MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of July 17, 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, July 17, 2024 – 9:00AM**

***Note: The July 17 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:

Join by Web:

<https://zoom.us/j/98655991638?pwd=RgS4ulaVSZDH23LkjLQI6jryNQmfDN.1>

Dial in Telephone Number: 929-436-2866 Webinar ID: 986 5599 1638

Passcode: 008780

1. **ROUTINE ITEMS**
   1. Introductions.
   2. Updates from Commissioner Robert Goldstein.
   3. Record of the Public Health Council Meeting held June 12, 2024 **(Vote)**.
2. **DETERMINATION OF NEED**
   1. Request by Beth Israel Lahey Health Surgery Center Plymouth, LLC for an Ambulatory Surgery Center **(Vote).**
   2. Request by UMass Memorial Health Care, Inc. for a Transfer of Ownership **(Vote).**
3. **REGULATIONS**
   1. Request to promulgate amendments to 105 CMR 130, *Hospital licensure* **(Vote)**.
   2. Request to promulgate amendments to 105 CMR 222, *Massachusetts immunization information system.* **(Vote)**.

*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: July 17, 2024 - Start Time: 9:00 am. Ending Time: 11:30 am.

| **Board Member** | **Attended** | **First Order:**  **Approval of**  **June 12, 2024 Minutes (Vote)** | **Second Order:**  **Request by Beth Israel Lahey Health Surgery Center Plymouth, LLC for an Ambulatory Surgery Center**  **(Vote)** | **Third Order: Request by UMass Memorial Health Care, Inc. for a Transfer of Ownership**  **(Vote)** | **Fourth Order: Request to promulgate amendments to**  **105 CMR 130, Hospital licensure (Vote)** | **Fifth Order: Request to promulgate amendments to**  **105 CMR 222, Massachusetts immunization information system (Vote)** |
| --- | --- | --- | --- | --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Edward Bernstein** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Lissette Blondet** | Yes | Abstain | Yes | Yes | Yes | Yes |
| **Kathleen Carey** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Harold Cox** | No | Absent | Absent | Absent | Absent | Absent |
| **Alba Cruz-Davis** | No | Absent | Absent | Absent | Absent | Absent |
| **Michele David** | No | Absent | Absent | Absent | Absent | Absent |
| **Robert Engell** | Yes | Abstain | Yes | Recused | Yes | Yes |
| **Elizabeth Evans** | Yes | Abstain | Yes | Yes | Yes | Yes |
| **Eduardo Haddad** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Joanna Lambert** | Yes | Abstain | Yes | Yes | Yes | Yes |
| **Stewart Landers** | Yes | Yes | Abstain | Yes | Yes | Yes |
| **Mary Moscato** | No | Absent | Absent | Absent | Absent | Absent |
| **Gregory Volturo** | Yes | Yes | Yes | Recused | Yes | Yes |
| **Summary** | 10 Members Present;  4 Members Absent | 6 Members Approved;  4 Members Absent;  4 Members Abstained | 9 Members Approved;  4 Members Absent  1 Member Abstained | 8 Members Approved;  4 Members Absent 2 Members Recused | 10 Members Approved;  4 Members Absent | 10 Members Approved;  4 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, July 17, 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; Robert Engell; Elizabeth Evans; Eduardo Haddad, MD; Joanna Lambert; Stewart Landers; 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 9:00 am and made opening remarks before reviewing the docket.

**1. ROUTINE ITEMS**

*b. Updates from Commissioner Robert Goldstein*

Commissioner Goldstein proceeded to update the Council on the following:

**Disability Pride Month**

Commissioner Goldstein said July is Disability Pride Month, honoring the anniversary of the landmark Americans with Disabilities Act, passed on July 26, 1990. It is a time to celebrate the contributions of people with disabilities and to reflect to promote equitable access to health care for people with disabilities. The Health and Disability Program in the Office of Health Equity and Community Engagement engage in this work every day in a variety of ways.

