MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF JUNE 8, 2011

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

THE PUBLIC HEALTH COUNCIL OF
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston MA

Updated Docket: Wednesday, June 8, 2011, 9:00 AM

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1. ROUTINE ITEMS: No Floor Discussion

a. Compliance with Massachusetts General Laws, Chapter 30A **(No Vote)**

b. Record of the Public Health Council Meeting of April 13, 2011 **(Approved)**

2. REGULATIONS: No Floor Discussion (Votes)

a. Request for Final Promulgation of Amendments to 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements to Establish a Statewide Secure Electronic Infectious Disease Reporting and Notification System (**Approved with PHC amendment)**

b. Request for Final Promulgation of New Regulation 105 CMR 201.000: Head Injuries and Concussions in Extracurricular Athletic Activities **(Approved)**

3. PRESENTATION: No Vote / Information Only

"Update on Measles Infections in the Commonwealth"

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

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council (M.G.L. c17, §§ 1,3) was held on June 8, 2011 at 9:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room.

Members present were: Chair, Mr. John Auerbach, Commissioner, Department of Public Health, Mr. Harold Cox, Dr. Michéle David arrived at about 9:10 a.m., Dr. Muriel Gillick, Mr. Paul Lanzikos, Ms. Prates Ramos, arrived at 9:25 a.m., Mr. Josè Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman arrived at 9:15 a.m., Dr. Michael Wong arrived at 9:30 a.m., Dr. Alan Woodward, and Dr. Barry Zuckerman. Also in attendance was Donna Levin, General Counsel.

Absent members are as follows: Ms. Helen Caulton-Harris, Dr. John Cunningham, and Mr. Denis Leary.

Chair Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. He summarized the agenda of the day. He noted that we would be hearing the presentation on measles infections while we await the arrival of more Council Members to secure a quorum.

Presentation: Update on Measles Infections in the Commonwealth. Presenter: Noelle Cocoros, PhD Candidate, Sr. Vaccine-Preventable Disease Epidemiologist, Bureau of Infectious Disease

Addressing the Public Health Council, Ms. Cocoros noted that overall, most people born prior to 1957, have been considered immune to measles. Immunity can also be indicated through receiving two doses of the vaccine; both given after the age of one, at least 28 days apart. Serologic proof of immunity (titer drawn, showing you are IGG

positive) is an additional way to prove immunity. Physician diagnosed history of disease is not considered proof of immunity; however this differs from the CDC. Ms. Cocoros also acclaimed their higher criteria for immunity for health care workers and others in high risk situations, such as a day care with infants.

Ms. Cocoros noted that in 2006, there were 19 confirmed cases, an outbreak based in the City of Boston. For 2011, as of this morning, there were 17 cases. Of these 17 cases, the first five occurred in January and February. Ms. Cocoros stated that the issue currently is that there have been 12 confirmed cases, including rash onsets, since May 1st. Further, she elaborated that the real concern is that no connection has been established between cases.

The vaccination statuses for the cases to date in 2011 are as follows: two have had two MMRs, three have had one MMR, and seven are unknown. The "unknown" statuses are typically people in their forties, fifties, sixties, who just don't know what their immune status is, or if they were vaccinated. There were five unvaccinated. Two were siblings who had religious exemptions. Two missed their twelve month visit, thus not completing their vaccine regimen. She noted that they are investigating suspect cases; of which, 19 had been revoked as of today (laboratory testing has come back negative) and 10 were still being investigated.

Discussion followed by the Council. The Council asked why two people who were vaccinated came down with measles. Ms. Cocoros replied that there is no 100% protection from any vaccine, further, depending on the regime received, protection varies. Regarding international travel, the high rate of measles in Europe is due to a combination of populations or countries that haven't had consistent two dose vaccination (France) and other countries that have had a decline in vaccinations due to the fear of autism (UK). Dr. Larry Madoff, Division Director, Immunology and Immunization noted an estimated mortality rate for measles to be about one to three per 1,000 cases. He further noted a much higher morbidity rate, with 30% having complications.

Dr. Alan Woodward suggested we utilize this time to publicize the importance of appropriate immunizations.

Ms. Cocoros cited statistics on vaccination rates for some Massachusetts school children. Notable information submitted by school nurses, includes: 97% of "child care age" (before kindergarten) had one or two doses of the vaccine; 92% had two doses in kindergarten; 99% of 7th graders had at least two doses. Ms. Cocoros stated they infrequently see exposures due to these high vaccination rates.

