MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of January 15, 2024

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

**PUBLIC HEALTH COUNCIL MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**Henry I. Bowditch Public Health Council Room, 2nd Floor 250 Washington Street, Boston MA**

**Docket: \*\*\*REMOTE MEETING\*\*\* Wednesday, January 15, 2025 – 9:00AM**

***Note: The January 15 Public Health Council meeting will be held remotely as a video conference consistent with St. 2021, c. 20, s. 20, which provides for certain modifications to the Massachusetts Open Meeting Law.***

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

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Dial in Telephone Number: 929-436-2866 Webinar ID: 995 9081 5847

Passcode: 372728

1. **ROUTINE ITEMS**
	1. Introductions.
	2. Updates from Commissioner Robert Goldstein.
	3. Record of the Public Health Council Meeting held December 11, 2024 **(Vote)**.
2. **DETERMINATION OF NEED**
	1. Request by Atrius Health, Inc. for a freestanding ambulatory surgery center **(Vote).**
3. **PRELIMINARY REGULATIONS**
	1. Overview of proposed amendments to 105 CMR 210.000, *The administration of prescription medications in public and private schools.*

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

Attendance and Summary of Votes:

Presented below is a summary of the meeting, including timekeeping, attendance and votes cast.

Date of Meeting: January 15, 2024

Start Time: 9:02 am. Ending Time: 10:42 am.

| **Board Member** | **Attended** | **First Order:****Approval of****December 11, 2024 Minutes (Vote)** | **DON****Request by Atrius Health, Inc. for a Freestanding Ambulatory Surgery Center (Vote)** |
| --- | --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes | Yes |
| **Edward Bernstein** | Yes | Yes | Yes |
| **Lissette Blondet** | Yes | Yes | Yes |
| **Kathleen Carey** | Yes | Yes | Yes |
| **Emily Cooper** | Yes | Yes | Yes |
| **Harold Cox** | No | Absent | Absent |
| **Alba Cruz-Davis** | Yes | Yes | Yes |
| **Michele David** | No | Absent | Absent |
| **Robert Engell** | Yes | Yes | Yes |
| **Elizabeth Evans** | Yes | Yes | Yes |
| **Eduardo Haddad** | Yes | Yes | Yes |
| **Joanna Lambert** | Yes | Yes | Yes |
| **Stewart Landers** | Yes | Abstain | Yes |
| **Mary Moscato** | Yes | Yes | Yes |
| **Gregory Volturo** | Yes | Yes | Yes |
| **Summary** | 13 Members Present;2 Members Absent | 12 Members Approved;2 Members Absent;1Member Abstained | 13 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, January 15, 2024, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Commissioner Robert Goldstein; Edward Bernstein, MD; Lissette Blondet; Kathleen Carey; Emily Cooper; Alba Cruz-Davis; Robert Engell; Liz Evans; Eduardo Haddad, MD; Joanna Lambert; Stewart Landers; Mary Moscato; Gregory Volturo, MD.

Also in attendance was Beth McLaughlin, General Counsel at the Massachusetts Department of Public Health.

Commissioner Goldstein called the meeting to order at 9:02 am and made opening remarks before reviewing the docket.

**1. ROUTINE ITEMS**

*b. Updates from Commissioner Robert Goldstein*

**MLK Day**

Commissioner Goldstein said Monday is Martin Luther King Jr. Day, an opportunity to remember and celebrate the visionary leader who inspired and shaped the Civil Rights Movement. Of interest to those of us in public health, Dr. King also deserves recognition for his work promoting our collective understanding of health equity.

**CHEI Data Dashboard/Report**

Commissioner Goldstein said connected to our commitment to health equity, DPH continues to engage with communities and share data that can be used for policy making and action. DPH’s Community Health Equity Initiative recently rolled out several new ways to explore the 2023 Community Health Equity Survey data. First, there is a brand-new dashboard that allows anyone to access the data online. Second, we have a community partner data request form, which allows organizations and groups interested in reviewing and using data for the communities they work in and with to obtain specific cuts of the data. And third, we have posted a deep-dive report on mental health in Massachusetts based on data from the Community Health Equity Survey and other sources. Partners have already been using the Community Health Equity Survey data for a variety of efforts, including SNAP outreach, community health needs assessments, and developing guidance for providers serving gender-expansive clients.