**BCEH Heat Education and Alert Tools**

Commissioner Goldstein said that DPH’s Bureau of Climate and Environmental Health, in collaboration with the Office of Preparedness and Emergency Management and the Office of Local and Regional Health, recently announced the launch of the Heat Education and Alert Tools Response Initiative, or HEAT Response. The initiative builds on the new HighRisk Tool from the National Weather Service of the National Oceanic and Atmospheric Administration and the Centers of Disease Control and Prevention. The tool synthesizes health, heat, socio-demographic, and natural/built environment data to forecast community heat risk.

**Beach Closings**

Commissioner Goldstein said DPH’s Beach Water Quality Monitoring Program tests the water of bathing beaches to assess levels of bacteria that could cause illness. The results of the tests and the notices of beach closures are made available to the public on the DPH website. The Beach Water Quality Dashboard, which is updated twice a day, provides water quality testing results and offers a map to check the status of your local beach. The data collected when testing beach water serves as a barometer of overall health of our coastal ecosystem and the impact of climate change on water quality in the state.

**Mosquitos and Ticks**

Commissioner Goldstein said DPH began surveillance for West Nile Virus and Eastern Equine Encephalitis (EEE) on June 17th of this year. Two mosquito samples confirmed the presence of West Nile Virus in Quincy. The next day, the presence of EEE in mosquito samples was discovered in Carver, MA. This year. So far, there have been no human cases of West Nile or EEE. People over 50 are at higher risk for severe disease with West Nile but most people show no symptoms. Others may have flu-like symptoms. EEE is rare but serious and potentially fatal and affects all ages. People should use repellant, wear long sleeve, long pants, and socks outdoors if not too hot, and consider rescheduling outdoor activities between the hours of dusk to dawn, which is peak biting times for mosquitos. He said May through August is also peak period for tick-borne diseases. In Massachusetts the deer tick can carry five different diseases including Lyme disease and Powassan virus. Tick repellants with an EPA registered active ingredient can help prevent tick bites along with covering any exposed skin, showering to wash of unattached ticks, and doing daily checks to find and remove them.

**Long COVID**

Commissioner Goldstein said late last month, DPH updated their website to include information on post-COVID conditions, or also know as long COVID. Long COVID is defined as signs, symptoms, and conditions that continue or develop after COVID-19 infection and are present for at least three months after the initial illness.

**Emergency Abortion Care – Executive Order and Guidance**

Commissioner Goldstein said on June 24, he participated in a press event with Governor Healey and Lt. Governor Driscoll, Attorney General Campbell, and others to reaffirm the Commonwealth’s commitment to reproductive health including abortion care. The event recognized the threats to reproductive freedoms across the country and marked the two year anniversary of the *Dobbs* decision. Last month, Governor Healey signed an executive order reaffirming that Massachusetts law provides a right to prompt treatment in an emergency, including abortion care. The executive order also required DPH to provide guidance to health care providers and facilities stating clearly that abortion care is emergency care and that all providers and hospitals must comply with the applicable state and federal statutes, including EMTALA. No facility or provider, therefore, may choose to NOT provide abortion care in the setting of an emergency. DPH is committed to improving access to comprehensive reproductive health care, and has issued guidance to facilities and professionals underscoring their obligation to provide information about all reproductive health options and to not mislead or deceive individuals seeking comprehensive information. DPH has also launched a public awareness campaign focused on the dangers of anti-abortion centers. The campaign has received significant attention. Other work DPH is doing in reproductive health care includes stockpiling mifepristone, developing a medication abortion toolkit for public colleges and universities, providing grants to support abortion infrastructure and security, and funding a medication abortion fellowship.

**Caring for Residents with SUD Conference**

Commissioner Goldstein said that on June 18, the Office of Health Care Strategy and Planning hosted the “Caring for Residents with Substance Use Disorders Across the Continuum of Care Conference,” focused on supporting people with substance use disorders in long term care settings and expanding access for residents to medications for substance use disorder.