It was noted that health care workers are required to have two doses, regardless of their date of birth. Ms. Cocoros stated further that exposures in health care facilities require collaboration with Infection Control to identify potential exposures. Either epidemiologists at DPH or the local board of health will do direct follow-up with the exposed individuals, along with either Infection Control or clinician follow-up with these patients.

It was noted that the majority of cases have been in U.S. born, Caucasian individuals. Discussion continued. Please see the verbatim transcript for full presentation and discussion.

NO VOTE/INFORMATION ONLY

Note for the record: Council Member Dr. Michéle David arrived at 9:10 a.m., the start of the measles presentation. Council Member Mr. Albert Sherman arrived at 9:15 a.m., during discussion on the measles presentation. Council Member Ms. Lucilia Prates Ramos arrived at 9:25 a.m. near the end of the discussion securing a quorum. Please note these times are approximates.

RECORD OF THE PUBLIC HEALTH COUNCIL FOR THE MEETING OF APRIL 13, 2011

Dr. Woodward moved approval of the minutes as presented. After consideration upon motion made and duly seconded it was **voted**

presented.

Dr. Woodward asked for follow-up on the MOLST project, as noted in the April Minutes. He mentioned that the Massachusetts Medical Society passed a resolution that it will be involved in supporting statewide dissemination. Further the MA Medical Society has indicated it will be happy to be involved in the education of physicians and health care workers, as well as creating education programs. The real issue however, as indicated by Dr. Woodward, is funding to get this across the state. Dr. Woodward recalled that $200,000 is to be forthcoming from Partners, yet he questions if there are other sources to be pursued. The critical nature of statewide implementation was stressed and the importance of a time table for strategizing collectively for this effort. He noted the widespread recognition of the critical importance and excellence of this program.

Chair Auerbach asked Mr. Daniel Delaney of DPH to put this on the Public Health Council docket for an update.

Dr. Wong commented on the measles issue, citing an example he encountered in his hospital. His report illustrated the reasoning behind his assertion that all primary care physicians should be reviewing vaccination histories for patients that cannot provide documentation of either adequate vaccination or clear measles infection at some point in their life. Additionally, his suggestion included that such individuals should receive an IGG for measles to check for indicators of protection. Please see transcript for full account.

Chair Auerbach responded that this issue questions our assumption that people born prior to 1957, whom had measles, are naturally immune. He noted that the discussion suggested we in fact do not know for certain the extent of this natural immunity. He suggested we consider policy implications as we continue to monitor the issue.

REGULATIONS: REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 300.000: REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS TO ESTABLISH A STATEWIDE SECURE ELECTRONIC INFECTIOUS DISEASE REPORTING AND NOTIFICATION SYSTEM

Mr. Kevin Cranston, MDiv, Director, Bureau of Infectious Disease, accompanied by Ms. Gillian Haney, MPH, Director, Integrated Surveillance and Informatics Services, Bureau of Infectious Disease presented the request for final promulgation of 105 CMR 300.000 to the Council.

Mr. Cranston noted that even though their broader language clearly refers to MAVEN, the Massachusetts Virtual Epidemiologic Network, they are not specifying MAVEN by name to reserve the possibility that other platforms might be utilized in the future. Please see attachments and/or transcript for an outline of proposed revisions to the regulations.

Mr. Cranston indicated that two public hearings had been held on March 28 and March 31, 2011, in Framingham and Springfield, on the proposed amendments to 105 CMR 300.000. One individual testified at the March 28 hearing and also provided written testimony. No testimonies were given at the March 31 hearing. The Department received 17 additional written comments by April 1, 2011. Mr. Cranston noted the great majority of commentary received was supportive of the system. Comments included those by boards of health regarding the relative ease of use of the system, as well as others regarding its efficiency. Please see transcript for further discussion on comments received.

Mr. Cranston noted that there were also a number of concerns raised about the system, some technical and some jurisdiction specific. Comments included concern for a steep learning curve to become proficient in the system and how change can be difficult for those already trained in database systems. A number of jurisdictions spoke to the need for particular technical enhancements to the system. For

example, the ability to access large quantities of data rather than specific age reports, as well as the ability to choose between local boards of health for report running when a single user is responsible for more than one local board of health. Further comments were regarding reliance on the state Virtual Gateway which goes down for maintenance or technical glitches from time to time.