**Barriers to Entry Project**

DPH’s Bureau of Health Professions Licensure and other related teams embarked on a project over the past year to help alleviate shortages in the health and human services workforce. In the Reducing Barriers to Entry project, DPH engaged in a series of intensive workshops and activities to improve processes and policies related to training, certification, and licensure for nursing, behavioral health, and direct care roles. Staff analyzed pain points in current procedures and developed almost 200 strategies to eliminate unnecessary barriers keeping health workers from practicing. This includes simplifying application steps, leaning on technology advancements to improve the user experience, bolstering support for internationally educated nurses and applicants whose first language is not English, and more. As of December, 87 solutions have already been implemented and 35 are in progress, with more to come.

Cumulatively, we expect these changes will significantly reduce licensure processing times, enhance clarity during application processes, improve communication and customer service for applicants, optimize technology to streamline processes, and help us develop a strategic road map for improving diversity and inclusion within the workforce.

**Emergency Board Regulations – Shield Law**

Last week, five of the Department’s Boards of professional licensure approved emergency amendments to regulations that will protect healthcare providers from disqualification from licensure and from Board discipline for providing, or assisting in providing, reproductive and gender affirming health care services in Massachusetts.

The Boards of Registration in Nursing, Medicine, Pharmacy, Physician Assistants, and Psychologist voted to implement and codify into regulation the provisions of the Shield Law, Chapter 127 of the Acts of 2022, *An Act Expanding Protections for Reproductive and Gender Affirming Care,* to reinforce consistency with the law and to reassure providers in Massachusetts who may fear action against their license for providing, or assisting in providing, these services lawfully and consistent with good medical practice in the state. The emergency amendments reflect the rapidly evolving variations in state laws applicable to reproductive and gender-affirming health care services across the country. These amendments help reassure healthcare providers in Massachusetts of their protections from license denial, or disciplinary actions related to circumstances arising from the provision of reproductive and gender-affirming health care services.

This action by the Boards sends a powerful and reassuring message to the dedicated Massachusetts healthcare professionals who provide compassionate, high-quality, reproductive and gender-affirming health care, and who should be supported and celebrated in our Commonwealth. Similar amendments will be considered by the Boards of Registration of Social Workers and Genetic Counselors in the coming weeks. Doing the right thing for patients should never be a source of fear or concern, and DPH will continue to work in solidarity with providers across the state, dismantling barriers to critical, life-saving health care and services, and protecting those who courageously deliver this vital care.

**Respiratory Illness Season/Vaccination**

Commissioner Goldstein provided some timely reminders about respiratory illnesses. He said respiratory viruses are responsible for millions of illnesses and thousands of hospitalizations and deaths in the United States each year. In addition to the virus that causes COVID-19, there are many other types of respiratory viruses, including influenza and respiratory syncytial virus (RSV).

He said there are actions you can take to help protect yourself and others from health risks caused by respiratory viruses. The Department continues to strongly recommend vaccination, as it remains the best way to prevent serious illness from COVID-19, influenza and RSV. The Department echoes the U.S. Department of Health and Human Services’ *Risk Less. Do More.* campaign increasing awareness of, confidence in, and uptake of vaccines that reduce severe illness from influenza, COVID-19, and RSV in at-risk populations. As mentioned at previous meetings, COVID and flu vaccines in Massachusetts are available in a wide variety of health care settings including pharmacies, primary care provider offices, community health centers, mobile vaccination clinics, and local health department and community sponsored clinics. DPH also offers an In-Home Vaccination Program for COVID-19 and Flu, which is available for anyone who has difficulty getting to or using a community vaccination location.

He reminded everyone to continue to practice core respiratory illness prevention strategies in addition to vaccination. Please be sure to wash your hands, stay home when you are sick, and cover your cough. If you have signs or symptoms of respiratory illness, get tested. Testing for flu, COVID-19, and other respiratory illnesses is widely available at doctors’ offices, pharmacies, or health clinics in your community and treatments are available if you test positive for COVID, flu or certain other respiratory illnesses.

As a reminder, the federal government continues to offer four free at-home COIVD-19 tests, please order yours if you haven’t already by visiting [covidtests.gov](https://covidtests.gov/). Consider wearing a mask when you are sick and have to be around others, if you are caring for someone who is sick, or if you have a weakened immune system.

