/MGPO patient panel requirement an MRI in FY18. This is roughly a third of the patient panel, so roughly 130,000 patients needed an MRI within Partners. Should this application be approved, this would translate in to Partners running a capacity between 34-55% system-wide. Did the applicant investigate whether it could relocate machines in its system with low capacity where demand is higher? Why wasn’t this considered under factor 5? As it relates to factor 1F and factor 2A, Mr. Fuller does not believe the applicant would compete on price, total medical expense, provider costs, and other recognized measures of health care spending. This would not help the Commonwealth meet their goals of cost containment, improve public outcomes, and delivery system transformation. While he commends Partners for shifting MRIs from higher-priced hospitals to free-standing settings, Partners makes no commitment to transfer Partners’ high-priced MRIs to lower costs. Furthermore, The Health Policy Commission (HPC) in its 2009 cost trends report cautions though that shifting care from inpatient to outpatient settings can save money, savings are limited because lower-priced systems are losing volume to higher-priced systems like Partners. HPC found that Massachusetts is fourth highest for imaging spending services in the country, 14% higher than the U.S. average, and this is a contributing factor to the overall high costs of health care in the Commonwealth. Partners’ payer mix is roughly 60% commercial and 9% Medicaid. Factor 5, in its application, the only alternative to the proposed project that Partners considered was to do nothing. Several other alternatives should have been considered by the applicant. For example, as an alternative to new machines, did Partners consider relocating existing machines that have excess capacity? If they did consider this alternative and chose not to pursue it, what were the reasons? Why were these questions not considered? As an alternative to the project, did Partners consider contracting with existing providers in the area to provide MRI services to the patient panel, especially those providers who already offer these services at lower freestanding rates. This could potentially increase efficiencies and promote cost-containment. If they considered this alternative and chose not to pursue it, what were the reasons? Why were these questions not considered? If applicants only consider “do nothing” as a potential alternative to a project, this essentially renders Factor 5 meaningless. As such, Mr. Fuller asked program staff when considering all future projects, to ask at a minimum if existing resources and services be relocated or realigned to meet the identified need across the system or if contracting with other providers were considered during the process – buy vs. build. Mr. Fuller asked the Council to consider two further actions related to this approval. First, that the Council consider making a motion to make preliminary action on this application pursuant to 105 CMR 100.620 and to resume consideration at the next Public Health Council meeting. This action will allow the Department and Council members time to consider the concerns raised regarding the failure to meet the DoN conditions of approval and consider adding new conditions of approval. Second, Mr. Fuller asked the Council to consider a phase-in approach of the applicant’s request. This would require the applicant to demonstrate that the first machine is operating at 90% before the second machine is added, and for the second to operate at 90% before the third is added. Using the Partners’ yearly scan projection for the Somerville site submitted to the staff’s question number three and using DPH’s high and low estimate of 5,200 and 7,000 scans per machine, Partners projects that the Somerville site will operate between 37% and 50% capacity in year one, between 46 and 62% in year two, and between 66% and 89% capacity in year three. A staggered approval would ensure the applicant is only permitted to increase capacity based on true patient need, making sure costs are not increased unnecessarily. Mr. Fuller thanked the Council in advance for their consideration.

Once Mr. Fuller concluded his remarks, Commissioner Bharel thanked Mr. Fuller for being here to testify and invited Mayor Joseph Curatone to address the Council.

Mayor Curatone stated that the proposal will be an important addition to Somerville and improve access to services for the City’s residents who currently have to travel outside their city for their care and is reflected in the City’s wellbeing report and in the five-year health improvement plan. Mayor Curatone added that if this MRI clinic is allowed to open, patients would have increased access to needed health care services and importantly no longer have to travel into the heart of Boston when they need an MRI, with more convenient access to MRI services that allows patients to obtain their results more quickly for faster diagnosis and treatment as well as peace of mind for individuals facing a potential health crisis. The Mayor indicated the Somerville community welcomes this new service respectfully urged the council to support the staff recommendation.

Commissioner Bharel thanked the Mayor for being here today and then invited representatives of the applicant, Ms. Michaels, and Ms. Rodman to the table to address any questions Council members may have.

Secretary Chen asked if the applicant can address some of the concerns the TTG laid out in their presentation.

Dr. Timothy Ferris stated that the Determination of Need process is a very important process because it helps us all gain perspective because need is always in the eye of the beholder and these conversations are essential to helping us and all the parties involved come to a common understanding. Dr. Ferris thanked the staff for diligently producing this work. Dr. Ferris asked Secretary Chen for clarification around her questions.