**CDC Director Site Visit**

Commissioner Goldstein said he met with CDC Director, Dr. Mandy Cohen, in Boston to promote maternal health in conjunction with the Supporting Healthy Families initiative, one of her top priorities. She used this visit to express her support for maternal health action, particularly the Million Hearts Hypertension in Pregnancy Change Package, which was developed by CDC in collaboration with key clinical partners. She recognized the importance of on the ground public health work which impacts communities and was grateful to see how NeighborhoodHealth is Supporting Healthy Families in Boston.

**Steward Update**

Commissioner Goldstein said bids for eight Steward hospitals in Massachusetts were due on July 15. At this time, he had no information concerning the bids to share with the council members. He said after the auction, prevailing bids will be submitted for approval by the bankruptcy court, scheduled for July 31. Steward’s physician network, “Stewardship” is also up for sale and bids are due July 22 with auction on July 25. He said there is a decline in patient activity in most Steward hospitals. DPH continues to monitor the facilities to ensure there is necessary staffing, equipment, supplies, and processes. DPH monitors are confirming that care delivered in the hospitals continues to meet state and federal standards. He said regular meetings with partners in the health care community are being held and there is a collective understanding that the transition of Steward hospitals will have an impact on the health care ecosystem in eastern Massachusetts. Many non-Steward hospitals have seen an increase in their ED volume and inpatient admissions due to patients seeking care at non-Steward hospitals. DPH will be ready to move forward with regulatory processes to transition Steward hospitals to new operators. DPH is resolute in preserving access to safe, quality health care for all residents of the Commonwealth.

Commissioner Goldstein asked if any of the council members had questions.

Mr. Landers asked to publicly acknowledge of the passing on July 13th of Ruth Palumbo. He mentioned her long service at DPH where she became the state nutrition director and established the Office of Nutrition, worked for maternal and child health, worked with the Center for Disease Control and Prevention, and funded the Wise Woman Project. Later in her career she focused on aging and was the Assistant Secretary for program planning at the Executive Office of Elder Affairs. He said she would be missed.

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

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

*c. June 12, 2024 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the June 12, 2024, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the June 12, 2024, minutes.

Dr. Bernstein made the motion, which was seconded by Dr. Volturo. Ms. Blondet, Mr. Engell Ms. Evans, and Ms. Lambert abstained. All other present members voted to approve the minutes.

**2. DETERMINATION OF NEED**

*a. Request by Beth Israel Lahey Health Surgery Center Plymouth, LLC for an Ambulatory Surgery Center* ***(Vote)***

Commissioner Goldstein invited Dennis Renaud, Director of the Determination of Need (DoN) Program, to review the staff recommendation for Beth Israel Lahey Health (BILH) Surgery Center Plymouth, LLC’s request for an Ambulatory Surgery Center (ASC). Mr. Renaud was joined by Tony Sousa, Acting Director of the Bureau of Health Care Safety and Quality, and Rebecca Kaye, Deputy General Counsel.

Commissioner Goldstein asked if there were any questions from the council.

Ms. Blondet suggested that the projected numbers for the new ambulatory surgery center may be low based on its potential growth and wanted to know if there was a built-in expansion plan. She also said that the DoN referred to transportation based on the day of surgery, and she wanted to hear their transportation plans for those that may not have transportation access for pre- and post-op appointments. She then referred to the DoN staff for an explanation of the equitable access required of the applicant. Also, she wanted to know who will make the decisions and through what process for the $596,000 in local investment.

Kevin Coughlin, President, Beth Israel Deaconess (BID) Plymouth said that he felt the four room Ambulatory Surgery Center (ASC) will have the capacity to expand more than their projections in a five year period. Regarding transportation, he said they will pre-screen patients prior to the scheduling of surgery to identify any needs that they have to make themselves available for surgery. They will be linked with the transportation services that BID currently utilize, like rideshare relationships and community bus service.

Mr. Renaud addressed equitable access, saying it is a requirement to implement specific programs, understanding cultural and linguistic barriers, within a set timeframe while demonstrating the number of patients served and their impact.

