MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of June 11, 2025

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, June 11, 2025 – 9:00AM**

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

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

Join by Web: <https://zoom.us/j/94384425598?pwd=TdLawM2X3h1OCenvZKQXGSWnfKYq44.1>

Dial in Telephone Number: 929-436-2866

Webinar ID: 943 8442 5598

Passcode: 019852

1. **ROUTINE ITEMS**
   1. Introductions.
   2. Updates from Commissioner Robert Goldstein.
   3. Record of the Public Health Council Meeting held May 14, 2025 **(Vote)**.
2. **DETERMINATION OF NEED** 
   1. Request by Beth Israel Lahey Health, Inc. for a Substantial Capital Expenditure and
   2. Substantial Change in Service **(Vote)**.
3. **FINAL REGULATION**
   1. Request to promulgate amendments to 105 CMR 210.000, *The administration of prescription medications in public and private schools* **(Vote).**
4. **INFORMATIONAL PRESENTATION**
   1. Update on the Unified Recovery and Monitoring Program for Health Professionals.

*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: June 11, 2025

Start Time: 9:03 am.

Ending Time:11:33 am.

| **Board Member** | **Attended** | **First Order:**  **Approval of**  **May 14, 2025 Minutes**  **(Vote)** | **DoN**  **Request by Beth Israel Lahey Health, Inc for a Substantial Capital Expenditure and Substantial Change of Service**  **(Vote)** | **Final Regulation**  **Request to Promulgate Amendments to 105 CMR 210.000**  **(Vote)** |
| --- | --- | --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes | Yes | Yes |
| **Craig Andrade** | Yes | Yes | Yes | Yes |
| **Damien Archer** | Yes | Yes | Yes | Yes |
| **Lissette Blondet** | No | Absent | Absent | Absent |
| **Kathleen Carey** | Yes | Yes | Yes | Yes |
| **Emily Cooper** | Yes | Yes | Yes | Yes |
| **Robert Engell** | Yes | Abstain | Yes | Yes |
| **Marcia Hams** | Yes | Yes | Yes | Yes |
| **Stewart Landers** | Yes | Yes | Yes | Yes |
| **Tom Mackie** | Yes | Yes | Yes | Yes |
| **Mary Moscato** | Yes | Yes | Yes | Yes |
| **Ellana Stinson** | Yes | Yes | Yes | Yes |
| **Ram Subbaraman** | Yes | Yes | Yes | Yes |
| **Gregory Volturo** | Yes | Yes | Yes | Yes |
| **Aria Zayas** | Yes | Yes | Yes | Yes |
| **Summary** | 14 Members Present  1 Member Absent | 13 Members Approved;  1 Member Abstained;  1 Member Absent | 14 Members Approved;  1 Member Absent | 14 Members Approved;  1 Member 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, June 11, 2025, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Commissioner Robert Goldstein; Craig Andrade; Damian Archer, MD; Kathleen Carey; Emily Cooper; Robert Engell; Marcia Hams; Stewart Landers; Tom Mackie; Mary Moscato; Ellana Stinson, MD; Ram Subbaraman, MD; Gregory Volturo, MD; and Aria Zayas.

Ms. Moscato left the meeting at 11:15 am.

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

Commissioner Goldstein called the meeting to order at 9:03 am and made opening remarks before reviewing the docket.

**1. ROUTINE ITEMS**

*a. Introductions*

Commissioner Goldstein

*b. Updates from Commissioner Robert Goldstein*

**Pride Month**

Commissioner Goldstein recognized that this month is Pride Month. He reminded the Council that Pride Month’s roots lie in resistance, a legacy born from protests and struggles led by those who refused to accept silence, invisibility, and injustice. This is a time to honor the hard-won strides of the LGBTQ+ community, shine a light on the progress we have achieved, and double down on our resolve to confront and dismantle the discrimination that still persists.

**Juneteenth**

Commissioner Goldstein noted that next Thursday is Juneteenth. Also known as Freedom Day or Emancipation Day, Juneteenth commemorates the day when enslaved African Americans in Galveston, Texas, were finally informed of their freedom two and a half years *after* the signing of the Emancipation Proclamation. This holiday provides the opportunity to reflect on our collective commitment to advance racial equity and to continue strategizing ways to dismantle structural racism and the health inequities that we see in our work.

