MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of March 20, 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**

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**Docket: \*\*\*REMOTE MEETING\*\*\* Thursday, March 20, 2025 – 9:00AM**

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

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

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Dial in Telephone Number: 929-436-2866

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Passcode: 743312

1. **ROUTINE ITEMS**
2. Introductions.
3. Updates from Commissioner Robert Goldstein.
4. Record of the Public Health Council Meeting held February 12, 2025 **(Vote)**.

1. **DETERMINATION OF NEED**
2. Request by Dana-Farber Cancer Institute, Inc. for a Substantial Capital Expenditure and Substantial Change in Service. **(Vote).**

1. **INFORMATIONAL PRESENTATION**
2. Update on the Health Survey Program.

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*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.*

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Attendance and Summary of Votes:

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

Date of Meeting: March 20, 2025

Start Time: 9:03 am. Ending Time: 12:27 pm.

| **Board Member** | **Attended** | **First Order:**  **Approval of**  **February 12, 2025 Minutes (Vote)** | **DON**  **Request by Dana-Farber Cancer Institute for a Substantial Capital Expenditure and Substantial Change in Service (Vote)** |
| --- | --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes | Yes |
| **Edward Bernstein** | Yes | Yes | Yes |
| **Lissette Blondet** | Absent | Absent | Absent |
| **Kathleen Carey** | Yes | Yes | Yes |
| **Emily Cooper** | Yes | Yes | Yes |
| **Harold Cox** | Yes | Yes | Yes |
| **Alba Cruz-Davis** | Yes | Abstain | Yes |
| **Michele David** | Yes | Abstain | Absent |
| **Robert Engell** | Yes | Abstain | Yes |
| **Elizabeth Evans** | Absent | Absent | Absent |
| **Eduardo Haddad** | Yes | Yes | Yes |
| **Joanna Lambert** | Yes | Abstain | Yes |
| **Stewart Landers** | Yes | Yes | Yes |
| **Mary Moscato** | Yes | Yes | Yes |
| **Gregory Volturo** | Yes | Yes | Yes |
| **Summary** | 13 Members Present  2 Members Absent | 9 Members Approved;  4 Member Abstained; 2 Members Absent | 12 Members Approved;  3 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, March 20, 2025, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Commissioner Robert Goldstein; Edward Bernstein, MD; Kathleen Carey; Emily Cooper; Dean Harold Cox; Alba Cruz-Davis; Michelle David, MD; Robert Engell; Eduardo Haddad, MD; Joanna Lambert; Stewart Landers; Mary Moscato; Gregory Volturo, MD.

Dr. David left the meeting at 12:15 PM.

Ms. Moscato left the meeting at 12:25 PM.

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**

*b. Updates from Commissioner Robert Goldstein*

**Women’s History Month/International Women’s Day**

Recognition of March being Women’s History Month, Commissioner Goldstein shared the story of Mary Eliza Mahoney, a Massachusetts trailblazer who shattered racial barriers, elevated the profession of nursing, and who helped lay the foundation for compassionate, professional, and high-quality health care for all.

**Avian Flu**

Commissioner Goldstein said there haven’t been any significant changes in the epidemiology of H5N1 avian flu since last month. This continues to be an animal virus that most commonly affects wild waterfowl and other birds, domestic poultry and dairy cattle. There have been 70 human cases reported to date; 96% of them were exposed through direct contact with infected domestic poultry or dairy cattle. Although most people have been only mildly symptomatic, 1 person has died. There has not been any evidence of person-to-person spread of H5N1 at this time. Public health continues to assess the risk to the general public as low; individuals who have contact with infected animals are at somewhat higher risk for infection. The public health response to reported infected animals is to identify people who had contact with them and conduct symptom monitoring with testing if indicated. Cats continue to be highly susceptible to this virus and people are reminded to keep their pets and other domestic animals from having contact with wild birds. The Department continues to be concerned that due to uncertainties in federal funding for public health, academic research and agriculture, that our ability to be prepared for a possible pandemic in Massachusetts and nationally could be compromised.

Potential good news on the horizon is that avian flu activity historically declines in wild birds as the weather warms. If this pattern holds true, we are likely to see some reduction in spillover events from birds into other species.

**Influenza**

Commissioner Goldstein shared a brief update on influenza. He said in the past few weeks, Massachusetts has seen a slight decrease in flu and have lowered our estimated severity level from very high to moderate as we are getting reports of a decrease in cases in our state. DPH is hopeful that this trend will continue over the next few months. He said to consider wearing a mask to protect yourself and the people around you if you have a weakened immune system, if you are at increased risk for severe disease because of your age or an underlying medical condition, if you are caring for someone who is sick, if someone in your household has a weakened immune system or is at increased risk for severe disease, or if you are sick with any respiratory illness. He stressed to continue to practice core respiratory illness prevention strategies in addition to vaccination. Wash your hands, stay home when you are sick, and cover your cough.

**Measles**

Commissioner Goldstein reminded the Council of the measles outbreak in various areas throughout the country. As of March 13, 2025, a total of 301 measles cases have been reported by fifteen U.S. jurisdictions this year: Alaska, California, Florida, Georgia, Kentucky, Maryland, New Jersey, New Mexico, New York City, New York State, Pennsylvania, Rhode Island, Texas, Vermont, and Washington. Two hundred and one of these cases are associated with a single large cluster in Texas and New Mexico which is continuing to spread in an under-vaccinated community. However, individual cases associated with international travel have also occurred. There have been no recent measles cases reported in Massachusetts. Measles is a disease caused by a virus that spreads more easily than almost any other disease from person to person. It usually lasts a week or two. Measles looks and feels like a cold or the flu at first. A cough, high fever, runny nose and red, watery eyes are common. A few days later, a red, blotchy rash starts on the face and then spreads to the rest of the body. Measles often causes diarrhea, ear infections and pneumonia. Most people recover from the acute measles infection in a few weeks, but some cases can result in serious illness, hospitalization and even death. Measles is most dangerous for children under 5 years of age, adults over 20 years of age, pregnant women, and people with weakened immune systems. The good news is that there is a safe and effective vaccine available to protect individuals and communities from measles. Also, DPH is happy to report that the most recent National Immunization Survey showed Massachusetts had some of the highest vaccination rates in the country. In fact, Massachusetts ranks number one in the country for 19–35-month-olds vaccinated with MMR vaccine, DTaP vaccine, and the combined series of 7 vaccines recommended for children before they turn age 2. In addition, the vaccination rate for MMR for all children 17 and under is 98%. However, even in Massachusetts, there are areas with lower vaccination rates in children and therefore the potential for cases. As a precaution, the Department has issued an advisory to clinicians to amplify existing guidance for vaccination against measles and to support provider recognition and management of potential cases of measles should they occur in Massachusetts.