Mr. Cranston explained that concerns were raised by the Boston Public Health Commission, which has invested heavily in its own system, the Boston Surveillance System (BOSS). He elaborated on functionalities that BOSS possesses and MAVEN lacks. For example, BOSS collects a number of data elements, variables, and question packages, which guide specific types of investigation; MAVEN currently does not collect such information. Additionally, BOSS is capable of tracking and reporting on non-Boston residents who receive care in Boston facilities, particularly for the localized infection control in those facilities. MAVEN is only capable of allowing local boards of health to view data on their own residents, a significant constraint on Boston's ability to follow-up on non-Boston residents who are receiving care in Boston facilities. Mr. Cranston mentioned that a concern was expressed that the Department may not make timely changes to MAVEN, as requested by BOSS; particularly of concern for emergency disease scenarios. This concern was said to be based on the fear of prioritizing needs over a particular board of health's, along with the inability of BOSS and MAVEN to communicate with one another. Creation of a data sharing interface was said to be requested to enable interoperability between BOSS and MAVEN.

In conclusion, Mr. Cranston discussed the additional training and technical support currently available through the CDC, enabling the cities and towns to go on-line with MAVEN. Staffs from Boston and from DPH were noted to have met on three occasions, most recently last week. Mr. Cranston explained that several options were being considered for creating interoperability mechanisms. These options are all likely to respond to Boston's needs in maintaining its own system; while simultaneously participating in real time data entry into MAVEN. Mr. Cranston deplored their belief that the advantages of a secure statewide electronic epidemiologic system greatly outweigh

the concerns. The concerns of local boards of health, regarding their particular system needs, are all capable of being addressed with available federal resources and information technology solutions.

Discussion by the Council followed. Please see transcript for the full presentation and discussion. Dean Harold Cox disclosed that he is a member of the Boston Public Health Commission and asked staff to confirm that conversations with Boston will continue about creating interoperability between the two processes if this regulation is approved today. Mr. Cranston replied,

> …The final promulgation of these amendments only reinforces our commitment to continue those conversations and work toward a mutually beneficial outcome… We are working in close tandem with an IT consultant that has been deeply involved with the development of actually both systems and we have been assured that it is a relatively simple process once we have come to a decision about which system to employ.

He said he believed that this could be achieved within their stated timeframe goal, by the end of 2012.

Chair Auerbach replied in part, "I think this issue is comparable to an issue that we are seeing throughout the State as we are looking at issues of electronic medical records … I think that the ability to work on these issues is rich…how to look at different systems and make sure they are able to communicate, respecting the needs of for example, of a hospital, to have its own patient-specific approaches while, at the same time, being able to comply with the state requirements around pulling out data and downloading those into systems."

Ms. Gillian Haney, MPH, Director, Integrated Surveillance and Informatics Services, Bureau of Infectious Disease clarified that the CDC has established national standards for surveillance systems that are outlined in what they call the Public Health Information Network Standards (PHIN) and that all states are required to be compliant to enable standardized communication across states. She note that Massachusetts was the first state to develop MAVEN, since then, it has been adopted by 12 or 13 other states so far including

Washington DC, North Carolina, and Connecticut. Ms. Haney further clarified that, "MAVEN has the capability to share information amongst jurisdictions; it is just not done on a routine basis. The local board of health has to determine that it would be appropriate to share information about their case with another jurisdiction."

Dr. Alan Woodward noted that it is expensive to maintain computer interfaces and suggested that if Boston has data benefits, it should incorporate those into the statewide MAVEN system. He recommended an amendment to 105 CMR 300.160, where it states, "... the Board of Health may report by telephone or by secure electronic surveillance case management system". He recommended that we change the word "or" to "and".

Chair Auerbach clarified with Donna Levin, General Counsel, indicating the wording to read, "... the local board of health to report immediately by a secure electronic disease surveillance and case management system, designated and maintained by the Department and if indicated, by telephone."

Dr. Alan Woodward made the motion to approve the Regulations with his amendment. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Request for Final Promulgation of Amendments to 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements to Establish a Statewide Secure Electronic Infectious Disease Reporting and Notification System.** A copy of the staff memorandum and the regulations are attached and made a part of this record as **Exhibit No. 14,978.**

REQUEST FOR FINAL PROMULGATION OF NEW REGULATION 105 CMR 201.000: HEAD INJURIES AND CONCUSSIONS IN EXTRACURRICULAR ATHLETIC ACTIVITIES

Dr. Lauren Smith, Medical Director, Commissioner's Office, accompanied by Ms. Carlene Pavlos, Director, Violence Prevention Program and Attorney Peggy Wiesenberg, Deputy General Counsel,

Office of the General Counsel, presented the request for promulgation of a new regulation 105 CMR 201.000.