**Summer Safety**

Commissioner Goldstein said as summer begins, the Department has launched its annual public awareness campaign to help residents enjoy the season safely. We have distributed a press release and will continue to remind people about reducing the risk of tick and mosquito-borne diseases, lessening the increased risks of heat, and reinforcing essential summer safety practices.

**RVRS Launching MAVRIC**

Commissioner Goldstein said last week, our Registry of Vital Records and Statistics launched MAVRIC (the Massachusetts Vital Records Information Collaborative), the state’s new, modernized system for processing death registrations. The MAVRIC system is faster and more streamlined than our current system, enabling online messaging among all users, and reducing paper-based processes like faxing. Importantly, MAVRIC is also more secure and allows users to complete registrations online anytime. DPH has been preparing our death registration partners for over 2 years, with increased communication and trainings on the MAVRIC transition with city and town clerks, Massachusetts physician groups, hospitals and medical facilities, long-term care agencies, hospice programs, funeral homes, burial agents, and professional boards. We thank our DPH partners for their assistance, collaboration and patience as we move to a more modern, secured, and streamlined system for the processing of vital events in Massachusetts.

**Measles Updates**

Commissioner Goldstein said last week, CDC updated their global travel warning for measles to [Level 1 – Practice Usual Precautions](https://wwwnc.cdc.gov/travel/notices/level1/measles-globe) which includes recommending all international travelers be fully vaccinated against measles according to [CDC's measles vaccination recommendations for international travel](https://www.cdc.gov/measles/plan-for-travel.html) before departing. Measles is a highly contagious respiratory illness that [spreads to others](https://www.cdc.gov/measles/causes/index.html) through coughing and sneezing. Most people who bring measles into the United States are unvaccinated U.S. residents who get infected during international travel. Travelers can be exposed to measles in many settings, including airports, train stations, public transportation, tourist attractions, and large events. According to [CDC](https://www.cdc.gov/measles/data-research/index.html), as of May 29, 2025, a total of 1,088 [confirmed measles cases](https://www.cdc.gov/measles/data-research/index.html) were reported by 33 US jurisdictions so far this year. There continue to be no recent measles cases reported in Massachusetts.

**Vaccination Updates**

Commissioner Goldstein said over the past 3 weeks there has been a flurry of communications coming from federal government agencies regarding COVID-19 vaccine recommendations. Initially, the leaders of HHS and FDA raised significant alarm in the health care community when they announced that COVID-19 vaccines would be removed from the CDC routine immunization schedule for healthy children and pregnant people. However, at this time, COVID-19 vaccines remain available. The revised CDC immunization schedules recommend that COVID-19 vaccines may be administered to children aged 6 months through 17 years old, with shared decision-making in consultation with a clinician. And, while the previous recommendation for pregnant people to be immunized was removed from the schedule, currently, there is no recommendation for pregnant people regarding COVID-19 vaccination in the immunization schedule.

Pregnant women remain at high risk for serious complications from the virus. Vaccinating pregnant women also protects newborn babies, who can't get vaccinated themselves but are at very high risk for serious complications from the virus. Getting the COVID vaccine during pregnancy protects newborns from hospitalization. We know that COVID vaccination prevents severe illness, hospitalization, and death in those at risk, including children and pregnant people. DPH will continue to lift up the data and evidence that are available to inform our recommendations, and we will work with insurers, healthcare providers, and others across the state to maintain access to evidence-based, safe vaccines.

This week, Health and Human Services Secretary Kennedy abruptly dismissed all members of CDC’s Advisory Committee on Immunization Practices, or ACIP. In dismissing the members, the Secretary stated his intention to repopulate the Committee and to hold the scheduled ACIP meeting June 25th to June 27th. This news is troubling. It upends a science-based process that has informed vaccine recommendations and promoted vaccine access for decades. The future of federal vaccine policy is unclear. We do not know who Secretary Kennedy will appoint to reconstitute ACIP, nor do we know when he will make those appointments. We also don’t know if those on the newly reconstituted committee will continue the tradition of evidence-based decisions, made transparently, and with public comment or how these decisions will change insurance coverage for vaccines, or access to vaccines through the Vaccines for Children program. What we do know is that Massachusetts will stand strong and continue to use evidence and science to guide our vaccine recommendations and vaccine policy. We have been preparing for a number of scenarios, including this one and are well positioned to respond and maintain access to vaccines across the state. Starting in November we have been analyzing the legal and regulatory landscape, identifying resources that could be used to guide vaccine recommendations, strengthening our data systems to understand vaccine effectiveness, and building a coalition of like-minded, evidence-based public health organizations in this state and others.