**Pappas Update**

Commissioner Goldstein said last month at the Public Health Council meeting, he updated the Council about the plans to relocate the care and services of Pappas Rehabilitation Hospital for Children from its current campus in Canton to a renovated unit at Western Massachusetts Hospital in Westfield. This action was intended to enable children with the most complex medical needs, including those who depend on mechanical ventilation, to receive the care they need in a high-quality setting that can safely accommodate the kinds of technology that the Canton facility is not able to offer. Following this announcement, the Governor received significant feedback expressing concerns about the vital role Pappas has played in the lives of children with disabilities and the special place the hospital holds in the Canton community. In response to these concerns, the Governor has decided to pause these relocation plans. She has asked the Department to gather a broad group of stakeholders including patients, families, labor representatives, local officials, and medical professionals, to undertake a further review of the Pappas and Western Massachusetts hospitals. This group will assess the challenges and deficiencies of the Canton campus and what renovations would be needed to continue to serve patients; review the needs of the patients and families who depend on the Commonwealth to provide important care and services; and make recommendations about the best path forward given the available resources. DPH remains wholeheartedly committed to supporting the needs of these young patients, who are among the most vulnerable individuals in the Commonwealth. Our ultimate goal is to deliver care and services in the most effective and compassionate manner in facilities that are safe, comfortable, and equipped to address the specific needs of those who have looked to the state to provide the vital medical care and support that every person deserves.

**Update on Working Groups**

Commissioner Goldstein updated the Council on the progress of the Working Groups that Governor Healey formed last fall to address the health care gaps created by Steward Health Care’s closures of Nashoba Valley Medical Center and Carney Hospital.

**Federal Updates**

Commissioner Goldstein said the rapid shifts and changes, starts and stops at the federal level have continued to keep those of us in public health guessing as to what challenges, and what disruptions the next day will bring. DPH staff members have been tracking and monitoring the federal actions that may impact our work. DPH lawyers are reviewing the changes and providing guidance as to how we can best move forward. And amid this uncertainty, Department staff have continued to fulfill our commitment to improve the health and safety of the individuals and communities we serve. The work of the Department continues to be guided by facts, compassion, equity, science, and an unshakable dedication to public health. He said he will continue to update the Council as about federal changes that affect the work DPH does and those we serve.

**Members Sendoff**

Commissioner Goldstein acknowledged that today is the last Public Health Council meeting for four of our colleagues: Dr. Eduardo Haddad, Dr. Alba Cruz-Davis, Dr. Edward Bernstein, and Dr. Michele David, and thanked each for their service.

In acknowledgement of their service, these members will all be receiving a Commissioner’s Citation, recognizing them “For your dedication, commitment, guidance, and public service to the Public Health Council and your many years of service to the health and wellbeing of the residents of the Commonwealth.”

Commissioner Goldstein asked if there were any questions.

Dr. David said it has been a pleasure being on the Public Health Council and be able to bring the primary care perspective to public health. She’s always been a believer of combining medicine and public health as the best way to achieve population health and the Council allowed her that voice. She appreciated the opportunity to be a part of the Council.

Dr. Cruz-Davis said it had been an honor to serve. She thanked the Commissioner Goldstein and all of his staff and the Council. She said it’s been an honor and a pleasure. She said she hopefully achieved always speaking to the needs of others, especially those that aren't at the table.

Dr. Bernstein thanked the Council for everything he’s learned from them over the years and noted what a responsibility they've had and will continue to have in in the current crisis that the Commissioner articulated today. He believes it necessary to keep in mind that we are in difficult times. He appreciates the Council’s commitment to equity and standing up to bullies. He said he’s learned so much here and has been part of Determinations of Need and updates from the different sectors of the Department. It's been enlightening. He said he has had the opportunity to develop himself as a public health advocate. He thanked the Commissioner and his dedication to the mission of DPH especially around DEI.

Dr. Haddad also shared his gratitude and thanked the Commissioner creating a comfortable arena for discussion, allowing him to share his thoughts. He said he has learned much from the Council members. He said as an immigrant from Brazil and living here for 45 years, he’s sees the best of America in the Public Health Council. Coming from Latin America, there’s an idea of the United States as a place where there's freedom, there's knowledge, there's an opportunity, and there is equality that of course, isn't complete. But there is work toward that goal. He said being in the Council was a validation of these ideals for him, and he is very thankful for the opportunity and appreciates all the members.

Mr. Landers echoed the appreciation of the four members leaving the Council. He thanked Dr. David for her many contributions over the years. He mentioned that as the representative from the Mass Public Health Association, being inspired by Commissioner Goldstein's comments last month, they have renamed the Public Health Leadership and Medicine award the William Augustus Hinton Award. He mentioned the award winners for that award, the Paul Revere Award, and the Lemuel Shattuck award.

Mr. Engell applauded the tremendous commitment, dedication, and contributions made by the members who are leaving and as a new member of the Council, he said he had benefited from watching how they contribute and shape the discussion and further the work of public health in the Commonwealth. He asked the Commissioner to explain how states are or are not collaborating with information and research around vaccine hesitancy. He asked for the states that are inclined to continue to follow vaccine trends, how data is being shared and how a collaboration with these states can become stronger.