Ms. Blondet asked if equitable access is only language focused.

Mr. Renaud said it’s serving various ethnic populations, not just linguistically.

Ms. Blondet said more should be added to define equitable access, but it could be discussed later.

Jennica Allen, Manager of Community Engagement Practices for DPH, said regarding the local community investment, there are always a number of unknowns. Before the application is finalized, they make sure there are the right decision makers and a minimum level of engagement. The applicant has a community benefits advisory council, which as a team, work with the applicants to make sure that they engage with participants that are able to move them forward toward sustainable, equity-focused investments. They don’t know now what the investments will be, and it is typically too early in the process to know that, but they will ensure that those important investment decisions are guided over time.

Ms. Blondet said her original question about the local investment pertained to the infrastructure and mechanisms that BID Plymouth was deciding to fund.

Ms. Allen passed the question to the applicant but added that the decision mechanism would be through any of those public meetings of the Community Benefits Advisory Council. They ensure that this group comprises of those that have an understanding of local health, housing, transportation and all the pieces that are part of the decision making process.

Nancy Kasen, VP of Community Benefits and Community Relations, BILH, said they have a well-integrated community benefit advisory committee structured at BID Plymouth to comply with sub regulatory guidance of sector representation. It is an ongoing committee with regular quarterly meetings to include all of the sectors that are specified and recommended by the Department of Public Health. It is not an advisory committee put together for a specific DoN. It is an ongoing engagement related to emerging needs, starting with a comprehensive community health needs assessment submitted with the application. They follow the DPH community engagement continuum and try to move towards community driven priorities. For this DoN, they have begun engaging with the community benefits advisory committee. They hold an annual public meeting to communicate with the community. They then work with DPH to make sure what the community benefit advisory committee recommends for funding the priorities and sub-priorities comply with the sub regulatory guidelines. All of it is driven by the community.

Dr. Carey agreed that the growing number of orthopedic surgeries done in ASCs are much less costly. The other consideration is patient safety and prevention of avoidable errors. ASCs don’t have emergency departments or accommodations for overnight stays. She asked to hear more about protocols in place for emergencies. She also wanted to know about ownership and if it would be partially or largely owned by the physicians that work there. She mentioned that physician self-referral to ASCs has been a large public policy issue for years and she wanted to know if there will be guidelines to assure that older patients who are less healthy are referred to the hospital, while the healthier patients are referred to the ASCs, to reduce the risk of complications. She wanted to know how these decisions were made.

Mr. Coughlin added that the ASC is roughly four miles from the hospital for emergencies. One of the benefits of this being a joint venture with the physicians in BILH hospital is they can leverage some quality infrastructure that exists in the hospital to the ASC.

Julia Kenniston, MD, Orthopedic Surgeon, BID Plymouth, agreed that it is important that the appropriate candidate is chosen for the ASC, which makes the pre-op evaluation so important. All patients having surgery will have an evaluation before to determine their medical status and medical history, and not all patients will be candidates for the ASC, but instead will be referred to the hospital setting. Regarding ownership, the joint venture is divided at 51% by the hospital and 49% from Plymouth Bay Orthopedics. In terms of self-referring to the ASC, all the orthopedics take Medicare and Medicaid patients with the goal of providing the best care possible and to allow some cost savings as it’s a 60% savings for Medicare being at an ASC and the deductibles are lower for the patient.

Dr. Bernstein brought up the point that the Plymouth Hospital is on indigenous people’s land and should be acknowledged. The data of patient population shows .1% American Indian. However, according to the US Bureau of Census report for Plymouth County, a significant number of residents self-identify as at least part American Indian. Dr. Bernstein noted that we would like to see how the community resources mentioned will be dispensed to that population, and how this population has been engaged in this planning. He also wanted to see American Indians listed in their patient panel because there is no mention now.

Dr. Kenniston remarked that although the hospital is on indigenous people’s land, they don’t see that population represented very much. She said it might be a perception of costs. They hope to improve access to orthopedic care through outreach and collaboration with both the BID Plymouth Community Health implementation strategy, through primary care doctors, and the community to let them know that these services are financially feasible.