Dr. Smith identified the main components of the regulations and spoke to the public comments received on the proposed regulations. Please see staff's memorandum to the Council, stating in part, "The new regulations are mandated by Chapter 166 of the Acts of 2010, An Act Relative to Safety Regulations for School Athletes will require all public, middle and high schools and those non-public schools that are members of the Massachusetts Interscholastic Athletic Association (MIAA) to have policies and procedures governing the prevention and management of sport-related head injuries".

The regulations include provisions regarding: (1) statutorily required annual training (athletic directors, coaches, trainers, parents students); (2) statutorily required documentation of an athlete's history of head injuries that have occurred prior to the start of each sport season; (3) required documentation of head injuries that occur during the season; (4) requirements for medical clearance in those instances where a student athlete has been removed from play for a head injury or suspected concussion; and (5) record retention and annual reporting of incidence and prevalence statistics to the Department of Public Health.

Dr. Smith noted that information on these regulations was presented to the Council on January 24, 2011 and that public hearings were held in Northampton on March 10 and in Boston on March 15, 2011. Seven persons presented oral testimony in Northampton, which was attended by about 12 people. Fifteen people testified at the Boston hearing, which was attended by about 32 people. Written testimony was received through April 8, 2011. Written comments were received from approximately 175 individuals and organizations.

Dr. Smith noted that many of the comments asked for the regulations to be expanded beyond the proposed scope. Staff noted they could not expand the regulations beyond the scope of the statute but, "... recognize the schools or school districts can choose to apply these same approaches to how they handle head injuries.

The organizers of town and club sports are encouraged to adopt these approaches…".

Dr. Smith explained highlights of revisions to the proposed regulations in response to comments from the public, including:

- Expanded definition of parents to include foster parents, to be more all encompassing.
- Revised section on school policies as follows:
    - To require that school policies include a teacher and guidance counselor on the teams that developed both head injury policy and reentry planning. This was noted as a request by parents.
    - Revised policy to ensure that schools have a provision or approach to doing outreach to parents with limited English proficiency. This will work to make sure all parents are well aware of these issues and are able to comply.
    - Deferred to the Department of Elementary and Secondary Education, and to schools, regarding the need for clear definition of academic accommodations. Dr. Smith noted, "We didn't feel like that was within the scope of this Department to identify exactly what that entailed, including MCAS and other testing accommodations. We know that this will come-up and we are very happy to be able to work again with school districts, as well as Elementary and Secondary Education to provide guidance and data as they purse that."
- Revised the section on exclusion from play to strengthen reentry planning; highlighting that the school-based team has to develop this plan in consultation with either the student's primary care physician or the physician who is managing the student's recovery. The goal here is to seat this work in a medical home. Dr. Smith continued, "Throughout the Department, we are trying to promote the medical home as a robust concept and it makes sense that something as important as a reentry plan should be connected with the student's primary care physician or the physician who is managing that

- Dr. Smith also noted, “There were a number of comments highlighting the administrative burden that the draft regulations would have imposed and the need for greater flexibility. Both athletic directors and school administrators are concerned about burdensome clerical paperwork requirements. Parents and others expressed concern about what we would do about non-compliance with these regulations.”

In response to public comments, staff added flexibility for documenting training completion for school staff, parents, and students. The statute requires schools to keep track of an athlete’s history as it relates to head injuries, but it is up to the schools on how to document that information. Dr. Smith elaborated, “We also added the option for schools to use their own equivalent forms as long as the required information is included. We also added the option for sharing information from the forms rather than having to photocopy the forms themselves ... Annual physical exams can be completed within 13 months per school policy and we provided six months, until January 1, 2012 for schools to submit an affirmation that they have developed their policies. We don’t need the written policy; just the affirmation that it is done”.

