**MINUTES OF THE PUBLIC HEALTH COUNCIL**

**Meeting of March 6, 2018**

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**PUBLIC HEALTH COUNCIL**

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**Henry I. Bowditch Public Health Council Room, 2nd Floor**

**250 Washington Street, Boston MA**

**Docket: Tuesday, March 6, 2018 - 9:00 AM**

1. **ROUTINE ITEMS**
   1. Introductions
   2. Updates from Commissioner Monica Bharel, MD, MPH
   3. Record of the Public Health Council February 14, 2018 Meeting **(Vote)**
2. **DETERMINATIONS OF NEED**
   1. Partners HealthCare System, Inc. application for a substantial capital expenditure and acquisition of new technology at Brigham and Women’s Hospital. **(Vote)**
   2. Reliant Medical Group, Inc. application for a transfer of ownership of two ambulatory surgery centers due to a transfer of ownership of Reliant Medical Group, Inc. to Collaborative Care Holdings, LLC, a subsidiary of OptumCare. **(Vote)**
3. **FINAL REGULATIONS**
4. Request for final promulgation of proposed amendments to 105 CMR 430.000, *Minimum Standards for Recreational Camps for Children (State Sanitary Code, Chapter IV)*. **(Vote)**
5. Request for final promulgation of proposed amendments to 105 CMR 150.000, *Standards for Long-Term Care Facilities.* **(Vote)**

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

**Public Health Council**

Attendance and Summary of Votes:

Presented below is a summary of the meeting, including time-keeping, attendance and votes cast.

**Date of Meeting:** Tuesday, March 6, 2018

**Start Time:** 9:15am **Ending Time:** 11:17am

| **Board Member** | **Attended** | **Record of the Public Health Council February 14, 2018 Meeting (Vote)** | **Partners HealthCare System, Inc. application for a substantial capital expenditure and acquisition of new technology at Brigham and Women’s Hospital. (Vote)** | **Reliant Medical Group, Inc. application for a transfer of ownership of two ambulatory surgery centers due to a transfer of ownership of Reliant Medical Group, Inc. to Collaborative Care Holdings, LLC, a subsidiary of OptumCare. (Vote)** | **Request for final promulgation of proposed amendments to 105 CMR 430.000, *Minimum Standards for Recreational Camps for Children (State Sanitary Code, Chapter IV)*. (Vote)** | **Request for final promulgation of proposed amendments to 105 CMR 150.000, *Standards for Long-Term Care Facilities.* (Vote)** |
| --- | --- | --- | --- | --- | --- | --- |
| Monica Bharel | Yes | Yes | Yes | Yes | Yes | Yes |
| Edward Bernstein | Yes | Yes | Yes | Yes | Yes | Yes |
| Lissette Blondet | Yes | Yes | Yes | Yes | Yes | Yes |
| Derek Brindisi | Yes | Yes | Yes | Yes | Yes | Yes |
| Harold Cox | Yes | Yes | Yes | Yes | Yes | Yes |
| John Cunningham | Yes | Yes | Yes | Yes | Yes | Yes |
| Michele David | Yes | Yes | Yes | Yes | Yes | Yes |
| Meg Doherty | Absent | Absent | Absent | Absent | Absent | Absent |
| Michael Kneeland | Yes | Abstained | Yes | Recused | Yes | Yes |
| Joanna Lambert | Yes | Yes | Yes | Yes | Yes | YEs |
| Paul Lanzikos | Absent | Absent | Absent | Absent | Absent | Absent |
| Lucilia Prates-Ramos | Yes | Abstained | Yes | Yes | Yes | Yes |
| Secretary Francisco Ureña | Yes | Abstained | Yes | Yes | Yes | Yes |
| Alan Woodward | Yes | Abstained | Yes | Yes | Yes | Yes |
| **Summary** | **12 Members Present, 2 Members Absent** | **8 Members approved, 4 members abstained, 2 members absent** | **12 members approved, 2 members absent** | **11 members approved, 2 members absent, 1 member recused** | **12 members approved, 2 members absent** | **12 members approved, 2 members absent** |

**PROCEEDINGS**

A regular meeting of the Massachusetts Department of Public Health’s Public Health Council (M.G.L. c. 17, §§ 1, 3) was held on Tuesday, March 6, 2018 at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108.