**Avian Flu**

Commissioner Goldstein discussed the dynamics of H5N1 avian influenza in the United States as it continues to evolve. In the 30 days leading up to January 6, 2025, 182 new dairy cattle herds and 111 domestic poultry flocks were newly identified with H5N1 infections, and public health and agriculture authorities continue to detect the virus in wild birds, which serve as the reservoir hosts of the virus. Of greatest significance to animal health professionals has been the death of 20 captive wild cat species at an animal sanctuary in Washington State. In addition, there have been multiple domestic cats infected with H5N1 identified across California, Washington, Oregan and Minnesota.

Possible routes of infection in these animals include consumption of raw milk or uncooked poultry or contact with infected wild birds. USDA, FDA, CDC, and state departments of agriculture and public health have all been involved in investigating these situations in an effort to learn more. As a result, there have already been recalls issued for two different raw pet food brands due to concerns about H5N1. Veterinarians working with cats with confirmed or suspect H5N1 infections are advised to wear protective equipment, including an N95 respirator, although no human infections due to exposure to infected cats have yet been identified.

There were a total of 66 human infections with H5N1 reported in the US during 2024. 40 cases were exposed through contact with infected dairy cattle, 23 from contact with infected poultry, one case from contact with an infected backyard flock, and two cases with unknown exposures. And sadly, on January 6, 2025, the Louisiana Department of Health reported the first death in a US individual from H5N1 bird flu. While most cases have had relatively mild disease, this patient, who was exposed through contact with a backyard flock, was over 65 and had underlying medical conditions, putting them at risk for severe disease and complications.

In Massachusetts, a collaboration between the Massachusetts Department of Agricultural Resources, DPH, and the Broad Institute continues to demonstrate that milk collected from all 95 dairy cattle herds in the state and tested monthly, remains negative. USDA has begun an effort to expand milk testing nationally and FDA has begun collecting aged raw cow’s milk cheese for H5N1 testing. At this time, CDC and DPH continue to assess the risk to the general public as low, but the situation is being monitored closely.

Despite this low risk, DPH recommends following CDC guidance. For people who have had direct contact with infected animals, such as birds, dairy cattle or other animals, they should symptom-monitor for 10 days following their exposure and can arrange for testing through DPH if they develop symptoms. Raw milk, milk that is not pasteurized, can contain bacteria and viruses that are dangerous to animal and human health. DPH advises against consuming raw milk or feeding it to your pets. Given the link between infection in pet cats and raw pet food, owners are advised to speak with their veterinarians about any potential risk to their pets.

**Norovirus**

Commissioner Goldstein said that we are also currently seeing a rise in the number of norovirus cases. Norovirus is a very contagious virus that causes vomiting and diarrhea and is the leading cause of foodborne illness in the United States. Norovirus infections can occur at any time of the year, but cases occur most frequently during the colder months. CDC has recently reported that we are seeing a nationwide increase in the number of norovirus outbreaks this winter compared to prior years. Massachusetts has also seen an increase in norovirus cases reported so far this season, compared to prior seasons. Norovirus spreads very easily and very quickly. You can get norovirus by ingesting contaminated foods or liquids, touching contaminated objects, or having contact with an infected person, including activities such as changing diapers and sharing food, drink or eating utensils. There is no vaccine to prevent norovirus, but there are effective steps that you can take to protect yourself and others from infection which include frequent hand washing with soap and water, cooking shellfish thoroughly and washing fruits and vegetables cleaning and disinfecting potentially contaminated surfaces and staying home when you are sick. People infected with norovirus typically recover in one to three days if they rest and remain well hydrated. There are no specific medications to treat norovirus. A person infected with norovirus should not prepare or handle food for other people for at least three days after symptoms go away.

Commissioner Goldstein asked if there were any questions.

Ms. Moscato mentioned the approval of a name change for the former “Executive Office of Elder Affairs” and felt it was important that the council be aware that the term “elderly” will now be replaced with older adults. She felt it was important for the Council to be aware for future references that may come before them.

Ms. Cooper said the Executive Office of Elder Affairs will now be known as the Executive Office of Aging and Independence. She said through much discussion and speaking with older adults, the term elderly was determined to have negative connotations. As regulations come in front of the Council, she hopes they can change some of the terminology. She encourages the members to be ambassadors for this name change.