Commissioner Goldstein said he’s been impressed by the collaboration of public health among states all across the country. He said he was recently in Washington DC with the Association for State and Territorial Health Officers, where the vast majority of state health officials from all states were there. They collaboratively worked together for what they believed to be best for public health. He said the measles outbreak in west Texas, which spread quickly into New Mexico and is spreading to other states in the region, demonstrated that those states need to work together to help protect residents in this vaccine preventable disease. In the Northeast, he believed we have a history of committing to collaboration and there is a history of Northeast states meeting on a regular basis at the leadership level including epidemiologists across Maine to Pennsylvania and New Jersey to discuss how best to respond to public health issues. He said nothing on the federal level will disturb this alliance.

Dean Cox thanked the four members leaving the Council. He asked the doctors in the council if older citizens are unaware if they were vaccinated for the measles or were infected at one point, are there things they need to do to protect themselves now.

Commissioner Goldstein said for people who were born before 1957, then the understanding is that those individuals were exposed to measles as a child and have immunity which should last. There was a period of time from 1958 to 1966 where there was a different measles vaccine on the market. There is a recommendation that individuals who fall into that age range should talk to their provider and get another vaccine, one that will provide them protection. Beyond that, individuals received the vaccine that's currently on the market, which provides a high level of protection. If you are in that cohort, there is nothing that you need to do unless you are in a certain high risk category, those who work in healthcare who need some documentation of their immunity or individuals who are working with those who are immunocompromised or where there's a significant risk of transmission.

Dr. Cruz-Davis spoke of lost data and data going dark. She said data regarding LGBTQ care, DEI efforts, health disparities, health equity, and more is being lost under new federal guidelines. She asked what is happening collectively to preserve this data. She was concerned too about the defunding of medical research.

Commissioner Goldstein said first, recognize that retrospectively, the surveillance data, the large data sets that existed on federal websites, in particular CDC's website, has a massive effort across the country to download those data, and make sure that they're publicly available and maintain them for the long run. While we did see an initial removal of some data from the CDC website, many of those databases were put back onto the website, but for those that weren't, they are publicly available through various locations. Johns Hopkins has been a particular center that has tried to collect as much data as possible. He said what Dr. Cruz-Davis is referring to is a concern on prospective data about the research infrastructure that's necessary to collect the data, whether it be surveillance or research data and then analyze it and put that out publicly. He said he didn’t have an answer to what will happen there. We should all recognize and be clear that threats to NIH funding are going to make it incredibly challenging for life saving research to be done and that the data generated from that research is going to be lost if we don't have the resources and the support that's necessary. It’s true for the grant that goes to researchers, many of which are here in Massachusetts. That also brings into play the indirect costs that are associated with research that help build that infrastructure around research and help maintain the data sets so that people can publicly access it. That is currently under threat in the way that the federal government is responding to incoming research requests and the approval or denial of grants.

Dr. Cruz-Davis asked that leaders like the Commissioner and Governor Healey make this a priority because it’s going to be incredibly crucial to be able to access and have these databanks preserved.

Dr. Bernstein commented on the question surrounding the immigration laws and their impact on our state. People are more hesitant to access the healthcare system, the education system and the workplace. He said there should be data collected and stronger shields in place in the healthcare system for providing medical care. He said emergency room data should be collected regarding ICE raids to reflect which type of people are being affected.

Commissioner Goldstein said the Attorney General's office has been an incredible partner in this work and has put out many advisories to hospitals, to schools, to individuals to make sure they understand their rights and understand what is protected here in Massachusetts.

Mr. Engell mentioned changes recently announced by the federal government about the supply chains for local food banks and schools and various sources of food. He asked if the Department is keeping abreast of that as a public health metric that needs to be monitored, evaluated, and assessed to help, as a Commonwealth, local food banks and schools relative to the issue of food insecurity.

Commissioner Goldstein said there's a working group between the Department of Public Health and the Massachusetts Department of Agricultural Resources to make sure that we are thinking about food security, and we are identifying ways that Massachusetts can step up to make sure their food is available in schools, at food pantries and communities all across Massachusetts. He said the reality is there is a large amount of federal money that comes into the state to help with food security, and we are seeing threats to that funding. In the past couple of weeks, removal of some of that funding is going to make this more challenging.

Dr. Volturo reassured Dr. Bernstein that those, like him, in the emergency departments have been very thoughtful about the protection of immigrants’ right to healthcare and have been discussing it for some time and feel that everyone has a right to receive healthcare, and they will hold up to that. They have had ICE working almost directly across the street from one of their emergency departments and they have not come into the ED. They have legal counsel, and the Attorney General has been actively involved in providing some guidance to hospitals.

Dr. David was concerned about undocumented immigrants on Medicaid and asked if the state had a safety net in place and what impact changes in the federal government would have on them and those with temporary protection status.

Commissioner Goldstein said this would be a question to bring to MassHealth, the state Medicaid program to understand their plans going forward. He noted that in this state, Medicaid, MassHealth access has been provided to those who are undocumented and that is done not through the federal government, it is done through a state investment and a state commitment.

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

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

*c. February 12, 2025 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the February 12, 2025, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the February 12, 2025 minutes.

Mr. Landers made the motion, which was seconded by Dr. Bernstein. Ms. Cruz-Davis, Dr. David, Mr. Engell, and Ms. Lambert abstained. All other present members voted to approve the minutes.

**2. DETERMINATION OF NEED**

*a. Request by Dana-Farber Cancer Institute, Inc. for a Substantial Capital Expenditure and Substantial Change in Service.* ***(Vote)***

Commissioner Goldstein took a moment to comment on this particular application, which has generated significant discussion and media interest since it was first announced in the fall of 2023.

He stated that the Department of Public Health and the Determination of Need Program recognize the important role of the Determination of Need process, including the analyses within the staff report, the engagement around an Independent Cost Assessment, and the presentation to this Council. Like with all applications, the process for this application was guided by state law, Department regulation, and programmatic guidance. This assures that each application is fully evaluated and appropriately open to public comment, and that the staff report reflects the position of the Applicant, input from the community, and an overall assessment from the program.