Members present were: Monica Bharel, MD, MPH; Edward Bernstein, MD; Lissette Blondet; Derek Brindisi; Harold Cox; John Cunningham, PhD; Michele David, MD; Michael Kneeland, MD; Joanna Lambert; Lucilia Prates-Ramos; Secretary Francisco Ureña; and Alan Woodward, MD

Absent member(s) was: Meg Doherty and Paul Lanzikos.

Also in attendance was Margret Cooke, General Counsel at the Massachusetts Department of Public Health.

Commissioner Bharel called the meeting to order at 9:15 AM and made opening remarks before reviewing the agenda.

**ROUTINE ITEMS**

**Updates from Commissioner Monica Bharel, M.D., MPH**

Commissioner Bharel began updates by discussing the recent March 2nd storm that resulted in significant flooding, structural damage and power outages across the Commonwealth, with the greatest impacts to the South Shore, Cape and Islands. At the height of the storm there were 450,000 power outages.

The Department was asked by MEMA to staff the Health and Medical Desk at the State Emergency Operations Center. Beginning at 8:00am Friday morning and for the next 86 hours, staff from the Office of Preparedness and Emergency Management rotated in/out for 12-hour shifts. The Desk stood down at 8pm last night (March 5, 2018).

Over the course of the activation OPEM staff provided support to healthcare facilities impacted by the event. This included a loss of commercial power to: 6 acute care hospitals, 5 assisted living facilities, 1 outpatient clinic, 2 rest homes and an incredible 47 skilled nursing facilities. OPEM tracked these outages, coordinated with regional partners and facilities, liaised with the utilities to prioritize restoration, and responded to resource needs and requests.

Throughout the event OPEM utilized the Health and Homeland Alert Network to provide situational awareness to partners and they produced 6 Statewide Public Health and Medical Situation Reports.

Next, the Commissioner addressed the budget. The FY2019 budget process is in full swing, with the House planning to release its proposal next month.

As part of that process, Commissioner Bharel had the chance to provide testimony before members of the House and Senate Committees on Ways and Means. It was a great opportunity to share some of the essential work of the Department and highlight some of the key investments in the Governor’s FY2019 budget. The Commissioner then shared some of the highlights from her testimony.

DPH has a total budget of roughly $1B – two thirds of which comes from state appropriations – and nearly 3,000 employees who all share the same driving purpose: to promote health equity and improve health for all residents of the Commonwealth. Below are some of the FY2018 accomplishments:

* Massachusetts has the lowest teen birth rate in the country, more than half of the national rate, thanks to our primary and secondary pregnancy prevention work;
* Our national SANE TeleNursing Center is the first and only of its kind in the nation, marking the first time telehealth has been used to support the care of adult and adolescent sexual assault patients;
* Last year, the Massachusetts WIC program provided more than $78M of healthy foods to WIC-eligible families; seeing 39% of all children under age 5.
* Our Early Intervention program served more than 41,000 children, representing nearly 6% of infants and toddlers from birth to age three.

For the first time, DPH was allowed to link data sets from across state government creating a rich database to analyze the current opioid epidemic and draw actionable conclusions. These data sets now form the base of our ongoing precision public health work. Massachusetts was ranked the healthiest state in the nation, a distinction our state has never before held. However, as we continue the work of our core mission around health equity, the reality is that too many Massachusetts residents experience persistent, negative health outcomes that we must continue to work to change. It is 2018, and the zip code of someone’s home address is still the single strongest predictor of their health. Childhood lead exposure, which has lifelong negative health effects, disproportionately impacts communities of color. In particular, Black non-Hispanic and American Indian populations are disproportionately impacted and have rates of high blood lead levels almost twice those of the White non-Hispanic population.

Despite an overall decline in adult smoking over the past 20 years, smoking remains the leading cause of death and disease in Massachusetts. Smoking prevalence among individuals with mental illness is double that of the general population. In Massachusetts, adults with an annual household income of less than $25,000 have three times the prevalence of diabetes compared to those with an annual household income more than $75,000 (5%).