Mr. Landers commended DPH and the Commissioner for the work that has been done with the Bureau of Health Professional Licensing to support and protect people providing gender affirming care. He feels the transgender and gender diverse communities are at risk at this time.

Commissioner Goldstein said we all know that the Shield Law has been in effect, but codifying the Shield Law into regulation, which is where health professionals go to understand their practice and what their protections are, was very important to do.

Dr. Carey said she will support the new term of older adults and appreciates that older adults were consulted as to how they feel about the terminology.

Commissioner Goldstein noted that there's been a lot of effort across the Executive Office of Health and Human Services to really think about our language. The Department has pushed forward a “Words Matter” campaign within the Executive Office to think about what language is used regarding substance use disorder and people who use drugs. MassAbility is the new name for the organization focused on those with disabilities, formerly named the “Massachusetts Rehabilitation Commission.” We're being very conscious of what words we use because the words do matter.

Dr. Bernstein commented on the benefits of using the term “unauthorized immigrant” rather than “undocumented.”

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

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

*c. December 11, 2024 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the December 11, 2024, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the December 11, 2024 minutes.

Dr. Volturo made the motion, which was seconded by Ms. Moscato. Mr. Landers abstained. All other present members voted to approve the minutes.

**2. DETERMINATION OF NEED**

*a. Request by Atrius Health, Inc. for a freestanding ambulatory surgery center.* ***(Vote)***

Commissioner Goldstein invited Dennis Renaud, Director of the Determination of Need Program, to review the staff recommendation for Atrius Health’s, Inc. request for a freestanding ambulatory surgery center. He was joined by Jaclyn Gagne, Chief Deputy General Counsel.

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

Ms. Moscato said that the application was very compelling with the information related to inventory of surgery centers in Massachusetts. She said the Council hasn’t seen that information before as clearly as they did in this application from other surgery centers. She also noted Atrius Health’s significant relationship and value-based and risk-based care with 67% of their revenue, according to the application, is in these areas which she thinks is significant. The opportunity to lower their cost, the continuity of care, and also the electronic medical record, which she found also compelling. She then asked about ownership noting that recently Atrius Health was acquired by Optum and wanted to know if Surgical Care, Inc. was also owned by Optum.

Chris Andreoli, MD, CEO of Atrius Health, answered that Atrius Health Physician Group is an independent non-profit. They participate with an MSO arrangement and their MSO, Atrius Health MSO is owned by Optum. SCA is the Optum owned surgical care group. They’ve been highlighted by ownership changes throughout Massachusetts.

Ms. Moscato asked regarding the almost 5,000 cases that are currently done in the Massachusetts hospital outpatient departments that will be moving to the center: what impact on those hospital discussions that they've had about cases being transferred to their surgical care center versus the hospitals, and is there any particular hospital that would be impacted, or they would have concern with.

Dr. Andreoli said they have long standing hospital collaborations across their geography and all of their communities, with roughly sixteen different preferred hospital relationships. They've been in ongoing collaboration conversations with those hospitals for decades, including their plan to develop an ASC. One of the issues that the hospitals and Atrius are facing is lack of staffing in hospital settings and being somewhat overburdened by lower acuity cases, blocking out the ability to do larger cases. They feel like they've had a good relationship with their hospital partners forecasting this.

Ms. Moscato then asked about staffing. In the report it is stated that 56% of their current cases are with networks outside of the Atrius surgeons. She asked how they thought about growing their surgical compliment and recruitment for other staff positions like nursing, front office staff as it relates to the staffing issue existing within Massachusetts and the nation.

Dr. Andreoli replied that staffing is a challenge in their hospitals and was certainly a factor in location choice for the center. They’re finding along with their hospital partners, difficulty recruiting staff particularly into the Boston urban area with transportation costs and parking costs and they are finding an easier time in suburban community centers. They feel that will help in staffing. They've been successful in staffing across their clinics, although they know this will be a challenge at the moment. Partnering with SCA, they believe will help them both in recruiting and training on the staff side. In regard to staffing of physicians: they’ve had robust growth at Atrius Health. They employed prior to this year approximately 800 to 1000 physicians, and increased that number by net over 100 this year. They believe in a multi-specialty model based on primary care and build their specialists to the demand of the patient population. They’re constantly looking to fill in the geographies where they can find appropriate high quality, committed to value based care specialists, and they'll continue to do so. He believed they will never fully be able to service all the needs of their patients, but they have a particular focus on ambulatory specialty needs, so many of the hospital-based needs, they will always need a partnership with their hospital partners. Some of the geographies just don't have penetration of volume so they don't expect that 50% number to ever get down to zero, but they try to build their ecosystem to meet their patient population demands.