Secretary Chen elaborated, the alternatives that the TTG presented and their two alternative suggestions that were not in the Partners application, and to speak to whether the applications were considered and if they were, what the downside would be. The first one was relocation of machines across the system and the second is why the applicant did not consider contracting with local providers.

Dr. Ferris stated that care is local and the delivery of care should be. For example, we have a scanner in Cooley-Dickenson Hospital in Western Massachusetts and we have scanners on the islands, so the number of the scanners does not reflect that these MRI machines are dispersed throughout the state. And they do not meaningfully provide access to people that are so far away from them as Mayor Curatone mentioned. Additionally, the capacity estimates that we have are based on a lot of changes in the use of this technology, and as a primary care doctor, Dr. Ferris wanted to provide one example on the changing use of this technology. Prostate cancer, which is one of the most common cancers, there is trouble detecting this cancer because the available technology to detect it, a PSA test, has a lot of false positives and a lot of false negatives. In the last several years, the technology of using MRIs in combination with a PSA test has dramatically decreased the morbidity associated with testing of biopsies of prostates so they are doing less invasive procedures because we are able to image better using these magnets, a process that did not exist a few years ago. This is one example of the new uses of MRIs that are increasing the use of MRI to decrease the illness burden and simplify the process of diagnosis illness in patients.

Dr. David Rossman stated that regarding addressing capacity issues, Partners cannot take the one MRI at Cooley-Dickenson and move it to Assembly Row because then there would be no services in Western Mass, nor could Partners take MRIs from the Cape and Islands and move it to Somerville because then there would be no services there. There is also some capacity in Wentworth-Douglas hospital, but that is not in our state. For example if you look system-wide at Partners’ metro Boston area locations, there is no capacity in those pieces of equipment. If you were to try to get a scan today and you go and see a doctor and have headaches and they do not think it is a tumor but they are worried and request a brain MRI and you are on main campus at Mass General, our first available appointment during any primetime is almost nine weeks out now at 55 days. Regarding capacity constraints, we talk about whether a scanner can do 5,000, 6,000, or 7,000 scans, the only way to get to those numbers is if the machine is operating a scanner 16 hours per day, which works for some of us in the room, but the elderly population, somebody with children, they cannot get to those. Those waits in the North Shore are six to seven weeks out, in Waltham six weeks out, and so there is no capacity in the system that is mobile. Regarding partnering with local providers, this is a continuity of care issue. From a radiology perspective, having the prior examinations means everything. If he is following your cancer and does not have all of the prior examinations, does he know whether or not that chemotherapy is working. Being able to see changes in a patient’s response is critically important because it allows us to keep on the drug or change if it is not being effective.

Secretary Chen asked in the age of electronic health records (EHR), is there some way to share records across systems.

Dr. O’Neil Britton stated that he was responsible for implementing EHR across Partners and that other providers’ systems do not interact well with Partner’s EHR system. The ability to detect subtle changes in images, and the ability to communicate with physicians, and have a coordinated care plan to consult with physicians. The complexity of our patients, we do tests that are very complex and our patients are comfortable with their current radiologist would be disrupted. Yes, we would like to get to a point where one day we all have the same systems, but the day that comes, they will also be worried that they would be sending patients our way again – it is a two way street.

Mr. Brindisi asked a question for Mr. Ben Wood, a DPH employee, about if health care access was a priority in the 2017 Cambridge Health Alliance Somerville Health Improvement Plan.

Commissioner Bharel invited Mr. Wood to the table to answer.

Mr. Wood stated yes.

Mr. Brindisi stated so it sounds like the community is working with Partners to address one of the priority areas. Regarding the phase-in approach, Foxborough just received one MRI and Waltham received two, he asked if the applicants can address the phase-in approach.

Dr. Rossman stated that there are multiple components. One is the economies of scale by having multiple MRs simultaneously, we create much more efficiency in being able to operate the practice and move patients in. The other piece is addressing the current backlog at Partners’ main campus, which has an almost nine-week wait time for MRIs. One MRI wouldn’t make the difference; Waltham still has a four-week backlog.

Dr. Ferris stated that one other issue that this proposal is addressing is a pervasive technology issue. Many of the new studies that need to be done need to be done on a three-tesla magnet and a lot of the systems that the TTG was citing are 1.5-tesla magnets that cannot do the studies that are required in the contemporary environment.

Mr. Brindisi asked the applicant what the projected wait time they are trying to achieve with this proposal.