Vaccines are the most effective public health intervention of the past century. They provide safe, effective protection against diseases that were previously fatal. While changes at the federal level may change how we manage vaccine access, they cannot change the truth about the power of vaccines and our state’s commitment to protecting people with them.

**Federal Updates**

Commissioner Goldstein then discussed the headwinds we are facing from the federal government; from the cuts in programs and grants, from the barrage of executive orders, from the fear and the uncertainty and the disruption.

* A President’s budget proposal that guts core public health programs.
* A court battle over billions in public health funding . . . money that supports vaccines, disease tracking, and infrastructure.
* A rising tide of anti-science rhetoric – especially around vaccines.
* And a surge in immigration enforcement that is shaking families and communities to their very core.

Recently a federal judge issued a preliminary injunction to stop the Trump Administration from stripping more than $11 billion in COVID-era public health grants, money that 23 states, including Massachusetts, rely on to keep basic public health systems and programs running. The court said plainly that the Administration overstepped its authority. But while the pause remains in place, the uncertainty continues. Meanwhile, vaccine science is once again under attack, not just among fringe factions, but from federal sources where facts should be sacred. We are already preparing for disruptions in access and messaging this fall. But here in Massachusetts, we will stay rooted in science, and we will continue to lead with evidence.

And then there is the Trump Administration’s budget. If passed as proposed, this federal budget would force devastating choices, scaling back programs that are saving lives, pulling back from communities we have worked for years to build trust with. Equity, prevention, community care – all of it is on the line. Add to that the chilling rise in ICE activity across the Commonwealth, and the country making people afraid to go to the doctor, to seek help, to ask questions or to answer the door when someone knocks. That fear spreads and it hurts health. The staff at the Department of Public Health feels the strain. But the truth is it’s what we were built to do. Public health shows up when systems fall apart, get messy, unclear, and even hostile. We lean in, we protect, we inform, and we hold the line. We are the safety net for the safety net. And no matter what storms may come from Washington, our commitment has not changed. Our values have not shifted. We will keep standing up for what’s right, for evidence, for equity, for every person in this Commonwealth. Massachusetts is where public health in this nation was born, and we must not back down.

Commissioner Goldstein asked if there were any questions.

Mr. Landers thanked the Commissioner for his comments about Pride. He then highlighted several people whose work helped the causes of the Massachusetts LGBTQ+ community.

Ms. Moscato asked for confirmation that there was no update to the closure of Pappas Rehabilitation Hospital.

Commissioner Goldstein said there was no new information to provide the council. The working group for Pappas Hospital assigned by the Governor is meet soon and he will provide the council with any new information.

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

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

*c. May 14, 2025 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the May 14, 2025, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the amended May 14, 2025 minutes.

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

**2. DETERMINATION OF NEED**

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

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

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

Dr. Carey said the demand for a satellite location in Plymouth was very well documented in the application, but the justification for Quincy was much more general. There was no trending forward forecast of need and there was nothing about what capacity would be required to meet the demand. Her second question had to do with Plymouth where the supply and the demand for specialty physicians for hematology and oncology went unmet. She asked what challenges the applicant might expect in terms of providing the workforce needed.

Pete Healey, President, BIDMC and BILH Metro Boston Division, said both of these projects fall under what is a declared operating objective for BILH of extraordinary care closer to you. They have a stated goal by 2030 and beyond to be providing 70% of specialty care in their communities versus in their two academic centers at BIDMC and in Lahey and improving access, particularly to specialty care closer to people's homes in their communities.

Ben Wilson, Counsel, Ropes and Gray, answered Dr. Carey’s first question regarding the need for a patient panel in Quincy. He noted it is challenging to produce existing data on patient panel. They spent quite a bit of time internally trying to produce hard numbers to demonstrate what the lived experience of BI has been in that market, which is difficult to assess. This is validated both by community health centers in the market and local officials finding specialists to whom primary care doctors can refer. The trend has been that those patients go to BIDMC in Boston, and the hope is that they can keep them in the local community. He said it is difficult to find numbers at this point substantiate that.