Massachusetts being ranked the healthiest state does not make sobering facts like these any more acceptable. We still have a lot of work to do together. Part of that work includes fulfilling core public health functions. Our work in protecting, promoting and preserving the health of all individuals in the Commonwealth is paramount. The Commissioner highlighted several areas of the budget in her testimony, including the need for additional inspectors.

H.2 includes a ~$1.3M increase across three accounts to support DPH’s inspectional capacity, including:

* a ~$1M retained revenue increase to support 11 health facility inspectors needed for the inspection and certification of health care facilities and the investigation of complaints submitted by patients and their families to ensure safe, high quality care delivery in hospitals, nursing homes, rest homes, hospice programs, clinics, dialysis centers, and other health care facilities;
* a ~$170K increase for two food inspectors; and,
* a ~$100K retained revenue increase for one additional radiation inspector.

DPH is responsible for oversight of more than 1,400 health care facilities, including hospitals, clinics, nursing homes, rest homes, hospice programs, dialysis centers, and responds to more than 16,000 incident reports and consumer complaints on an annual basis related to patient care and safety.

DPH’s Food Protection Program (FPP) is responsible for licensing and inspecting over 2,000 food manufacturers. State food inspections are critical to the purity of the food supply and to the health and safety of Massachusetts residents. Since 2014, over 2,000 foodborne illnesses have been reported, resulting in 159 investigations and 54 enforcement actions taken against Massachusetts food manufacturing firms.

These funding increases are not for new initiatives or programs. Rather, this funding is needed to maintain DPH’s core public health functions that we all expect to happen behind the scenes every day.

Commissioner Bharel asked that they all keep these critical funding initiatives in mind as the state moves through the budget process. These are necessary to maintain DPH’s ability to protect the health and safety of Massachusetts residents.

Concluding her updates, the Commissioner discussed personnel updates. Carlene Pavlos has resigned from her position at Director of Bureau of Community Health and Prevention and will be the new Executive Director of the Massachusetts Public Health Association. Ms. Pavlos will be leaving DPH at the end of March. She began her career at DPH in 1999 as the Director of Injury and Violence Prevention. Associate Commissioner Lindsey Tucker is working closely with Ms. Pavlos on developing a transition plan, and an acting bureau director will be named shortly. She asked the Council to join her in thanking Ms. Pavlos for all her contributions to DPH over the past two decades.

The Commissioner then asked if the Council had any questions or comments regarding the updates.

Seeing none, the Commissioner proceeded with the docket.

**1. ROUTINE ITEMS**

**c. Record of the Public Health Council February 14, 2018 Meeting (Vote)**

Commissioner Bharel asked if any members had any changes to be included in the February 14, 2018 meeting minutes.

Seeing none, the Commissioner asked for a motion to accept the minutes. Dean Cox made the motion and Dr. David seconded it. Secretary Ureña, Dr. Woodward, Ms. Prates Ramos, and Dr. Kneeland abstained as they were not present at the February 14th meeting. All other present members approved.

**2. DETERMINATIONS OF NEED**

**a. Partners HealthCare System, Inc. application for a substantial capital expenditure and acquisition of new technology at Brigham and Women’s Hospital. (Vote)**

Commissioner Bharel then invited Nora Mann, Determination of Need Program Director, and Rebecca Rodman, Deputy General Counsel, to the table to review the DoN staff recommendation for Partners HealthCare System, Inc. application for a substantial capital expenditure and acquisition of new technology at Brigham and Women’s Hospital.

Upon the conclusion of Ms. Mann’s presentation the Council was asked if they had any questions or comments.

Christopher Baugh MD, MBA, Medical Director, Department of Emergency Medicine, Brigham & Women's Hospital; Ron Walls, MD, FAAEM, FRCPC Executive Vice President and Chief Operating Officer of Brigham Health; Raymond Mak, MD, Thoracic Radiation Oncologist; Assistant Professor, Radiation Oncology, Brigham and Women's Hospital; and Srinivasan Mukundan, Jr.,M.D.,Ph.D., Medical Director of Magnetic Resonance Imaging (fMRI) for Brigham Health joined the table to answer questions.