Dr. Smith continued, “Some suggested that athletic directors shouldn’t be responsible for the record-keeping and implementation. In response to this, we have given the schools the ability and flexibility to designate another administrator to identify school policy, with the athletic director as the default. We gave schools the flexibility to set their own policies, as long as they allow for the timely review of key information by the appropriate personnel outlined in the regulations.” She further explained that DPH will allow school

districts to create their own head injury reporting forms, and further allow flexibility about where the forms go. “We identified the athletic director as non-responsible for collecting training verification for the individuals because that would impact the burden … We revised the definition of school nurse to be consistent with the Board of Education Licensure Standards. We added a new definition of nurse practitioner, which was informed by the Board of Registration of Nursing, and we didn’t tie registration to Massachusetts only because people seek care outside of the state …We revised the section on Information Sharing to be based on FERPA, the Family Educational Rights and Privacy Act … We revised the definition of certified athletic trainer to emphasize licensure as an Allied Health Professional and added a new definition for trainers and a requirement that they also complete annual training as with the other athletic staff. We added a new section specifically on the athletic certified athletic trainer responsibilities. We elected to maintain the annual training requirements for certified athletic trainers, although we were requested to eliminate that … We revised the education requirement for health professionals that are providing medical clearance to allow for an equivalent way to satisfy this through new licensure requirements … We revised the definition of game official to include those that are enrolled in MIAA, but not limited to those. We provided flexibility for game officials to submit their training documentation to schools upon request. We did elect to maintain a requirement for documenting training of coaches”.

Dr. Smith continued with staff’s response to the public comments. “We declined to specify the hierarchy of removal decision making. It really was our belief that all of the adults on the field or in the court, have to use the same approach: ‘when in doubt, sit them out’. We have included forfeiture of games and a revised policy section on penalties to allow schools to have that as an option if there is not compliance … We revised the definition of head injury to exclude simple lacerations of the scalp or face, but if someone has a significant scalp or facial laceration or is bleeding, my hope would be that they would be taken off the field and attended to, but that is not the specific purview of these regulations. We added a new definition of team physician that is to distinguish from school physician. We

determined it was not appropriate to allow sideline diagnosis, as the statute and the regulations specifically refer to suspected concussion. We did not want to get in a position of having people try to make definitive diagnosis at the sidelines. That is sort of counter to the approach that this statute wants to take ... We did adopt the Massachusetts Medical Society's suggestion for strengthening the graduated reentry plan section".

She noted that they received many comments regarding neuropsychologists' roles. In response to these comments, revisions were made to the proposed regulations, including:

- The section on school policies, requiring schools to include a neuropsychologist, if available, on the teams that develop the head injury policies and students' reentry plans, recognizing they can offer important insight.
- With regards to the section on monitoring recuperating students, including the reentry plan. Dr. Smith noted: "... you will see that there are components for the frequency of assessments by school nurses, school physician, team physician, as well as the certified athletic trainer, or the neuropsychologist, as appropriate, until full return to the classroom and athletics are allowed...".
- In terms of the medical clearance section, Dr. Smith noted, "We identified the following individuals as being authorized to return students to play: a duly licensed physician, a duly licensed certified athletic trainer with the new refined designation and definition as we had talked about before in consultation with a licensed physician, a licensed nurse practitioner, also in consultation with a licensed physician. Those two were retained that way to reflect the practice of how those health professionals practice and lastly, a duly licensed neuropsychologist in coordination with the physician managing the student's recovery".
- Dr. Smith noted, "We elected to not expand the categories of professionals authorized to provide medical care beyond those proposed in the draft regulations. We retained the modifiers for nurse practitioners. DPH agrees that many medical providers could benefit from training and development of

In closing, Dr. Smith noted that schools are required to maintain certain records; however they have flexibility to use their own forms. Staff plans to have forms on-line by August 1st. Staff further plan on working hard to develop DPH criteria for the approval of additional training opportunities for school personnel, parents, students and health professionals. CDC is in the process of developing training for clinical professionals. In these regulations, clinical professionals who return students to play must document that they received specific training by August of 2013. Schools are required to report two numbers to DPH: (1) the total number of the Report of Head Injury forms received by the school; and (2) the number of students who sustained head injuries or concussions during extracurricular activities.