Ms. Blondet was concerned about transportation. She said Waltham has limited public transportation and it's not an easy location for many MassHealth patients. She requested comments on their commitment to ensuring that the transportation needs of their specific client population based on the various ZIP codes has been thought out.

Dr. Andreoli said they have a commitment to take care of all the populations and all the communities we serve. That's highlighted through their participation in Mass Health, which has been growing through their various programs. He said Atrius Health wide has built an extensive network of clinics and deployed various resources in a regional method in terms of where they place their sub specialist, where they place their imaging, where they place their lab and pharmacies with an eye towards meeting the needs of their population and with an eye towards public transportation.

When they chose this location, they looked at their total population, where they could service the greatest number of their patients through one center and that led to the choice of Waltham. All locations will have some transportation challenge. They believe there's a greater accessibility to a suburban site than a downtown Boston site, a little bit different than some of our ambulatory clinic based settings. Different than ambulatory clinic settings, surgical care is a unique, one-time experience. If you go in for a surgery, you're going to get anesthesia, you're going to be sedated. You can't bring yourself there and you need to go with someone. It’s unlikely in this case you will be taking public transportation. The site is accessible by bus, and they have a commitment to work with all their patients to increase accessibility. They have transportation program for those who don't have adequate transportation that they can help arrange. They have surgical coordinators and social workers all focused on making the experience safe and accessible for all of their patients.

The struggle over the past decade serving their MassHealth population, is initially MassHealth didn't cover all surgical cases to be at ASC’s. They successfully led conversations with them over the decades to change that. Some ASC’s will not accept MassHealth at their centers. Atrius has been very committed to this population and will only collaborate with centers that access all of their patient population. He said they’re building this Center for that purpose, to be more accessible for all of their patients. Their surgeons have the luxury of being able to be payer blind and ensure the same high quality model of care for all of their patients, regardless of their socioeconomic status, or regardless of their payer. They also think this lowers cost of care for their patients, which will differentially help their most in-need patients as co-pays and cost shares will be significantly less than in a hospital setting.

Ms. Blondet suggested that they ensure that patients are aware of their commitment to help with transportation needs.

Dr. Carey commented on the compelling application being presented and the surprising ASC data comparing Massachusetts to the national level, and the cost savings that ASC’s will bring.

Ms. Cooper mentioned a large ASC being built by MGH in Waltham. She asked if the state takes into consideration a possible saturation of services in localities.

Mr. Renaud answered that with the current regulations, each DoN application is based on the patient panel need of the applicant. It's individualized towards the need of the patient population. In this situation, Atrius’ application was analyzed based on their panel. The same thing occurred for MGH, as that's the current regulation model. Over the next year we will be looking at our regulations and we'll be looking to potentially make some changes where there's more of a geographic wide assessment.

Dr. Haddad said from a physician perspective, we know the value is clearly greater if we do things in the outpatient setting. But to maintain quality it is critical that we have patient selection that's appropriate. He asked who decides on the appropriateness of site, depending on patients’ acuity and mobilities and in the case of acute complications, which he said inevitably occur, whether it's outpatient or inpatient, is there a particular hospital contract where these patients are quickly transported to in that area.

Dr. Andreoli stated there will need to be a hospital transfer agreement contract protocol in place by regulation, and they’ll have that in place prior to opening the center. In terms of determination of appropriate cases, he said it's a combination of many things starting with Medicare and their population base indicates which surgical types are even candidates just based on CBT code for site of care. Some are inpatient only; some are eligible for HOPD or ASC. So, in a Medicare population, you can only start within that envelope, but then only a subset of those patients are appropriate based to your point on comorbidity, some cases obesity or other chronic medical diseases. So that's a combination of determination by the surgeon, but also by their primary care doctor. Both of those collaborate in their group very well together to discuss the appropriateness of patients.