Mr. Healey added they have large wait times at BIDMC Milton. They’ve done a lot to expand specialty physician sessions and participation at Milton. They plan to have fifteen additional providers to create enough specialty care access for patients. Also, in the Milton community there was Quincy Hospital and Carney Hospital, which are both gone, accelerating demand for the community.

Mr. Wilson referred to Dr. Carey’s second question about the supply and demand for oncologists and oncology specialist physicians in Plymouth, and the plans to meet that need.

Mr. Healey said they have a strong reputation as an organization with a workforce development program. They need to continue to make investments in the pipelines and workforce programs. BILH has an entire program related to that and would have extra emphasis both in Plymouth and in Quincy for these pipelines.

Ms. Moscato said as she was beginning to read the application it looked like it was a BIDMC application. But, she said, it really is one that takes their academic center and brings it into the community hospitals through a network to lower the cost by way of their pharmaceutical structure and to use their current administrative structure, to limit overhead and bring these services to the community. She said she was still worried about the 150 positions that are needed to be filled.

Mr. Healey confirmed that she read their approach correctly and said that is a common story in community hospitals across the state that infusion is a service that is closing because it's not viable. They can do it in a financially sustainable way.

Mr. Landers commended the applicants on their application. He asked to have a presentation separate from an application about how the department monitors costs once an application has been approved. He said that he understood the cost year over year is the metric, but what happens when costs are unexpectedly higher than what was presented in the application. He asked if the Cordage Park building exists, and if it will be rehabbed. He also asked in Quincy if the current sites for treatment will close in favor of the new satellite site. He then mentioned that the application said that space would open up in Plymouth with the BID site to expand the emergency department. He wanted to know if the costs of that expansion were included in the current application, or if another application would be needed. Lastly, the Boston Globe had an article that talked about the $25 million inserted in the budget for the parking garage in Quincy to support the hospital.

Commissioner Goldstein said they've been talking about how they can best come to this council with the current regulations and discuss what is allowable, or not allowable and how to interpret the regulations and how to manage these applications. He said they'll work towards a presentation that the Council can review outside of an application.

Mr. Wilson said regarding the Plymouth site, it will make room for the expansion of the ED and it is the subject of a separate DoN application. Regarding Quincy, services will move from Quincy Square to the new site.

Mr. Healey confirmed that the Cordage Park building does already exist and will be renovated.

Mr. Wilson said, regarding the intersection between the DoN file for Dana Farber Cancer Institute for the new hospital center done in collaboration with BIDMC as well, intersects only as it is an inpatient project. This DoN being a community outpatient infusion center, he expects that there will be a degree of coordination throughout the system, but the BIDMC expectation would not be that these patients who are currently struggling to get timely appointments in Plymouth would be traveling into the city. The collaboration with the Dana Farber and the related cancer building is isolated to Longwood and Chestnut Hill and does not involve BILH cancer services that are all across our network and does not involve the Dana Farber cancer programs that are in their outlying communities.

Jaclyn Gagne, Chief Deputy General Counsel, DPH noted that the Council did approve the emergency room project portion of the application at its December 11th, 2024, meeting and the details are available on the website.

Dr. Volturo asked if by creating these two facilities, does it create more space in the existing facilities that would allow expansion of additional services, maybe additional geriatric care or some specialty services that are currently not available in Milton, or Plymouth. And he asked regarding cost, BI, just as every other academic Medical Center, is leveraging 340B pricing to do this sort of work. And obviously our political environment right now leaves a lot of questions up in the air. He asked if 340B were to go away, would it be more cost effective to manage it from Plymouth as opposed to from BI.

Mr. Healey said when it comes to federal cutback threats to healthcare operations, for the last number of years, 340B has been at the top of the list. Now it is less threatened in part because other risks are so significant and new, and because 340B in the current administration is more of a bipartisan support issue. He also answered Dr. Volturo saying yes, that moving services and growing services outside of their main campus allows them to use the main campus for some other things.