The Commissioner noted the various components of this, and many applications. As Dennis will describe, for this application, the program requested and evaluated an Independent Cost Assessment, or ICA, to help evaluate whether the proposed project will meet the Commonwealth’s cost containment goals. This ICA provides in depth analysis of the proposed project, which is the construction of an inpatient hospital for cancer care. It assesses the need, demand, cost, and impact. In addition to the ICA, the Health Policy Commission has elected to pursue a Cost and Market Impact Review, or CMIR. The CMIR is a helpful, additional analysis for the Council to review, but we should acknowledge its different intentions and scope. The CMIR is evaluating the merger of Dana Farber Cancer Institute (DCFI), Beth Israel Deaconess Medical Center, and Harvard Medical Faculty Physicians. It evaluates the impact of that merger, and assesses changes that may occur for inpatient care and outpatient care. In preparation for this meeting, Council members were provided with a preliminary CMIR Report from the HPC, published on February 27, 2025. Members have this analysis available to review and help inform their decisions, and they should be aware that any decision by this Council to approve the Application by Dana Farber Cancer Institute would be provisional pending the final CMIR Report. Any potential approval would only go into effect 30 days after the final CMIR is released, allowing time for HPC to inform the Department of any findings that may alter the decision made by this Council.

The Commissioner acknowledged that this process is complicated, and so is healthcare. We are fortunate to have a Determination of Need program and legal staff who can guide us through the statutory and regulatory requirements to make sure that this Council can make an informed decision.

Commissioner Goldstein then invited Dennis Renaud, Director of the Determination of Need Program, to review the staff recommendation for Dana-Farber Cancer Institute, Inc.’s request for a Substantial Capital Expenditure and Substantial Change in Service. He was joined by Jaclyn Gagne, Chief Deputy General Counsel.

After the presentation, Representative Chynah Tyler and Representative Ann-Margaret Ferrante addressed the council, each providing remarks in support of the application.

Commissioner Goldstein then introduced David P. Ryan, MD representing Mass General Brigham Ten Taxpayer Group, to address the council. He also spoke in support of the application, but recommending a stepwise process to opening all of the requested beds.

Commissioner Goldstein then introduced Shelly Plumb, representing the Patients and Family Advocates of Dana-Farber Cancer Institute Ten Taxpayer Group, who addressed the council in support of the application.

Following the speakers, Commissioner Goldstein invited the council to ask questions of the applicant.

Dr. Haddad asked what the effect will be in the emergency rooms. He thinks it would be positive effect, because of the creation of this urgent care, where cancer patients having cancer complications may go directly to. He said there is also the argument of somebody getting very sick and needing a full emergency room evaluation. He asked what the capacity of the urgent care will be and what it is geared to attend.

Ben Ebert, MD, Ph.D., CEO & President, DFCI said they have placed a great deal of focus in minimizing the use of emergency rooms. They’ve done that in a number of ways. One, they have developed an acute care facility for outpatients who are developing complications. They find that that has decreased emergency room utilization by 20% and subsequent hospitalization for those patients by 80%. The proposed cancer hospital includes 20 observation beds for cancer patients. This allows patients to be observed overnight and hopefully turned around and avoid an admission entirely. Then, he said, they are working with Beth Israel Deaconess to streamline the emergency room process for patients who do need to visit the emergency room through a rapid triage service. And finally, the coordination of care between the ambulatory and inpatient setting enables them to time things to coordinate better to admit patients and avoid the emergency room. Right now, their patients are competing with the full range of patients being admitted to a General Medical center and in the proposed cancer hospital they will be in control of those beds for only cancer patients. They are also shifting a lot care from the inpatient setting to the outpatient setting, which also allows them to coordinate that care and hopefully avoid emergency room visits as well. Dr. Ebert wanted to clarify a point in Commissioner Goldstein’s introduction to the application stating that DFCI is merging with BI Deaconess. He said they have separate licensed beds, separate employees and separate board of directors. They are completely independent institutions, but they will be collaborating deeply on clinical care across all of the specialties that Doctor Ryan mentioned, neurology, infectious disease, all of the types of care that patients need will be provided by Beth Israel Deaconess and a deep collaboration, but they are not merging in any way.

Craig Bunnel, MD, Chief Medical Officer, DFCI added that with the establishment of their acute care clinic, they reduced emergency room visits by 20%. They are confident that they will be able to reduce that substantially more because the acute care clinic is only able to operate between about 9:00 AM and take patients to 4:30 PM because they need to have time to be able to evaluate them. The difference with an acute care clinic is that these are all oncology trained staff who are evaluating the patients, who are familiar with the diseases, familiar with the side effects, familiar with the treatments and those side effects and because of that familiarity, can often treat these patients. As Dr. Ebert said, when a patient with cancer hits the emergency room, they have an 80% chance of being admitted. When they come to their acute care clinic, there is an 80% chance that they will go home from the acute care clinic after treatment. When they have these observation beds available, they will not have to stop taking these patients at 4:30, because their clinic closes at 8:30. If they are still there at 8:30, then they have to transfer them over to the emergency room. With this new observation area, they will be able to transfer them into the observation area, still ambulatory, an ambulatory area, not inpatient, substantially less cost and a much better patient experience as well, and they will be able to run this 24 hours a day, seven days a week.

Mr. Landers mentioned his personal experience as a patient with Merkel cell carcinoma. He wanted to understand the degree of collaboration and separation between the two hospitals. He also asked if patients from outside Massachusetts, nationally and internationally, were included in the calculations of utilization.