Dr. Bernstein said in the past, Medicaid patients’ wait times for access to care has been an issue. He thinks in future data collection, it should include race and ethnicity of those that exceed the baseline waiting time. He then asked in their community assessment, to what extent are indigenous peoples involved in having a voice.

Dr. Kenniston emphasized their commitment to reach out to this population and assured Dr. Bernstein that Medicare and Medicaid patients are treated equally and have no longer wait times than others.

Ms. Kasen said that they have attempted to reach out to the American Indian population. She said they will bring this topic back to the community benefit advisory committee and underscore this, but they have been included to the best of their ability in the community health needs assessment. They will pay closer attention, and they are open to other strategies and being connected to individuals in that community for their fiscal 25 assessment.

Mr. Engell mentioned the presentation’s information regarding the increase in joint replacement but a decrease in other categories of services, as well as the staffing mix which would have five specialists with joint replacement. He asked if the numbers of patients who require the other services are going elsewhere, or have the patients numbers for these services decreased also.

Mr. Coughlin said that several of the surgeons do surgeries other than arthroplasty but are listed as arthroplasty surgeons and the decrease in patients for alternative surgeries is due to the competitive disadvantage of not having an ASC.

Dr. Kenniston added that in their area, the patient population has a large percentage of individuals over 65 years old, requiring more joint replacements. Also, outpatient joint replacements are dramatically increased, possibly due to COVID-19.

Mr. Engell asked if the economics of joint replacements incentivized the organization to focus their surgeries to that instead of more minor procedures,

Mr. Coughlin said that is not the case.

Mr. Engell mentioned that the applicant stated that there was room for capacity growth, yet the presentation showed in five years capacity would reach 86%. He asked how there would be room for capacity growth after five years.

Mr. Coughlin said that the projection of 86% is based on normal operating hours. Currently in their hospital there are eight ORs in operation seven days a week. The ASC will have the ability to expand from normal operating hours allowing for more patients.

Crystal Bloom, Regulatory Counsel for the applicant, added that there was caution in not overbuilding. They believed that they assessed a reasonable capacity projection for the coming years.

Mr. Engell asked about staffing for the additional healthcare services at the ASC. He wanted to know if there was outreach being done to acquire staffing from the local communities.

Mr. Coughlin said that healthcare staffing is a challenge everywhere. They work hard to acquire staffing through outreach to every community that they can, including building relationships with the educational facilities in Plymouth County and Cape Cod Community College. They are fully unionized with the MNA and the SEIU to whom they contribute over $200,000 a year to help with development training for existing employees.

Mr. Engell asked about emergency response to issues that may occur in the ASC, acknowledging that they said the hospital was only four miles away. Using Boston as an example of road closures and traffic congestion, making a short four miles quite distant, he asked if there was an emergency preparedness plan for licensing because it was not in the DoN.

Ms. Bloom confirmed for licensure an emergency plan with other hospitals must be in place.

Dr. Haddad asked if moving a large volume of procedures from the hospital to the ASC, decreasing volume in the eight ORs, will there be enough volume in the hospital, and if not, are they planning on increasing the level of acuity in their operating rooms.

Mr. Coughlin said that Plymouth is fastest growing community in the Commonwealth with a 6 – 8% annual increase in residential building. They’ve seen an annual increase at the hospital of roughly 10%. They are strategically building their organization to be more of a regional center for Beth Israel Lahey Health. They have partnered with Harvard Medical faculty physicians who are academic partners with BIDMC. They export their expertise into Plymouth’s community settings they employ and manage all the physician services there. Every year they are raising the acuity and types of care that they are providing, so people no longer need to go elsewhere for care.

With no further questions, Commissioner Goldstein asked if there was a motion to approve Beth Israel Lahey Health Surgery Center Plymouth, LLC’s request for an Ambulatory Surgery Center.