Dr. David asked if there was any thought to geriatric emergency beds with special lighting etc. as part of the ED redesign.

Dr. Walls replied that the redesign of the ED is to facilitate the care of all of their patients including geriatric patients. The segregation of behavioral health patients into a private unit where they can receive specialized care in a non-obtrusive environment is an example of that. He stated that model is something that will be common amongst the ED. The expansion will allow for an enhanced care environment and longitudinal assessments.

Dr. Baugh stated that when discussing design elements they realized that features beneficial for geriatric patients were overall great features for all.

Dr. Woodward asked for clarification on the ED volume. He also inquired about the average length of stay for medical/surgical, transfer and admitted patients.

Dr. Baugh stated that length of stay is broken down into two main categories: discharge and admitted patients. They can follow up with the exact numbers but the estimated time for length of stay for discharge patients is closer to 3 hours and the average length of stay for admitted patients is between 5-6 hours. As for ED volume, it is 62,000 visits per year.

Dr. Woodward discussed the variation in length of stay times and asked if the variation in times has to do with an outflow problem.

Dr. Baugh informed him that it is due to operational changes that have occurred in recent years to initiate care sooner so that patients are discharged quicker. He also discussed their home hospital program.

Dr. Woodward then asked how may observation beds do they have now.

Dr. Baugh replied that the currently have 20 observational beds and will be adding 10 beds into a larger flexible zone.

Secretary Ureña leaves the room at 10:05am and returns at 10:06am.

Dr. Woodward then asked if they are finding they are getting increased transfer times for behavioral health.

Dr. Baugh replied that they are and they are also seeing a higher percentage of patients with a longer length of stay (several days).

Dr. Woodward asked staff about the cost of square footage and if it is consistent with previous ventures.

Ms. Mann replied that under the current regulation the way they assess financial feasibility has changed. They no longer look at the comparatives for square footage.

Dr. Baugh added that from his understanding, a part of that cost is replacing existing infrastructure with current facilities.

Commissioner Bharel asked for clarification if the 6 per day is mental health and substance abuse.

Dr. Baugh informed the Commissioner that it is often comorbid and it is behavioral health, substance and psychiatric emergency.

Ms. Blondet asked if they know the demographic profile of 3.3% of patients with complex conditions. She also asked for the surrounding neighborhoods.

Dr. Baugh informed her that the neighborhood they are immediately in is the Mission Hill area and therefore serve a large amount of that community. He went on to say that either through EMS or self-presenting, they see patients from West Roxbury, Roxbury, Roslindale, Brookline, and Fenway. Those are the neighborhoods in immediate geographic location to the ED.

Ms. Blondet asked if they had any information on who comprises the 3.3%.

Dr. Walls informed her that these are patients from their ICMP program.

Andy Levine, hospital counsel, informed Ms. Blondet that they could provide that information at a later date.

Ms. Lambert asked if there any parallel initiatives to reduce ED admissions or readmissions, especially amongst patients with a history of substance abuse.

Dr. Baugh replied that the bridge clinic will provide services to substance abuse patients it will also allow initiation of treatment without a delay and will be located next to the ED. He then discussed the usage of acute care plans in targeting an approach for patients with reoccurring conditions.

Dean Cox asked why there was not a hearing for this particular application.

Ms. Mann replied that no one from the public requested a hearing. If they received comments from community members or other stakeholders then a hearing would have taken place.

Dean Cox then asked for factor 6 and tier 2 to be explained again.

Ms. Mann invited Ben Wood, Director, Office of Community Health Planning and Engagement in the Bureau of Community Health and Prevention, to the table to answer the question.

Mr. Wood replied that at the time of application, factor 6 determines whether the current CHNA meets basic standards for community engagement and whether it adequately looks at the DoN health priorities. The tiers are in reference to having different expectations in accordance with the size of the CHI project. This is a tier 2 project because it is under $4 million but greater than $500,000.