Dr. Ebert said Merkel cell is a good example of what makes Dana Farber so special in that it is a relatively rare cancer, yet they have a whole team of people, and laboratories, that work just on Merkel Cell cancer. They work only on Merkel cell cancer and have NIH grants and DFCI has helped make many of the major advances in therapy that have transformed the care of Merkel cell carcinoma. Another great example is of coordinated care with other individuals, other sub specialists, including dermatologists. He said there were a couple parts to this: one is that they are working very diligently to make sure that patients always have access to all of the sub specialists that they need. At times that may be at Israel Deaconess, but patient preference is always supreme. Should a patient say, “I really like my dermatologist at Brigham”, they will work with that dermatologist at the Brigham for as long as the patient would like. The question of the transition is an extremely complicated one and one that they are working very hard in negotiating exactly how to do that. He said patient safety and quality is the top goal. Their aim is to transition in a very phased and thoughtful and proactive way to make sure that all of the care is provided and there's no lapses in care of any kind. Answering Mr. Landers’ question about patients from outside Massachusetts, he said they have referrals from around the United States, around the Commonwealth, and around the world. He said international patients are a small fraction of their patients, so their calculations were not inclusive of that population.

Ms. Cooper, acknowledging her role within the Executive Office of Aging and Independence, said regarding the age friendly measures and being an age friendly healthcare system, she believed there's some work that DFCI could benefit from reaching out to other groups, particularly the Mass Healthy Aging Collaborative. There's been a lot of work in the dementia friendly world, as well as in the housing world about just changing paint colors and floors and walls for wayfinding. There is robust work that has been done, and she encouraged them to learn more in that area. She added that she was very excited to learn that they will take deliberate measures to increase the number of MassHealth consumers that that would get services at the new facility. She said they mentioned that they have contracts currently with all but three of the MassHealth accountable care organizations. In addition to the accountable care organizations, MassHealth has other health plans. They have managed care organizations with Tufts and WellSense Health Plan, they have three different kinds of One Care for people who are younger and on Medicaid and Medicare, and they have six plans for Senior Care options for those over 65. Given that they stated there's a growing incidence of cancer among older adults, it seems like it would be especially prudent to have contracts with the six senior care option plans. She asked them to confirm if they have contracts with the accountable care organizations, but not with any of the other MassHealth plans, and if that something they will be pursuing.

Dr. Ebert said they have a high focus on aging in cancer. Cancer is a disease of the aging and both on the research front and on the clinical front, they’ve done pilots of coordinated care with geriatricians and oncologists to optimize care. Their hospital is populated by young volunteers who make sure that every single patient finds their way appropriately.

Michael Reney, EVP & CFO, DFCI said they are contracted with the six senior care plans.

Ms. Cooper said across the state that aren’t enough nursing beds. She said she works in housing and homelessness and every hospital she speaks to says there are people stuck in the hospital because there are not enough places for them to go. She said that the DoN application currently says that patients are discharged to skilled nursing facility (SNF) beds. An increase in hospital beds might lead to an increase in the need to access to these SNF beds. The Mass Hospital Association and others have consistently cited a lack of access to these beds as a primary reason currently for hospital overcrowding and ED boarding. She wanted clarification on what DFCI planned on doing to not exacerbate the current situation. She wanted to know if they are considering hospital to home programs or utilizing discharge planners.

Dr. Ebert said that having their own inpatient hospital will enable them to improve discharge planning. He noted that about 7% of their patients are discharged to post-acute facilities and about 13% of patients are discharged to post-acute care. They are able to manage less discharge to SNFs or other post-acute care than other academic medical centers. He said they handle extremely sick patients in the outpatient setting. They’re doing outpatient transplants. They're administering extremely advanced therapies with lots of toxicity in the outpatient setting. So when they discharge a patient, they can be seen very rapidly in the outpatient clinic and followed very closely even if they're very unwell there, minimizing the discharge to post-acute facilities. Given the logjam mentioned by Ms. Cooper, he said they will be able to coordinate that better since they will own the post-acute coordination in a way that they're not able to do at present. They are working very hard with the Deaconess and other institutions to coordinate performing care and all of the unique aspects of post-acute care for oncology patients, whether that's Hospice, whether that is other types of rehab and what can be done in the outpatient setting.

Dr. Bunnel added as Doctor Ebert said, they will own the post-acute care coordination. They intend to have a cancer focus robust rehab program in order to try and have patients when they enter the hospital be in the best shape possible. An ongoing occupational therapy and physical therapy program within the hospital as well in order to try and keep patients as functional as possible and able to go home.

Ms. Moscato asked about the utilization of the 300 beds in the application. She said there are 30 licensed beds at Brigham and Women’s and 204 leased beds utilized, which she concluded was how the application earmarked 200 to 420 beds. She said the application requiring 300 beds includes the 30 beds they have, they are adding 20 observation beds, and then an additional 250. She reiterated that the Mass General Representative, Dr. Ryan indicated that the 204 advisory beds would be going to Dana Farber. She asked them to provide a better sense of the bed need.

Dr. Ebert said the observation, or ambulatory beds don’t count toward the 300 bed total; they are separate. He offered numbers that he admitted might be a bit different from 18 months ago when the Determination of Need was first put together. He said about 210 to 220 beds per day are Brigham and Women’s leased beds where Dana Farber has oncology patients. And there are about 80 beds at Beth Israel Deaconess. That earmarks the 300 beds, but with the increased incidence of cancer, he fears that they will likely be full on the day the hospital opens. Capacity was capped by the number of rooms that they could fit on that footprint in that real estate. They disagree with the characterization all the oncology patients won’t come over to the new facility. He said say that the relationship between a medical oncologist and their patient is among the strongest in medicine. And if a patient has a long term relationship with a medical oncologist, the idea that they could have an interaction in the emergency room and will suddenly become a Brigham patient, will have an interaction with a primary care doctor, will suddenly go to Mass General, is false. He thinks that those patients will stay with them and continue to get their care with them and continue to collaborate with their doctors at other hospitals if they so choose. The vast majority of their patients do not come to them through referrals from Mass General Brigham but come through providers throughout their communities or self-referred throughout out their communities, and that is unlikely to change.