Dr. Robert Cantu, Neurosurgeon, Boston University Medical Center in the Center for the Study of Traumatic Encephalopathy and a Clinical Professor of Neurosurgery at BU addressed the Council. He is a preeminent expert in the field, having advised the NFL and other sports organizations, along with serving on the DPH Clinical Advisory Committee. Dr. Cantu noted in part,

> I think we all know that concussion comes from violent shaking of the brain. That if properly managed, almost everybody makes a complete recovery. If not properly managed, people can die from second impact syndrome and post concussion issues … It is pretty self-evident that, if you can't rule out a concussion, they are out. That's clear. That's not an issue. There's a huge issue of who can return these individuals to play and what the qualifications of those people should be and this has been the work of Lauren and her committee and I commend her for undertaking a very difficult job … I am here because I believe it is so important that this work be done.

He noted that 16 other states have passed (Lystedt Law) legislation but Massachusetts will be the first to implement it. He said, "I think the process has to go forward and it is very important for the safety of our athletes."

Ms. Kaela Murphy, a 17 year old high school student, who has had five concussions in a three year period, addressed the Council. She said in part, "... As a brain injury patient, I need your help to educate both teachers and administrators, coaches and referees, and athletes and parents on the danger of head injuries ... People can study the pamphlets, look at posters, and read all the newspaper articles but still have little understanding of the day-to-day issues of a concussion. Teaching them symptoms and warning signs is one thing, but we need to educate these people on the damage that has been done, the rehab that the patients need, and the importance of waiting the extra time." Please see transcript for Ms. Murphy's full testimony.

Ms. Murphy noted that she was raising funds to enable all students attending her high school to be administered the impact test, beginning next year. She wanted this so that, "... no student will play a contact sport without first being administered the impact test and to actually all students because not all concussions happen while playing sports."

In conclusion, Ms. Murphy said in part, "... I ask you all to recall the three words I mentioned at the beginning of my presentation, education, eliminate and escalate. Please help me to help others. We need to get the word out that concussions are not something to be taken lightly. Let's try to educate the community, eliminate the busy work, and escalate our response...".

Chair Auerbach thanked Kaela Murphy for sharing her experience with the Council and for wanting to help others with brain injury. Dr. Robert Cantu returned to the table to answer questions from the Council. Please see the verbatim transcript for the full presentations and discussion.

In response to a question by Chair Auerbach on what is being done regarding concussions at the collegiate and professional athletics levels, Dr. Cantu said in part, "A very unique thing has happened around the concussion issue, and there is no question that part of it is being driven by the seriousness of mismanaging concussion in terms of second event syndrome and to a lesser extent but

significant in terms of more of them, post-concussion syndrome, but also the effects of too much total concussive trauma and sub concussive trauma in the sense of the chronic traumatic encephalopathy issues that has been brought to the public at BU and involve now 14 NFL players ... The National Football League flipped a 180 degrees from 2009 to 2010, as the leading advocate for concussion management. The Return to Play Guidelines that I and other members of the Return to Play Committee worked on, and will be made public as soon as the CBA is signed because they are done, mandate any athlete who you can't rule out a concussion, not even diagnose it, you just can't be sure he didn't have one, is out of an NFL game, or an NFL practice, cannot be returned until not only the team physician feels they can safely go back, but an independent outside neurological consultant. This is more stringent than any other level. The NCQA has adopted the same legislation. I am sure the National Federation of High Schools will be doing the same. So, it is taken very seriously ... Hockey Canada has outlawed all intentional and even unintentional hits to the head... ".

Dr. Zuckerman inquired about the importance of having this pre-participatory neurology screening. The purpose, of which he noted, is to understand where a child is from the beginning to end of participation. Dr. Zuckerman noted that outside of the aforementioned purpose, his perspective is that it makes the decision making process rather chaotic. Dr. Cantu replied, "It is absolutely essential without question and is used by the National Football League ... the Return to Play Protocol comparison to their baseline screening protocol, which is a combination of several tools out there and also adds in conditions like ADD, ADHD, panic attacks, anxiety disorders, depression, which prolong concussion effects ... Neuropsychological testing in and of itself, if you really don't have a baseline for an individual, it is also subject to interpretation. A very bright person can score high average and still be way down. I have no question Kaela would probably pass the impact, but not pass it where she once did while she was still symptomatic ... I think over time, these kinds of things should be added in".