Ms. Hams said her concerns were around cost. She asked about alternatives to the Plymouth infusion services and wondered if the applicant had considered a freestanding ambulatory clinic, not a hospital HOPD which would have fewer costs. And given the 340B potential risks, and that being the major rationale for the structure that was proposed in the application, then that could be even more significant if those savings weren't available to the extent that is planned under the application. She noted that the applicant didn't identify the ways in which the projected cost reductions would be achieved at Quincy and therefore, that is the rationale for condition 3, which does seem very important in that context.  She wondered if the DoN staff had requested any more documentation from the applicant on the cost savings at Quincy, and if that wasn't forthcoming, if there was anything more that the council should know about that. With the importance of this condition, she asked what are the consequences if there is a material cost increase and if there's a requirement for a plan, and what would be the consequences to the applicant if the applicant doesn't submit a plan, or there's an inadequate plan, or the plan isn’t followed.

Mr. Wilson answered the first question was about the alternatives to the Plymouth infusion site, whether they had considered having it be a clinic as opposed to a hospital site. Due to the site neutrality rules and it's not being an accepted site, most of these are Medicare patients. Over time, they would certainly expect the revenues to equalize to the extent they haven't already equalized for Medicare patients with a site to a clinic, so there would not necessarily be significant differences there. From a drug pricing perspective as others have noted, so long as those drug discounts exist, he noted that it would have been a significant difference to the feasibility of the project. And the last thing he noted is there are significant operational reasons why having this integrated with BIDMC, including the availability of other specialists, but also some of the core infrastructure and avoiding some of the duplication that would happen if this was technically separately licensed as a clinic and not part of the main BIDMC license.

Mr. Healey said they’re interested in Cordage Park because they already have services there and it's familiar to their patients and providers.

Mr. Renaud said the data the applicant provided did not specifically identify a way that the proposed project will compete on the basis of price, total medical expense, and other measures of healthcare spending. They decided to implement condition 3, which they went over already in the meeting. The Department will look at the percentage growth year over year and if they notice a material difference, they will have to justify that increase to them. Their ability will be to evaluate that justification and if they so desire, require a remedy to impact the increase in percentage growth year over year.

Ms. Hams clarified that her question was based more on the line if the plan is not submitted or it's an inadequate plan or there's no adherence.

Ms. Gagne said if for some reason they can't come to a remedy or it is inadequate, then this would be a situation where they would potentially not be in compliance with the terms and conditions of the DoN and could come back to this council.

Mr. Engell noted in the application the identification of wait times and they seemed to be fairly static around 25 days for three or four years. And then there was a doubling. He was curious if there was something that was specifically identified as the cause and rationale for the doubling in one year and if that's an aberration, or if it’s going to be mediated otherwise, or if it's requiring the expansion of capacity to address that specifically.

Mr. Healey said unfortunately that is not an aberration when they look at their specialty. During the pandemic many patients chose not to pursue elective specialty care and did not want to engage with the healthcare system. Then coming out of it, they saw a sharp uptick in specialty care demand. Those numbers are not particularly uncommon looking across their specialties and various operations across BILH. To resolve it is to improve access. And then continue to look for novel and innovative ways to use the appointments they have most judiciously online access for patients, and other methods to make sure that they’re prioritizing the right patients into those slots.

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

Dr. Carey made the motion, which was seconded by Ms. Moscato. All present members voted to approve Beth Israel Lahey Health, Inc.’s request for a Substantial Capital Expenditure.

**3. FINAL REGULATION**

*a. Request to Promulgate Amendments to 105 CMR 210.000, The administration of prescription medications in public and private schools (****Vote****).*

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

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

Ms. Hams inquired about the training in the school health program mentioned by Ms. Robitaille and wondered if in the rescue opiate antagonist section, if the training includes students as well.

Ms. Robitaille said that the regulation does not address the training of students, but neither does it prohibit the training of students. It would be at the school or school district's discretion and many school districts are doing that already.

Mr. Engell asked about the training programs. He said it seemed the regulation was silent as to what the training requirements were, if there's any standardization or expectation associated with the training consistencies between school districts based on who's establishing that training for the particular school district.

Ms. Robitaille said there's training for the school nurses that are responsible for carrying out these regulations. Then separately there's a training that they could provide to their school staff who will be delegated to. Additionally, School Health will provide links to approved programs that train unlicensed staff to administer epinephrine or opioid antagonists. In Massachusetts, school nurses have to be licensed by the Department of Elementary and Secondary Education as well maintaining their nursing license. Required for that educator license, among other training, is more basic level medication training. A second training is required in order to get a Massachusetts Controlled Substance Registration as the medication program director. The latter goes very deeply into the regulations, making sure that nurses that are going to be managing the programs have a deep understanding of what is required.