Dean Cox then asked if there was an active CHNA in this community or is it involved in other community engagement opportunities that the hospital has.

Mr. Wood explained that the process is set up to align with ACA requirements and reporting to the Attorney General, both require a regular CHNA process.

Dean Cox then asked if the hospital complied with Factor 6 tier 2.

Ms. Mann and Mr. Wood replied that they did.

Mr. Wood also noted that the hospital will convene the advisory committee that will work with the hospital to determine a particular strategy and they have report to DPH the strategies they’ve chosen and comply with DoN health priorities.

Dr. Woodward asked if they have a separate PFAC and how they select and engage their ED PFAC.

Dr. Walls replied that 6-10 years ago they had patient family advisory committees for other services in the hospital and knew that their population in the ED was somewhat reflective of that. They went to the various PFACS and identified amongst those people who would be interested in improving the experience of those in the ED.

Mr. Brindisi asked if there will be another community engagement process.

Mr. Wood said informed him that there will not be another process, but the main focus is too look at the community health assessment.

Mr. Brindisi asked if that community health assessment engaged 100% of the constituents or is it focused on the local neighborhood.

Mr. Wood replied that the CHNA is focused on the historical neighborhoods that the Brigham things about in terms of their catchment area. To address the issue that Mr. Brindisi alludes to, the statewide CHI was initiated. A portion of the dollars that they are required to give will go that fund.

Ms. Blondet noted a disconnect between what the ED will address and what can be done encourage looking into programmatic strategies for the 3.3%.

Mr. Wood replied that there is nothing stopping the applicant to propose new strategies that would meet the new DoN Health priorities guidelines and would address why a certain percentage of the population are experiences issues that require reoccurring visits.

Dr. Walls replied that they will not need encouragement to do so since from a Brigham perspective it is an ideal way to use the dollars.

With no further questions, the Commissioner asked if there was a motion to accept the staff recommendation for approval of Partners HealthCare System, Inc. application for a substantial capital expenditure and acquisition of new technology at Brigham and Women’s Hospital.

Dr. Kneeland made the motion, Dr. Woodward seconded it. All present members approved.

**2. DETERMINATIONS OF NEED**

**b. Reliant Medical Group, Inc. application for a transfer of ownership of two ambulatory surgery centers due to a transfer of ownership of Reliant Medical Group, Inc. to Collaborative Care Holdings, LLC, a subsidiary of OptumCare. (Vote)**

Commissioner Bharel then asked Ms. Mann to present the staff recommendation for Reliant Medical Group, Inc. application for a transfer of ownership of two ambulatory surgery centers due to a transfer of ownership of Reliant Medical Group, Inc. to Collaborative Care Holdings, LLC, a subsidiary of OptumCare.

Dr. David leaves the room at 10:36am and returns at 10:40am.

Dr. Kneeland recuses himself as 10:37am.

Upon conclusion of her presentation, the Council was asked if they had any questions or comments.

Dr. Woodward asked if this is a change of ownership of these two ACs.

Ms. Mann replied that it is a change of ownership of the parent of the two ACs. The ACS will still be owned by Reliant but Reliant will have new ownership.

Dr. Woodward asked if the physicians at Reliant are convinced that there are sufficient local input and control in the community’s needs.

Ms. Mann replied that from their knowledge there is complete physician and community support.

Dr. Tarek Elsawy, President and CEO or Reliant Medical Group and Dan Egeland, Senior Vice President of OptumCare joined the table.

Dr. Elsawy informed Dr. Woodward that they have a board that is 50/50 community members and physicians. The board voted unanimously to proceed with the transaction and the 200+ physician group voted unanimously as well.

With no further questions, the Commissioner asked if there is a motion to accept the staff recommendation for approval of Reliant Medical Group, Inc.’s application for a transfer of ownership of two ambulatory surgery centers.

Secretary Ureña made the motion, Ms. Lambert seconded it. All present members approved.