Then the center usually employs or collaborates with an anesthesia group that will weigh in as well on high risk patients as to whether or not they're appropriate. They pride themselves in equality being their guiding force above all else. They’re committed to making sure that they provide the highest quality care to their patients. At Atrius Health, they did the first outpatient total joint surgeries in the state, which is now a standard of care and is leading to the need for more and more of these ASC’s. Using the orthopedic team as an example, he said they built all the protocols, went around the country finding the safest ways to do these things and insisted on above all else, patient safety being the most important factor. They feel they can deliver better safety, better quality when building the programs they have.

Dr. Bernstein asked about internal metrics like waiting times, scheduling times, and what would be the standard.

Dr. Andreoli said that system wide, they have a big focus on what they broadly define as access. This isn't just limited to surgical cases, but access of meeting patient’s need however they want to interface with them, whether that's a phone call or a digital interaction or an in person visit or surgical wait time is something that they feel is important to maintaining the collaboration with their patients and delivering on better health. In the Massachusetts community, access is strained for physical appointments and for surgical access. Some of their surgeons are booking six months out in their hospital facilities, and so they’re viewing this as building capacity to improve access. That will remain one of the metrics they watch. There are multiple steps to that, getting the patient seen and evaluated in clinic and then from there once the decision is made to operate, having access at an appropriate setting. So, there will be a variety of different access measures. There are other metrics that will follow, particularly looking at the quality of the center, things like infection rate, on time starts, hospital transfer rate, patient satisfaction rate, which are fairly standard metrics that are seen in their management tool, and which report out regularly on an ongoing basis across their center.

Dr. Bernstein asked if they would collect that database on payer mix and race/ethnicity as well to see that they’re meeting their standard for it.

Dr. Andreoli said they've shifted very explicitly their definition of quality over the past five or ten years to say that you can't have quality care without equitable care. So all of their different population health quality measures these days are now broken down by different DEI categories. Their primary care groups looking at hypertension or any various quality measure, they'll break it down by different site, by different provider, by different patient population, by race and ethnicity. And as they find disparities, they've now built programs to close those disparities. They have an ongoing commitment to look at all measures of their quality through DEI and a health equity lens.

Dr. Bernstein then asked Mr. Renaud in terms of financial stability what it means to be bought out, or under the ownership of Optum, and how the rules and regulations apply to non-profit status and the care of the patient.

Mr. Renaud suggested the applicant answer.

Dr. Andreoli said they went through a rigorous process to meet the threshold for financial security. Optum has committed to investing in our model of care and has provided some of that financial security that maybe we've lacked over the past 40 years that has led to us not doing this project sooner. Optum is committed to building and supporting a value based care model and is investing here.

Dr. Bernstein asked if they will still maintain their non-profit status.

Dr. Andreoli said their physician group, Atrius Health Inc., is a taxed nonprofit group. They collaborate with Atrius Health MSO, which is a wholly owned Optum subsidiary that is for profit.

Dr. Bernstein asked Mr. Renaud how they determine the future financial stability of an organization, saying based on past history, it doesn’t make sense that this would be based on a CPA. He wanted to know if there are independent CPAs that assess this for the State.

Mr. Renaud answered that factor four is an analysis which is conducted by an independent CPA and it's always included on our website where you can view it. Ultimately the CPA decides as to whether the project is financially viable, and it's not going to hurt the patient panel going forward. It is an independent CPA that that completes the factor four.

Counsel Gagne said the regulation specifically addresses that. “The said independent CPA’s analysis shall include, but not be limited to, a review of the applicants and where appropriate, as a matter of standard accounting practices, its affiliates, past and present, operating in capital budgets, balance sheets, projected cash flow statements, proposed levels of financing for the proposed project.” It is a comprehensive and independent CPA that is tasked with doing that to meet factor four, in terms of Optum now being the overriding responsible party for the corporation.

Dr. Bernstein asked if the finances of Optum and it's long range sustainability in that assessment would be considered.

Counsel Gagne said the financial feasibility assessment factors aren't including but not limited. There's nothing specifically structured around ownership in terms of financial feasibility. However, with respect to licensure, we do look at the suitability of all applicants, which includes their ownership structure.

With no further questions, Commissioner Goldstein asked if there was a motion to approve Atrius Health’s, Inc. request for a freestanding ambulatory surgery center.