With no further questions, Commissioner Goldstein asked if there was a motion to approve amendments to 105 CMR 210.

Mr. Andrade made the motion, which was seconded by Mr. Engell. All present members voted to approve the Request to Promulgate Amendments to 105 CMR 210.000.

**4. INFORMATIONAL PRESENTATION**

*a. Update on the Unified Recovery and Monitoring Program for Health Professionals.*

Commissioner Goldstein invited Jon Dillon, Director of Policy for the Bureau of Health Professions Licensure, to present an overview of the Unified Recovery and Monitoring Program for health professionals.

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

Mr. Engell asked how a person might be referred to the URAMP program, and how they are integrated back into their work setting.

Mr. Dillon said the most common route into the URAMP service would be a referral from board staff after they’ve investigated an adverse incident that's been brought to their attention and to determine whether disciplinary action is necessary. As part of that investigation, they identify that a health issue is at play and signpost to the URAMP program and encourage the individual to determine whether they want to make an application to that program. There are two other potential, but less likely routes into the program. The first is a self-referral. The legislation requires us to allow a self-referral which is a circumstance whereby an individual themselves recognizes that they have a mental health condition, or a substance use disorder. This is unlikely because the person can potentially impair their practice when they can access treatment rather than monitoring programs. The final route we foresee to entry into the program is again, self-referral. This is situation where an employer has been proactive in identifying a substance use disorder or a health condition which impairs practice, and they have encouraged the individual to engage with URAMP program. They think this is a good proactive way of employers to help staff to manage their own well-being and the safety of patients. Once individuals are within the program, there are monitoring conditions imposed upon them. There is currently an initial period of six-month suspension. They need to check in every day using an app. Random toxicology tests may be administered. They must adopt a peer support process. Then there is a stage of supervision and return to practice with restrictions. Compliance is monitored with a target of returning people after three to five years to unrestricted practice.

Mr. Landers mentioned that he was happy to hear the compassionate belief of the program that relapse is sometimes part of recovery. He was curious as to the annual financial cost of bringing someone back into the profession.

Mr. Dillon spoke first of relapsing and said they have a unique model of respite for those that have experienced relapse. Though they may want to return to engagement with the program, they may not be ready to do it. The program allows them to still be monitored but not engaged for up to three months. In regard to the cost, URAMP was not funded by legislation. They cannot offer financial assistance to participants to engage with their toxicology process. The individual bears the cost of that and in the course of a three to five year program can be as much as $5000. The operating costs currently are modest, but the growth expectation of the program will require additional operational people and the costs will grow.

Dr. Subbaraman mentioned that the Board of Registration in Medicine was not a board included in URAMP. He then asked when the mental health component of the program may be online. And thirdly, he spoke of the stigma attached to those that have struggled with substance use disorder and asked how the program helps to navigate that once they’ve recovered and are in a position to re-engage in providing care.

Mr. Dillon said regarding BORIM, the legislation created URAMP originally included the Board of Registration in Medicine, but BORIM made a specific request to be removed. BORIM licensees are overseen by the Physician Health Services Organization, which is part of the Mass Medical Society Corporation. In terms of the timeline for mental health, they will aim to have a process within their policy manual for the management of the wide range of mental health services before the end of this year. Finally, on stigma they believe one of the key aspects of URAMP is that it doesn't sit within the professional board and it doesn't require participants to be overseen within the profession. It also encourages peer support from profession specific peer groups. It operates independently. If an individual goes into the program, engages with conditions and successfully returns the practice, the fact of participation within the program remains confidential throughout. They hope that along with a really experienced set of staff, most of whom they were able to transfer from their existing alternative to discipline services will make this a supportive service that will achieve the aims that they’ve set out to achieve. He added what makes URAMP particularly effective is it was required by the legislation to appoint a specialized committee called the Rehabilitation Evaluation Committee, which has seven members that are experts within the field.

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 July 9, at 9:00 am.

Commissioner Goldstein asked if there was a motion to adjourn.

Mr. Engell made the motion which was seconded by Mr. Andrade. All present members approved.

The meeting was adjourned at 11:33 am.