Dr. Bunnel added that on any particular day, they have between seven and ten patients who are followed by their medical oncologists who are hospitalized at outside hospitals and trying to get in, but DCFI doesn't have the beds available for them. If you add just their census now plus the census from the Beth Israel inpatient, it already exceeds that 300 beds. That does not take into consideration at all the statistics which were heard that the American Cancer Society has estimated a 70% increase in the incidence of cancer by 2050 and that in the last four years there's been an 11% increase in the incidence of cancer across the nation, double that in Massachusetts. Add on to that, many of their newer technologies, cellular therapies, bispecific antibodies, CAR T-cell transplant - those therapies actually require, as shown in one of the earlier slides, longer durations of hospitalization, even though they are among the only cancer centers across the country that are trying to move many of these therapies into the ambulatory environment. The fact that it's not just the increasing incidence of cancer, but the rapidly increasing prevalence of cancer as the survival of cancer patients increases, they live long enough to require the hospital more often than in the past. He thinks there's really no question in any of the independent analysis that have been done that there will be plenty of cancer patients to fill these beds and more.

Ms. Moscato asked about staffing, noting that adding 2,400 new positions is significant and a challenge. Many of the workforce development items mentioned in the application comes from pipelines, colleges, high schools, as was noted. But there is concern of staff leaving from other healthcare facilities to work in a new setting. She asked that they address this concern.

Dr. Ebert clarified that all of the inpatients at the Brigham right now are taken care of by Dana Farber physicians in oncology and all the physicians taking care of BI Deaconess cancer patients will become Dana Farber faculty, so in that regard, they will be staffed. For the hiring of the full range of additional staff, they have engaged in many outreach programs, including Roxbury and Mission Hill, talking to people who are in high school now and will be the people at working age for many of those jobs when the cancer hospital opens, inspiring them to pursue healthcare careers at Dana Farber.

Anne Gross, MD, Ph.D., SVP, Chief Nursing Officer, DFCI said their approach to staffing is to look at the causes of these shortages. She said shortages are not due to lack of interest but to shortages of faculty, shortages of clinical placements in hospitals around the schools and exposure to these healthcare careers. The work that they've been doing with high schools for many years in Boston, providing these internships where students can come in and actually experience what it's like to be a lab tech, what it's like to be a nurse, and all the different areas. Another approach in her work with Deans of colleges of nursing and health sciences around Boston is to increase the number of faculty available to teach, because colleges of nursing are turning away applicants, not because of lack of interest, but lack of faculty and lack of clinical placement. She said they're working together to provide our nursing leaders doctoral-prepared and master's-prepared nurses that can teach in local colleges and universities to be able to increase the number of slots that these schools of nursing can have each year to accept applicants. They have partnered with Northeastern University and their co-op program. Also because of how specialized they are, they have created residency programs for newly-licensed nurses who are interested in the field of oncology, to train and become competent to work in their environment, and they will increase that. She said here are many other things she could detail but of great importance is they've just completed the first phase of a large 7,500 square foot simulation center where they will be able to train through simulation all of their students that come through, as well as all new employees, residents, nurses and other clinicians who are in their fellowship programs.

Magnolia Contreras, VP of Community Health, DFCI said they are excited about and challenged by working with the local community colleges, to double down on how they can bring opportunities that are real and accessible to the college-age students today that will be prepared for the kind of careers that they will need to hire here at Dana Farber. What they have heard through their community meetings, both from residents and parents of young people today is the need for DFCI to ensure that those young people are prepared for these jobs and further careers in healthcare so that their trajectory will be longer when they start working with them today. She said they have a strong track record of having all of the programs that Ms. Moscato alluded to, and that they have been doing for a long time. This opportunity will allow them to change some of their own systems to ensure access and to ensure that they are training those technologists, particularly among people of color, because they do need people that can speak other languages and look like the patients here in Boston.

Dr. Carey asked about payer mix. She said the application doesn't share the number of Medicaid patients, but it gives the revenues, which were 8.3% at the end of the five year, which fell over that five year period. She said she had concerns about this, but mentioned there are outreach efforts. She was concerned about challenges to more Medicaid patients to be able to fill these beds. She mentioned although they have networked with the six senior plans, they point out that patients’ lack of access doesn’t have to do with capacity restraints, but coverage issues. There are about fifteen MassHealth ACOs in the state, and she asked how she can be confident that the medically underserved will have more access to those beds. She then asked about the geographical mix of patients, noting that international patients were a very small percentage, but she pointed out that out-of-state patients are 44% of Dana Farber inpatients.

Dr. Ebert said they've invested heavily in their cancer care equity program led by Chris Lathan. They regard one of the primary rationales of building the hospital, is to increase access and equity for our communities. They aim to provide care for every patient and every zip code, regardless of their insurance. They work extremely hard with their patients to make sure that they're covered. They have community navigators that go out proactively into their communities and make sure that they understand the care that they can get at Dana Farber, how to navigate the system. It’s a bewildering time when a patient gets diagnosed with cancer, so they help them understand the full set of caregivers that they're going to interact with in the process. This is a major effort of theirs to both increase the diversity of their patient population and the diversity of their clinical trial participants.

Chris Lathan, MD, Chief Clinical Access & Equity Officer, stated that their collaboration with Beth Israel brings a patient mix with more MassHealth patients. These new partners bring a more expanded payer mix than past partners. Also, primary care referrals from community health centers provide an opportunity to bring in a payer mix. A few years ago, changing the contracting to WellSense has also showed some increases in their MassHealth population.

Dr. Ebert added they confirmed that 75% of their inpatients are from the state of Massachusetts. They work very closely with patients and collaborators in local New England states, so that makes up a substantial part of the 25% balance.

Dr. David inquired about community benefits and the community based health initiative requirement. She said a lack of stable housing increased the risk of poor health and wondered if there might be substantial investment in permanent affordable houses on the community benefit aspect of this project.

Dr. Ebert said they will be contributing over $82M in community health initiatives, and $20.5M will go straight to the state for their initiatives, leaving them about $62 million to distribute in other initiatives.

Ms. Contraras said they have had a strong track record of investing in housing for many years, most recently with the City of Boston to preserve housing through rehab projects and initially through the creation of a fund that would ensure access to affordable housing for priority populations that they have been serving with this project. Their current needs assessment shows housing still being a pinpoint priority for the community.