Mr. Rivera asked Dr. Cantu, “Are we doing everything we can about prevention and is that a conversation we need to engage in?” Dr. Cantu replied, “I think it is very important that proper techniques, proper training, neck strengthening, proper hydration, understanding individuals at risk for prolonged post-concussion issues because of underlying medical conditions and all of those things; I think should be discussed but concussions aren’t going to be eliminated as long as there is head contact. There is no helmet that is going to protect and eliminate legalized hits to the head. The way it will be reduced is to eliminate legalized hits to the head (like Hockey Canada) and diminishing the amount of total head trauma to these youngsters, that they are taking in practice, eliminate the blows to the head in practice, not because it is at greater instance per minutes of play. The incidence is three times greater in game play, but games are once a week and in some sports practice is four or five times a week”.

Chair Auerbach clarified, “… that due to obesity and diabetes, we want to promote greater activity among young people and we want to promote sports, but to minimize the likelihood of head trauma or other serious injuries…”. He thanked Lauren for her hard work and dedication to this effort. He noted that since first hearing of this issue, significant changes have been made. He stated, “I think this is really a ground breaking and culture changing regulation”.

To follow-up on Dr. Zuckerman’s question regarding base-line testing, Dr. Smith noted, “In trying to develop these regulations, we were trying to balance an evidence-based approach, but also a feasibility approach for what was practical for the 351 different school districts. What we realized is that requiring school districts to do the pre-participation Neuro-cognitive testing wouldn’t be feasible at this point. However, in our model guidelines, that we are in the process of developing, to the extent that schools are able to do that and many have decided that they are going to invest in that (not just private schools). That would be included in our best practices but we didn’t feel like, at this point, that we could mandate all of the school districts to do that, for all of the students in the schools”.

Discussion continued with Ms. Carlene Pavlos, Director of Violence and Injury Prevention participating on the base-line pre-participatory testing question. Chair Auerbach suggested investigation be done on this issue. He acknowledged that due to the level of detail, conversations, and discussions regarding capacity and training, it would be difficult to insert something new. Chair Auerbach requested staff further investigate how this is being incorporated into guidelines, remembering the issue of time lines. This request was given while acknowledging the interest of the Council.

Dr. Gillick asked staff how they will know this regulation is working, especially before extending it to another realm. Ms. Pavlos responded, "...that they have been fortunate enough to be working with the CDC, which has chosen Massachusetts and one other state to do a comprehensive evaluation of how the implementation of our Sports Concussion Law and Regulations are impacting outcome". Dr. Smith added, "We will also be receiving data reporting from the schools as mentioned earlier, which we don't have now".

Dr. Woodward inquired about the lack of response to a suggestion he made in January. He had suggested that staff, "... provide a software program that could be disseminated to the schools free, that would provide all of the infrastructure for them so that they could document everything, including the notifications and the reporting to the state so each town doesn't have to reinvent the wheel...".

Ms. Pavlos replied that since staff dramatically pulled back the amount of data schools will have to report to DPH,

> ...they just need to send us a very simple form and due to the extreme flexibility written into the regulations, it would be complicated... We could explore that with some of the schools and through our advocacy groups and see what might be most useful to schools.

Dr. Woodward responded, noting his concern over the amount of paperwork and its' subsequent implications, which may have an undesirable and unintended inhibitory effect. He noted that he is not

suggesting that a mandate be put in place, but more simply, a “free option” for such a platform.

Dr. Woodward asked why neuropsychologists coordinate rather than consult with the physician, as the others listed in the regulations. Dr. Smith replied in part, “... our intention was meant to try to describe the approach or the practice approach of neuropsychologists when they work with physicians. We felt it was important for the medical home piece ... to make sure that the children are seen by a clinician and it is done in a multi-disciplinary sort of coordinated way”. Dr. Woodward said he just wanted to make sure a clinician was involved.

Chair Auerbach acknowledged the difficulty encountered in writing this regulation, noting its complexity, along with the breadth of stakeholders that had to be included in the process. He also raised the topic of how difficult it is for DPH under current loss of resources. Chair Auerbach noted they have not received any money for this regulation, or for the 18 other regulations they were required to pass this year. Compounding the lack of new funds, there has actually been a loss of tens of millions of dollars. Chair Auerbach highlighted the division that Ms. Pavlos oversees, and how it is losing a significant amount of money for their injury prevention work. He continued that their database systems are losing millions of dollars in their work. Chair Auerbach stated, “I want to thank you, in spite of the fact that no work was lifted from your shoulders, you did so much work and I know a lot of it was nights and weekends”. He also shared with the Council that they have “hit a wall”, meaning that they cannot continue to do more, not only with their current resources, but in fact, with less. He affirmed the significance of this as a public health problem.