Dr. Rossman stated that it is his hope is to move as many patients as they can that are low acuity into the less expensive outpatient centers. Being able to do that does a couple of productive things. For example, MassGeneral is one of the only sites in the state that provides MRIs to people with pacemakers, and the first available appointment for that is in November 2020. So the hope is to move the folks who need a knee or prostate MRI to Somerville and keep the slots available for those cardiac MRIs.

Dean Cox asked the applicant if they can help with the idea of excessive imaging.

Dr. Ferris stated we are very fortunate to live in the only state in the country with a cap on TME expenditures and Partners has stayed under that cap every year since 2012 when it was implemented. So that is overall spending. He finds it difficult to understand the meaning of the data when you take one thing out of context regarding excessive imaging. We have the lowest mortality in the country, is the highest imaging rate in the country contributing to that? It is difficult to look at one fact in isolation, so he prefers to look at total spending, which in this state is relatively high, but when adjusting for Massachusetts’ standard of living, we are actually on the low end of costs. They have been working for 20 years on the issue of appropriateness for imaging, and as a primary care clinician, he has been subjected to the appropriate use methodology regarding ordering tests.

Dr. Jim Brink stated the decision support system they use was simultaneously launched at Brigham and MGH and has been in use for 15 to 20 years. He would say that because of that experience, Partners’ rate of inappropriate ordering imaging is 1-2%, national rates are 6%. Through the PAM legislation of 2014, it has now become the law of the land that as of this past January, all sites across the country use a decision support system for high cost imaging. 2020 is the grace period, but in January 2021, there will be penalties imposed for not using such systems. What he is proud of is that that legislation was inspired by the work here in Boston, and the system we use in Boston called ACR select is very similar to the homegrown system they made, which helped inspire a national movement.

Dean Cox stated it gets confusing for those of us who are not physicians to hear terms like excessive imaging and what does it mean. He thanked Margo for a comprehensive presentation. He asked the applicant if the Council approves this, what the real impact of these additional conditions that DoN staff has requested.

Ms. Michaels stated that the DoN staff are monitoring these conditions for five years, once the machines are operational they have to report to DPH annually, and depending on those statistics DPH can ask for explanations as to what has changed. The regulation allows DPH to put other conditions in place if the applicant is not meeting the original conditions.

Dean Cox stated but once the Council gives approval, this additional data just clarifies, but does not allow for enforcement.

Ms. Rodman stated if we find they are not complying, they need to get in compliance before they can apply for any other DoN across their system.

Dean Cox stated that this leads to the TTG’s concerns and the impact this proposal would have on a particular community and on a particular community hospital, but as the Council starts thinking about what its role is and thinking about the overall system and thinking about the responsibility we have to other community hospitals, this has an impact on what is happening to us. He asked the panel what the role of the Council is in this.

Ms. Rodman stated the regulation permits the Council to look at the need for this applicant and whether they made the case for their patients; DoN is not the only tool and lever in the Commonwealth that looks at how and where health care is provided.

Dean Cox asked the DoN staff if they are in disagreement with the TTG’s formula.

Ms. Michaels stated that the DoN staff respects their opinion, but the number they gave us was not realistic and we were not able to verify whether 55 MRI machines across the Partners system was correct. The DoN staff found that the applicant addressed that there would be a reduction in wait times at the main campus if these MRIs open, leading to less wait time as well as helping the community’s residents.

Dr. Bernstein stated that he is trying to create access and convenience, is that the intention there so there doesn’t have to be an extra trip to Boston? He then used prostate cancer as an example.

Dr. Brink stated what the imaging at Assembly Row would provide is the testing needed to address and monitor something like prostate cancer.

Dr. Bernstein asked the applicant about where the biopsy itself would take place.

Dr. Brink stated that the biopsy itself would happen at the main campus and the MRIs could be shipped electronically to the main campus and that would allow the urologist to make the appropriate determination.

Dean Cox stated he had a question about the phase-in approach, asking the applicant if it is just a matter that it is ideal to have the number of devices they are asking for. He explained that what the applicant is saying makes sense; however, it is the Council’s responsibility to think about the overall system and that the community hospitals are just as important as our large tertiary hospitals. He asked the applicants if there is a way to do the phase-in so we can look at the data to see if there is a need and how is it being utilized and what is the impact of the patient panel as well as the system as a whole.