Ms. Lambert said understanding the complexity in the payer models and variability in Medicare rates year over year, she asked applicant to speak to the Ten Taxpayer Groups’ concerns around forecasted reimbursement rates, maybe underestimating the impact on total medical spend in the state and how they may control cost containment in the coming years.

Dr. Ebert said there are many questions about reimbursement from the federal government that are in play right now.

Mr. Reney said Dana Farber's costs are different than they are at general hospitals, because their patients are all cancer, and they are very acute and often not at late stage disease. That impacts their pricing on the outpatient side. With respect to oncology drugs, he pointed out the Dana Farber is not eligible for 340B pricing, which allows discounted drug pricing. As a result of that, some of our drug costs are higher than other places and therefore that impacts the reimbursement levels because we treat only cancer, which is predominantly a disease of the old. They don't have a sufficient Medicaid patient base to qualify for that 340VE discounted drug program, which means they can't access the significant discounts that other academic medical centers are entitled to when purchasing the drugs there, which can often be up to 50%. Additionally, he said they are pioneers in transitioning complex and innovative treatments like CAR T-cell therapy and stem cells from the inpatient to the outpatient setting, lowering costs for the whole system, that makes their outpatient costs less than others. In their response to the Health Policy Commission’s preliminary CMIR, they have offered to work with the Commission to develop a methodology that provides a true comparison of their outpatient costs with other cancer costs at other locations. They believe adjusting for factors like acuity and outcomes, that using such a methodology will demonstrate the value of Dana Farber care model.

Dr. Bunnel talked about costs, saying that the independent cost analysis showed that their inpatient costs are lower. The inpatient cost overall for this, even with the backfill of beds, will be lower for the Commonwealth. If one looks at their outpatient costs, he said this is a different situation. The care that is delivered in the ambulatory outpatient setting at the Dana Farber is very different from the ambulatory care that is delivered at other cancer centers or at any other cancer centers in the Commonwealth and different from most cancer centers across the country. Their case mix index for inpatient is higher than any other adult hospital in the in the Commonwealth. The same is true in the ambulatory setting. If the patients are the sickest patients in the inpatient setting, why would they be any different in the outpatient setting. In addition, they have been leaders in taking therapies that other cancer centers hospitalize patients for, and moving them into the ambulatory environment. He said they do CAR T-cell therapy in the ambulatory environment, cellular therapies, and bispecific antibodies. They have moved chemotherapy regimens that are extraordinarily complex, high acuity, and high risk regimens out of the inpatient environment, and into the ambulatory setting. These often require one-on-one nursing frequently throughout the day. These patients often need to stay close in order to be able to come in on a daily basis. All of that is far more expensive in the ambulatory environment than other standard cancer care in an ambulatory development, but substantially less than what it would cost if they put those patients in the hospital, which is what other cancer centers do. He said their outpatients costs cannot be compared to other cancer centers. Their drug pricing is not 340B, so the drug costs are higher. Despite that, if you look at the HPCs own data, the difference in cost for some of these high cost therapies is not very different from other academic medical center's charges compared to theirs.

Dr. Ebert added the driving factor for these decisions are what's best for patients. Having a bone marrow transplant or cellular therapy treatment as an outpatient is not actually financially beneficial to them. It's usually beneficial to this total healthcare cost of this state because they're avoiding those admissions. But from the patient perspective, they are not admitted to the hospital, where they could be exposed to infections at their lowest point, and the outcomes are better. The patient experience is that they come in every single day to their outpatient clinic and get all the medications, blood products, and IV fluids that they would need and would get as an inpatient.

Mr. Landers said that he would like to look at the final HPC report to determine if these cost projections in the future were accurate. If not, he feared that Dana Farber may need to seek higher rates.He continued by saying that given the size of this investment, it may make sense to have a presentation to the Public Health Council soon regarding the methods and plans that are being used for this large contribution.

Dr. Ebert said not being a health economist, he shared Mr. Landers’ concerns of the complexity of forecasting with so many variables being unclear and the assumptions that are required. On the other hand, one thing that's been very reassuring is that this process has involved three extremely detailed independent analysis of cost. They performed their own independent analysis through consultants. The ICA is an independent cost analysis and then the CMIR is a third one. This has been studied arguably more than any other hospital has ever been studied in the state. This has been extremely well analyzed and with highly concordant findings.

Commissioner Goldstein noted condition five of the DoN application, which allows the Council to have broad oversight over the cost and any increase over the years to come.

Ms. Cooper stated that she is struggling with the timing of this large proposal in today’s atmosphere of federal cuts, the State’s fiscal situation, workforce shortages, and bottlenecks in hospitals. But yet, a billion dollar proposal is being discussed. She asked how the 2,400 people they hire will be housed, while the state generally needs 200,000 new homes. She spoke of the opportunity of this CHI to be used in a productive way. Rather than distributing the funds to multiple organizations, $62,000,000 is a unique opportunity to make a difference. She used the example that if all this money went to housing, it could go to the City of Boston’s housing accelerator fund, or in the state’s supportive housing pool fund, 800 apartments could be subsidized for 30 years. This, she said, would make an impact rather than distributing smaller sums to multiple organizations. She said as the Council decides whether they're going to vote to approve this request, given the magnitude of the CHI and this possible once in a lifetime opportunity presents itself, they could think about this differently. Maybe it is not the CHI board alone that makes these decisions, but it is in concert with the state, with the administration, perhaps even with the city of Boston to say if there is $61 million, what kind of an impact could be made and how to leverage and align with current state and local housing efforts that are going on right now. This CHI is different and it's not business as usual. She said she would vote for this proposal but needs to see that the CHI is done differently in this case than it normally is because of the amount of the money and the opportunity for impact.