Dean Harold Cox, added, “I think it is very important for us as a Council to actually think about and to reflect on a little bit, and it is about the losing of significant dollars, not only here in state agencies, but in local public health, to actually do the work that we consider to be important, and that we are seeing the dismantling of our very important public health system....While our Council has not taken an active role in making a statement to the Legislature and to the

Governor, that it would be appropriate for us, in whatever way you would consider us to be able to do that, to actually make that kind of statement to talk about the devastation, and I use that word purposely because I do think that it is a devastating effect of actually losing the dollars to do the work that we need to do ... I do think in some way, it would be important for us to take a very deliberate stand and to actually be able to say that there is devastation that is occurring, that is not a good thing. It is not the right thing for the public...".

Dr. Michèle David agreed with Dean Cox, adding her desire to advocate on behalf of public health. Dr. Alan Woodward concurred and elaborated,"... a letter should be sent to the appropriate people and talk about the potential impact on the citizens of this Commonwealth if we dismantle what was the premier public health system in the country, taking leadership on MOLST and because of funding they can't be implemented in a timely and appropriate fashion ... I will leave it to Dan Delaney and others to decide the most appropriate and politically astute fashion to deal with this...".

Mr. Sherman moved for approval of the regulation with the aforementioned notations regarding further investigation of screening mechanisms and time lines, as well as the database issue. After consideration upon motion made and duly seconded, it was voted unanimously to approve the **Request for Final Promulgation of New Regulation 105 CMR 201.000: Head Injuries and Concussions in Extracurricular Athletic Activities** and that a copy be attached and made a part of this record as **Exhibit Number 14,979.**

CONCLUDING REMARKS FROM CHAIR AUERBACH

Chair Auerbach asked Linda Hopkins, Secretary to the Public Health Council to draft a letter to Council Member Helen Caulton-Harris, Director of Health and Human Services for Springfield, Massachusetts, on behalf of the Public Health Council, to offer any assistance to her in light of the tornadoes that devastated the region.

SUMMARY OF FOLLOW-UP REQUESTS AND ACTION STEPS ARISING FROM THIS MEETING

Presentation: Update on Measles Infections in the Commonwealth (See p. 5 above)

- During discussion by Council Members regarding Ms. Cocoros's update on Measles, Dr. Alan Woodward suggested we utilize this time to publicize the importance of appropriate immunizations.

RECORD OF THE PUBLIC HEALTH COUNCIL FOR THE MEETING OF APRIL 13, 2011 (See p. 6 above)

- Dr. Woodward requested a follow-up on MOLST as indicated in April's Minutes. Chair Auerbach asked Mr. Delaney to put this on the PHC docket for an update.

REQUEST FOR FINAL PROMULGATION OF NEW REGULATION 105 CMR 201.000: HEAD INJURIES AND CONCUSSIONS IN EXTRACURRICULAR ATHLETIC ACTIVITIES (See p. 20 above)

- Chair Auerbach requested that staff further investigate how base-line pre-participatory testing could be incorporated into the guidelines, while remembering the issue of time lines. Request involved Chair Auerbach, Ms. Carlene Pavlos, and Dr. Lauren Smith)
- Dr. Woodward requested that there be investigation into the possibility of providing a software program to aid in uniformity and simplicity of implementation of the Head Injury Prevention Regulation. Ms. Carlene Pavlos noted she would speak with schools regarding their needs. (Note inclusion of Dr. Smith in this discussion).

REMARKS FROM CHAIR AUERBACH (See p. 22 above)

- Chair Auerbach asked Linda Hopkins, Secretary to the Public Health Council to draft a letter to Council Member Caulton-Harris, on behalf of the PHC, to offer assistance in light of the tornadoes in Springfield.

LIST OF DOCUMENTS PRESENTED TO PHC MEMBERS FOR THIS MEETING

- Docket of the meeting
- Copy of the meeting notices to A&F and Secretary of the Commonwealth
- Draft Minutes of the Meeting of April 13, 2011
- Staff's memorandum to the Council, dated June 8, 2011: Requesting Approval to Promulgate Amendments to 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements to establish a statewide secure electronic infectious disease reporting and notification system.
- Staff's memorandum dated June 8, 2011: Requesting Approval for Final Promulgation of Regulations 105 CMR 201.000: Head Injuries and Concussions in Extracurricular Athletics.

This meeting adjourned at 12:00 p.m.

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Chair John Auerbach

JAC