Dr. Carey made the motion, which was seconded by Dr. Haddad. Mr. Landers abstained. All other present members voted to approve the request for a significant change in service.

*b. Request by Umass Memorial Health Care, Inc. for a Transfer of Ownership* ***(Vote)***

Commissioner Goldstein invited Dennis Renaud, Director of the Determination of Need Program, to review the staff recommendation for UMass Memorial Health Care’s, Inc. request for a Transfer of Ownership. He was joined by Tony Sousa, Acting Director of the Bureau of Health Care Safety and Quality, and Rebecca Kaye, Deputy General Counsel.

Dr. Volturo and Robert Engell recused themselves.

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

Ms. Blondet asked if annual reporting is typically a DoN requirement.

Mr. Renaud answered that not all applicants must report annually, but this has specific questions related to essential services unique to this application.

Ms. Blondet asked if we are requiring the MassHealth Equity incentive dashboard from every applicant.

Mr. Renaud said they require payer mix information, reporting on Medicare and Medicaid as well as race and ethnicity.

Mr. Landers wanted to know if there were any thoughts of closure or minimizing services after the guaranteed five year period. He also asked if with the closure at Clinton Hospital whether any problems have surfaced due to the increased distance for obtaining delivery care.

Mr. Renaud said that the condition related to essential services only applies withing the first five years and currently there is no language extending past that time.

Eric Dickson, MD, President and CEO, UMMHC assured the council that there are no plans to close anything, especially core essential hospital operations even after the five year mark. Milford Hospital is a critical outpost for the state and the region. He said the closure of OB services at Leominster was a difficult decision made with the assurance that patients could receive the highest quality care possible. There was transitioning of the obstetricians there and the vacancies couldn’t be filled. In turn, they could not assure the safety of birthing persons at the hospital any longer and the deliveries were shifted to Worcester.

Dr. Bernstein asked for comments on Milford’s emergency department issues around boarding, transfer and diversion and how will this merger going to affect that.

Dr. Dickson said Milford has some capacity on their in-patient side and in their ICUs and their boarding issues are not as extreme as the Worcester campus. They are planning to move patients in Worcester that live in the Milford region to that hospital. They will utilize other regional hospitals also.

Mr. Landers commented on his work at Milford Hospital some years ago when Frank Sava was CEO and it was run well. He feels it’s a good thing that UMass Medical Center network is expanding. He feels this is better than the hospital going to one of the other two large systems and further unbalancing where services are offered now in MA.

With no further questions, Commissioner Goldstein asked if there was a motion to approve UMass Memorial Health Care’s, Inc. request for a Transfer of Ownership.

Dr. Bernstein made the motion, which was seconded by Dr. Haddad. All other present members voted to approve the request for a significant change in service.

Dr. Volturo and Mr. Engell returned to the meeting.

**3. REGULATIONS**

*a. Request to promulgate amendments to 105 CMR 130, Hospital licensure* ***(Vote).***

Commissioner Goldstein provided a short update on hospital capacity monitoring and the Department’s efforts to collect data necessary to take action. In January, DPH previewed the Department's Automated Capacity and Occupancy Reporting Network, (ACORN). CDC funded DPH to collaborate with GE Healthcare to establish a daily automated reporting feed of hospital capacity data that can provide near real time data while reducing the burden on hospitals that comes with the reporting. DPH has received interest from 44 hospitals, all of whom are in different stages of implementation. He then mentioned several hospitals and the stage of their implantation. DPH is providing ACORN to hospitals at no cost because it strongly believes it’s an important tool that reduces the administrative burden on the hospital. It is vital to understanding where there are staffed beds and available beds across the system.

Commissioner Goldstein invited Marita Callahan, Director of Policy and Health Communications for the Bureau of Health Care Safety and Quality, to present a request for final amendments to the Department’s regulations regarding hospital licensure.

Upon the conclusion of the presentation, Commissioner Goldstein asked if there were any questions.

Mr. Engell was curious why non-acute hospitals have only an annual reporting requirement. He asked if the Department doesn’t feel that the information is valuable.