Dr. Ebert agreed that so many things are happening around us in the midst of this enormous effort, but patients need this. It’s important to deal with whatever complexity comes along and to get this done, adhering to the values and the mission of decreasing the burden of cancer. Secondly, they are not asking the state for $1.67B to build this. They'll be able to rely on philanthropy for a large part of the cost and will be able to borrow the rest. The additional jobs are a challenge on one hand, but of course they are good for the economy as well. That will help people be able to afford housing. He agreed that $62M in community health initiatives has the potential for tremendous impact on housing. They recognize that housing is an important determinant of outcomes and cancer. And it fits well with their mission and their goals, as well as the goals of the community and state.

Ms. Contreras said that collaboration with DPH in implementing CHI proposals is standard. Collaboration determines where investments have the most impact. She reassured Ms. Cooper and the Council that the commitment, recognition and understanding that this is a different resource than they've ever had is something that is taken seriously and have already engaged with the CHI to discuss what would have the greater impact.

Mr. Engell asked about the impact on community based hospital programs as well as non-Boston based academic programs. He asked how those coming from Western and Central Massachusetts would be housed as outpatients when they are not from Boston.

Dr. Ebert said they've worked very hard to make sure that care is delivered as much as possible close to where people live. They have a network of sites that collaborate with community hospitals close to where they live. They may occasionally see those patients in town, but generally they deliver all of that care in the community close to where people live and close to community hospitals where they live. Beyond that, they have collaborative hospitals going all the way out to Berkshire Medical Center in Western Mass, who will have a cancer patient that will be referred to Dana Farber’s tumor board, given advice, and treated close to home. If they have leukemia or they need a stem cell transplant or cellular therapies that are very advanced, they do have to come in to see them and they try to send them back as quickly as we can. When the patient needs to be close by, housing is critical for that. It is extremely high on the priority list for the CHI and how it can be applied to help that population of patients who may not be able to afford a fancy hotel room in town. They already do that in collaboration with area hotels in a needs adjusted way but is something that we will need to potentially expand.

Mr. Reney spoke of the model for a regional campus site. They have regional oncologists in the regional campus sites to consult and manage patient care. Outside of the metro Boston area, they work with collaborative relationships sharing information through their tumor boards and case conferences.

Dr. Cruz-Davis questioned the optimism to fill 2,400 staff positions in this current market. She was concerned about the impact on community hospitals in potentially decreasing their bed capacity for oncology patients. She said she understood the daily census numbers presented, but questions if the practical discussion on community hospitals has been applied. She also asked about the additional strain on ERs.

Dr. Ebert said workforce is a big concern and while pipeline programs take a while to implement, it will be a few years before the hospital will be open. The timeline for those pipeline programs is actually aligned to when those people need to be hired, and they will be hiring gradually over quite a few years. Regarding community hospitals, their goal has always been to strengthen community hospitals, and the evidence shows that they have. Their network sites which are ambulatory sites are near community hospitals where those patients that they take care of are admitted to those local community hospitals. Those doctors who take care of the patients in their ambulatory clinics in the community have privileges at those hospitals. They saw over 12,000 oncology consults in those community hospitals in the last year, and that strengthens those community hospitals, enabling those hospitals to maintain those patients and maintain that revenue. Because they only do cancer, the patient sees their other doctors at the community hospital level, strengthening the community hospital. Regarding ER strain, the combination of their acute care clinic that decreases ER transfers, the use of 20 new observation beds to see patients overnight makes sure that they can turn patients around before, preventing a trip to the ER. Coordinating with Beth Israel Deaconess emergency room to have a rapid triage of cancer patients so they can get rapidly admitted to the hospital and not spend long hours and days in the emergency room. That combination will overall decrease the strain on emergency rooms.

Mr. Cox reiterated the importance in the placement of the CHI funding and agreed that to place a larger sum of money in one or two places will make a greater impact.

Ms. Contreras agreed and said she would like to have a conversation with the CHI office at DPH.

Jennica Allen, Manager of Community Engagement Practices, pointed to 2022, when DPH had a CHI of this size, and they did not change the rules. They didn't make any sort of edits to the regulation, not wanting to set precedent. One of the most important hallmarks of the CHI work is the meaningful community engagement. So, the people at the table getting to make the decision is critical. In 2022, when they had a $68M local CHI project, the work was the same. The process is the same with a small CHI or large. The process is the people who have been historically excluded from decision making, are the people who have the strongest input. Also, it's a bit of a mischaracterization to say that the money gets spread around. The entire process from when their team works with the hospital, when they tell us they're going to have a project all the way through to seeing it to implementation and evaluating it, is designed to sort of funnel into a focused selected strategy. They must tie back to one of the six social determinants of health that we identify. For the most part, they only see investments in one or two areas, regardless of the size of the CHI investment.

Dr. Bernstein asked what they learned from the response to the COVID pandemic that will help them in this turbulent time. He asked what the key point is that is driving them forward.

Dr. Ebert said they have a mission and culture there that's unparalleled compared to any institution he’s ever been part of or seen, that is committed to decreasing the burden of cancer for everybody and doing whatever is best for the patient while advancing Cancer Research to benefit patients in the future.

Dr. Volturo said the plan for an urgent care center for cancer patients is an excellent idea because they don’t belong in the ER. It will help ED backlogs.

Dr. Ebert thanked the PHC, the entire DPH for the work invested in this application. He echoed the sentiments about ERs for cancer patients saying, the drug regimens they are getting, they have often unusual cancers, and it's very difficult for an emergency room to be versed in all of that. To involve oncology as early as possible enables either patients to be turned around and sent home or the availability of a bed to take care of them, either an observation bed or an admission when needed.

With no further questions, Commissioner Goldstein asked if there was a motion to approve Dana-Farber Cancer Institute, Inc.’s request for a Substantial Capital Expenditure and Substantial Change in Service.

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

**3. INFORMATIONAL PRESENTATION**

*a. Update on the Health Survey Program.*

Commissioner Goldstein said due to time restraints, the update on the Health Survey Program would be postponed until next month.

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 April 9, at 9:00 am.

Commissioner Goldstein asked if there was a motion to adjourn.

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

The meeting was adjourned at 12:27 pm.