**3. FINAL REGULATIONS**

**a. Request for final promulgation of proposed amendments to 105 CMR 430.000, Minimum Standards for Recreational Camps for Children (State Sanitary Code, Chapter IV). (Vote)**

The Commissioner then invited Steve Hughes, Director of the Community Sanitation Program within the Bureau of Environmental Health; Dave Williams, Senior Analyst within the Community Sanitation Program; and Jim Ballin, Deputy General Counsel, to the table to present proposed regulation, 105 CMR 430.000, Minimum Standards for Recreational Camps for Children (State Sanitary Code, Chapter IV), and request approval from the Council.

Dr. Kneeland returns at 10:52am.

Upon the conclusion their presentation, the Council was asked if they had any questions or comments.

Dr. Cunningham asked why they removed background checks for counselors in training.

Mr. Williams replied that a counselor in training is actually a camper and they are not staff and therefore do not count towards the ratio. Since they do not count towards the ratio they should always be supervised at the proper ratio of 1 to 10 for staff.

Mr. Brindisi asked how they define a camp in terms of number of days.

Mr. Williams responded that a camp meets 5 days in a 2 week period. They put forth discussion to lower it to 4 days in a 2 week period so that athletic clinics etc. can be licensed as camps.

Mr. Brindisi then asked about swim lessons.

Mr. Williams stated they added reference to Christian’s law in the camps and applied the same criteria to swimming pools.

Dr. Woodward asked if there is someone trained on site to allow campers to administer epinephrine or insulin. He then asked if there was a reporting system in which camps send information on medical issues to DPH.

Mr. Williams replied that all camps are required to have a medical supervisor and that administration must occur in the presence of the health care supervisor. In the case of emergency situations, camps have camp doctor to train individuals and campers. All incidences that involve a camper going to the emergency room or seeing a doctor with a positive diagnosis have to be reported within 7 days to the local board health and DPH.

Ms. Lambert asked about staffing ratios in regards to children with disabilities.

Mr. Williams informed her that with feedback from the camp operators, they decided to give the camp and the parents more authority to make individualized assessments based upon need.

Ms. Lambert then asked if there was any consideration to look at a camper’s IEP.

Mr. Williams replied that it is something that they would suggest and that some camps do utilize IEP.

With no further questions, the Commissioner asked if there is a motion to approve the proposed changes to 105 CMR 430.000.

Dr. David made the motion, Dr. Woodward seconded it. All present members approved.

**3. FINAL REGULATIONS**

**b. Request for final promulgation of proposed amendments to 105 CMR 150.000, Standards for Long-Term Care Facilities. (Vote)**

The Commissioner then invited Suzanne Cray, Director of Health Care Integration and Strategic Initiatives within the Bureau of Health Care Safety and Quality; Sherman Lohnes, Director of the Division of Health Care Facility Licensure and Certification within the Bureau; and Rebecca Rodman, Deputy General Counsel, to the table to present proposed regulation, 105 CMR 150.000, Standards for Long-Term Care Facilities, and request approval from the Council.

Upon conclusion of the presentation, the Council was invited to ask questions.

Secretary Ureña inquired asked about long term care and the hours of care. He inquired how facilities would determine the appropriate levels of staffing.

Mr. Lohnes replied that they have moved away from set number of hours because of varying of needs for residents. This has allowed facilities to assess the needs of the residents and staff appropriately for that.

Commissioner Bharel asked Mr. Lohnes to discuss the role of inspections.

Mr. Lohnes noted that there is a new inspection process that is very resident centered. The surveyors talk to every resident in the facility and looking at the assessment for the residents to ensuring that care is provided on an individualized basis.

Ms. Prates Ramos asked how do inspection services at DPH interface with the ombudsman program at EOEA.

Mr. Lohnes informed her that the ombudsman works frequently and closely with DPH. They’ve invited the ombudsman to participate in the training that they have for surveyors.

With no further questions, Commissioner Bharel asked for a motion to approve the proposed changes to 105 CMR 150.000.

Ms. Prates Ramos made the motion, Dr. David seconded it. All present members approved.

The Commissioner then reminded the Council that the next meeting is Wednesday, April 4, 2018 at 9AM.

She then asked for a motion to adjourn. Dr. David made the motion Dr. Kneeland seconded it. All present members approved.

The meeting adjourned at 11:17AM.