Dr. Britten stated at the end of the day, these are our patients and they want to get care with us, but the wait time is balancing the needs of some patients on other patients. Partners did an experiment where we ran MRIs from 7am-11pm, but then we started scanning people at 5am, and we experimented for 1.5 months doing MRIs 24 hours a day and some patients showed up but it was not enough to justify the expense. Partners calculated that we need these magnets and are totally supportive of the community hospitals thriving. The phase-in does not address the issue entirely, to go from nine-week wait times to seven-week wait times, then wait two years and go to five-week wait times.

Dr. Carey stated she has two issues: the first being patient convenience, and the second is the wait time issue. She stated that these wait time numbers are totally inconsistent with her personal experience at Partners and does not think it is a nine-week wait time.

Dr. Rossman stated that the numbers come from MassGeneral booking, at the main campus during primetime which is from 8am-6pm, it is 55 day waiting time. If you go non-primetime it is 25 day. We live in a system of privilege where those that can figure out how to utilize the system are able to have less wait times than those who cannot.

Dr. Carey asked if there is a considerable amount of triage.

Dr. Rossman stated yes, we did an evaluation of the effect of wait times across demographics, if those who were offered same-day MRI, private payer it did not increase. However, for Medicaid patients it went up four times, compared to thirty day wait times; it went up two times for white patients, three times for black patients, and eight times for Hispanic patients.

Dr. Cunningham stated in our new conditions, we are monitoring partners MRI vs non-partners MRI. He asked the DoN staff what the compliance/non-compliance threshold is for cases 10% non-partners.

Ms. Michaels stated the percentage in report we wrote, that there would not be an appreciable difference. If we see a crazy imbalance of partners-ordered MRIs vs. non-partners-ordered MRIs, it would deem them out of compliance.

Dr. Cunningham asked what the threshold is.

Ms. Michaels stated that we do not know what the baseline is yet, so that is the first thing. If Partners does say that they are focusing on the patients at Partners, we would need to see the vast majority of cases coming from Partners patients.

Dr. Ferris stated a lot of healthcare demand is generated by patients and consumers, MRIs are not generated by consumers, a physician orders an MRI; for an outside patient to come to their MRI center, an outside physician would have to refer them to that.

Dr. Kneeland stated that he recognized that Partners hospitals are world-class hospitals; what he is hearing is the wait time is unacceptably high, this seems to be an effort to reduce the wait time while simultaneously making it easier for patients to get an MRI and not have to drive in the heart of Boston. He asked if that summary is accurate.

Dr. Bernstein asked about the payer mix and whether we are tracking it.

Ms. Michaels stated as part of the annual reports, they are required to show the annual payer-mix.

Dr. Rossman stated we have that data and we are happy to share it.

Ms. Rodman asked if Dr. Bernstein is asking if there something specific that we can add to the annual report.

Dr. Bernstein stated yes.

Ms. Michaels asked Dr. Bernstein if he is asking the comparison of wait times as it compares to payer mix.

Dr. Bernstein stated yes, as well as access to these services.

Commissioner Bharel asked Dr. Bernstein if he is asking for a comparison of wait time or procedures done.

Dr. Bernstein stated both.

Dr. Rossman stated Partners track by race, ethnicity, socioeconomic status, He added they do not have a recommendation on how to add it to the form.

Ms. Cooke asked if they need a minute to discuss.

Ms. Rodman stated yes with Partners.

Commissioner Bharel stated that they should continue discussion and then discuss after.

Dr. Bernstein stated his point is there is equity in the reduction of wait time.

Dr. Rossman stated he thinks we know that wait times affect vulnerable populations and we know moving this forward would reduce those wait times for vulnerable populations.

Secretary Ureña asked the applicants when the MRI machines would come online.

Dr. Rossman stated 2021.

Secretary Ureña stated any data we would see would be a year after that.

Dr. Rossman stated correct.

Ms. Rodman stated that the what they think you want is the report on the rate of cancelation and no-shows by race, ethnicity, income level, payer, and wait time. She asked if Partners could break that out.

Dr. Ferris stated yes and we are happy to.

Ms. Rodman stated she is repeating again, wait time and rate of cancelations and no-shows broken out by race, ethnicity, income, and payer.

Dr. Ferris stated the income will have to be zip code census analysis.

Dr. Bernstein stated to take out income.

Commissioner Bharel stated that income should be taken out because it would not be accurate.

Ms. Cooke stated that the TTG wants to speak again.

Mr. Fuller stated that he thinks this recent conversation urges us to take a pause and he understands that Cooley-Dickenson and the Cape cannot be moved but there are 53 other MRIs across the Partners system, and he thinks the phase-in approach still would work.

Dean Cox stated he wanted to get the real impact, asking Mr. Fuller if he could help clarify who are the patients we are talking about. He asked if there is a concern that having this device in Melrose-Wakefield’s catchment area would syphon real patients.