Dr. Katherine Fillo, Director of Health Care Strategy and Planning said the state regulation 105 CMR 130 for acute and non-acute hospitals are the same as what’s used from the Centers for Medicare and Medicaid Services, which is a broad definition. In this definition, post-acute settings, such as inpatient rehab facilities, and long-term acute care hospitals are considered acute and therefore report and share their data. What is outlined in the regulatory and sub-regulatory guidance leaves few facilities considered non-acute and therefore reporting only annually.

Dr. Bernstein wanted to be assured that hospital reporting includes the emergency department, and the data includes boarding, transfer, and diversion. The emergency department is a center where many decisions are made in both discharge and admissions that will impact capacity and reflect the problems of capacity.

Commissioner Goldstein reminded Dr, Bernstein that there are multiple data feeds that come in on healthcare capacity. We have separate feeds that give the department information about emergency room volume, time in the ER, those leaving without being seen, and syndromic surveillance.

Dr. Fillo said they are collecting data through Syndromic Surveillance on ED volume in real time and the average amount of time each visit is taking. They collect data of the number of patients that leave the ER against medical advice or without being seen so they can better understand capacity and stressors on the ED. She confirmed that they do collect boarding data from emergency departments.

Dr. Bernstein asked if the capacity data under the regulation and the ER data is analyzed together.

Commissioner Goldstein said the department look at data across the continuum starting in primary care and urgent care settings, through inpatient hospitalization to post-acute settings. The department soon will release a public facing dashboard that will provide the Commonwealth with information on hospital capacity and give people a sense of what is happening in emergency rooms across the state.

With no further questions, Commissioner Goldstein asked if there was a motion to approve the request to promulgate amendments to 105 CMR 130, *Hospital licensure.*

Dr. Volturo made the motion, which was seconded by Dr. Bernstein. All other present members voted to approve the request to promulgate amendments to 105 CMR 130, *Hospital licensure.*

*b. Request to promulgate amendments to 105 CMR 222, Massachusetts immunization information system* ***(Vote).***

Commissioner Goldstein invited Pejman Talebian, Director of the Division of Immunization for the Bureau of Infectious Disease and Laboratory Sciences, to present a request for amendments to the Department’s regulations regarding the Massachusetts immunization information system.

Mr. Engell commented that uploading data in three days rather than seven days will provide them with a better and more timely database.

Mr. Talebian noted that during the pandemic they had all their providers reported within 24 hours.

Mr. Landers asked what is the objection to data sharing that can be submitted.

Mr. Talebian said that an immunizing recipient can object to have their data shared with anyone other than the department or the original provider that provided the immunization.

Mr. Landers asked if this objection could extend to aggregate data that they might share on immunization rates.

Mr. Talebian said no, aggregate data is not a release of individual data so there can be no objection.

Ms. Lambert asked about providing this data to health plans. Does the department know if the payers use this information to guide reimbursement rates for immunization?

Mr. Talebian said they don’t have direct feedback on how the data is being used. They’ve been told that it is being used for quality improvement and they have been reassured it’s not going to be used for adjusting providers’ payments.

Lynn Squillace, Deputy General Counsel added that there is both statutory restriction that is reflected in the regulation with regard to how health plans that have access are using the data and it’s limited to immunization rate improvement and quality improvement efforts.

Upon conclusion of the presentation, Commissioner Goldstein asked if there were any questions.

With no further questions, Commissioner Goldstein asked if there was a motion to approve the request to promulgate amendments to 105 CMR 222, *Massachusetts immunization information system.*

Mr. Landers made the motion, which was seconded by Dr. Volturo. All other present members voted to approve the request to promulgate amendments to 105 CMR 222, *Massachusetts immunization information system.*

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 Wednesday, August 14, 2024, at 9 AM.

Commissioner Goldstein asked if there was a motion to adjourn.

Dr. Haddad made the motion which was seconded by Dr. Volturo. All present members approved.

The meeting was adjourned at 11:30 am.