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

**3. PRELIMINARY REGULATIONS**

*a. Overview of proposed amendments to 105 CMR 210.000,* *The administration of prescription medications in public and private schools.*

Commissioner Goldstein invited Karen Robitaille, Director of School Health for the Bureau of Community Health and Prevention, to present an overview of proposed amendments to the Department’s regulations regarding the administration of prescription medications in public and private schools.

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

Ms. Lambert asked if there are any age restrictions around the self-carry allowance and/or parental approvals or waivers for minors under a certain age.

Ms. Robitaille said there is no age restriction, but self-care and self-administration requires the approval of both the caregiver and the prescriber. And so those entities would be making the decisions around the appropriateness for any student regardless of age to self-care and self-administer.

Dr. Evans thanked Ms. Robitaille on the hard work and commended her group for including naloxone as an especially marked medication or a lifesaving medication that should be available in schools.

Dr. Volturo said he’s trying to understand the sort of org chart around the medication program manager, because that is a school nurse and as he understands, the program manager is then responsible for managing the program throughout the entire district but then has some supervisory role over other school nurses. School nurses are mentioned several times when you get to section G in in the document there's a lot of school nurses. He’s not clear how that organizational chart rolls out. So, whether clarifying how the program manager probably has some supervisory roles over the other school nurses to make sure they're adhering to the program. He also questioned the role of the emancipated minor or the student who's over 18 years of age who in some cases may be their own caregiver.

Ms. Robitaille answered the program manager position is a registered nurse in a school or school district. That nurse does not have to have a supervisory role or may have a supervisory role. Some school districts do have nurse managers that have a supervisory position but may not and may just be one of the school nurses. Their only responsibility under this regulation is for this program. So that's making sure that there is a policy in regard to medication administration, that their school physician is involved in those policies and procedures, and that the procedures that are outlined in the regulation are being followed in all of the offices in the district. That's what they're committing to when they're the medication manager of the program. The other thing they have to do is take a couple of trainings that are offered by the Department of Public Health so that they're aware of what their responsibilities are and how to carry those out.

Dr. Volturo asked when they put this program together who is responsible for assuring that it is carried out, and what happens if it is not carried out.

Ms. Robitaille answered that's why we've included that section now that clarifies our ability to do investigations, inspect records and provide a plan of correction. So, each nurse under their license is responsible for adhering to the regulation all on their own. That comes with the responsibility of your nursing license. The manager's responsibility is making sure that the program itself is in place. The manager is not responsible for individual nurses practice under the regulation.

Dr. Volturo understood the clarification and repeated the second part of his question about defining caregiver and where an emancipated minor falls as caregiver.

Ms. Robitaille said an emancipated minor would not need a caregiver consent. They would be consenting to their own administration of medication. The school would still require a physician's order, they would not require the caregiver’s consent.

Mr. Landers asked about the self-administration and self-carry regulations finding it complicated to read and asked if it could be simplified or streamlined for better understanding.

Ms. Robitaille said that wouldn’t be possible. This is part of the work of the everyday school nurse. If we are going to approve a student to self-care and or self-administer their own medication, we need to be assured that, A; they know how to do that in a way so that they're not going to harm themselves. And B, they know how to keep that medication secure so that it doesn't fall into the hands of other students for whom it could be harmful. Each case needs to be taken on a case by case basis. There is no way to streamline or simplify safety in that regard.

Mr. Landers said he worries because he’s seen this in other regulations that each of those is another judgement call without necessarily any clear criteria. He said he trusts the nurses but worries for the places where it's just not clear what the criteria are for making each of these decisions, where it says appropriate, or where needed, as judged by the nurse.

Ms. Robitaille said nurses are educated to be health educators and to assess our patients readiness to do things for themselves. This is part of our training, and this is part of our responsibility under the Nurse Practice Act. She said in a school setting, it is never an independent decision by the nurse alone, even though the nurse is the final decision maker. It is always a team approach between the student, the caregiver, whomever that might be, the student’s provider and the nurse. So, it's not the sole responsibility of the nurse to make those determinations, but the nurse is the final determinant because they are seeing the student in school. And sometimes how students behave or what they're able to do is different in school than it can be in other settings. And that's why it's written that way.

With no further questions, Commissioner Goldstein stated that this concluded the final agenda item for the day and reminded the Council that the next regular meeting is scheduled for February 12, 2025, at 9:00 am.

Commissioner Goldstein asked if there was a motion to adjourn.

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

The meeting was adjourned at 10:42 am.