Mr. Fuller stated that they are looking at patients being referred outside the system. Melrose-Wakefield has seen a significant decline looking at new patients coming in and selecting Partners. They have seen a significant decline in those patients looking at those services and more providers are choosing Partners as well.

Commissioner Bharel stated with no further questions, she would now like to ask if there is a motion to add the condition to the application. Dr. Bernstein made the motion and Dr. Cunningham seconded it.

Ms. Rodman stated that there would be additional condition to require the holder report on the wait time and rate of cancelations and no-shows divided by race, ethnicity, and payer mix.

Commissioner Bharel asked if they all approve.

Everyone approved.

Commissioner asked if there was a motion to accept the staff recommendation to approve Partners HealthCare’s request for three MRI units. Dr. Cunningham made the motion and Dr. Kneeland seconded it.

All approved except for Dean Cox and Mr. Brindisi.

Commissioner Bharel stated that the staff recommendation for approval of this substantial change in service is approved as amended.

At 11:03, Dr. Kneeland left for the day. Ms. Lambert, Dr. Carey, and Secretary Chen left the room.

At 11:05, Mr. Hovan returned to the room.

**3. FINAL REGULATIONS**

**a. Request to approve for final promulgation regulation 105 CMR 665.000, *Minimum Standards for Retail Sale of Tobacco and Electronic Nicotine Delivery Systems*. (Vote).**

Commissioner Bharel invited Ms. Lea Susan Ojamaa, Deputy Director for the Bureau; Ben Kingston, Director of Policy for the Bureau; and Lynn Squillace, Deputy General Counsel for the Department, to the table to present on final changes to DPH’s regulation addressing tobacco and vaping product sales.

Upon the conclusion of the presentation, the Commissioner asked the Council if they had any questions.

11:07, Secretary Chen and Ms. Lambert returned to the room.

11:08, Dr. Carey returned to the room.

Dean Cox thanked the presenters for the last comment they made about Local Public Health, if there are additional resources that DPH can provide to local public health because to put these regulations into effect it will cost money. He asked if there is consideration of additional financial resources to assist them with enforcing the regulations.

Ms. Ojamaa stated as the Commissioner mentioned earlier in the meeting the funding in the supplemental budget filed by the Governor will include additional funding for resources for enforcement. She added we already fund 155 municipalities and we are doing a Notice of Intent (NOI) for those that are not funded and we will utilize emergency contracts to fund these unfunded municipalities.

Dr. Bernstein asked if DPH can track products on the street.

Mr. Kingston stated the difficulty of tracking the products is that there are diverse in where they come from and some have serial numbers and some do not.

Mr. Brindisi stated the staff mentioned funding the unfunded municipalities, has there been a conversation about trying to regionalize the unfunded municipalities.

Ms. Ojamaa stated that as part of the Notice of Opportunity (NOO), we are asking municipalities to express interest to us and we are looking to pairing them regionally, they need to tell us their needs and resources needed.

Mr. Brindisi stated in this new regulation, you reference smoking bars, he asked what is the conversation around the smoke free workplace law (SFWL).

Mr. Kingston stated right now, vaping is covered by the SFWL, but smoking bars have exemption from the SFWL.

Commissioner Bharel stated with no further questions, she would like to request the Council vote to approve the post-public comment period changes to 105 CMR 665.000. She asked if there is there a motion for to approve 105 CMR 665.000. Dr. Bernstein made the motion and Ms. Prates-Ramos seconded it.

All present members approved.

**4. PRESENTATIONS**

**a. Developing a Public Health Awareness Campaign.**

Commissioner Bharel then invited Ms. Suzanne Crowther, DPH’s Health Marketing Director, to the table for a presentation on how public health awareness campaigns are developed. DPH’s Director of Communications Alison Cohen, will also come to the table to further introduce Suzanne.

Upon the conclusion of the presentation, the Commissioner asked the Council if they had any questions.

Dr. Bernstein asked if DPH advertises on Facebook.

Ms. Crowther stated yes, on Facebook and other social media platforms, which are really cost-efficient. Facebook is a regular part of DPH”s buy, as is Instagram, Snapchat, and they are exploring Tic-Tok.

With no further presentations, the Commissioner reminded the Council that the next meeting is Wednesday, March 11, 2020 at 9AM.

She then asked for a motion to adjourn. Secretary Chen made the motion, Dr. Bernstein seconded it. All present members approved.

The meeting adjourned at 11:46AM.