MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of May 14, 2025

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

**PUBLIC HEALTH COUNCIL MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

**Henry I. Bowditch Public Health Council Room, 2nd Floor 250 Washington Street, Boston MA**



**Docket: \*\*\*REMOTE MEETING\*\*\* Wednesday, May 14, 2025 – 9:00AM**



***Note: The May 14 Public Health Council meeting will be held remotely as a video conference consistent with St. 2021, c. 20, s. 20, which provides for certain modifications to the Massachusetts Open Meeting Law.***

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

Join by Web: <https://zoom.us/j/99935573977>

Dial in Telephone Number: 929-436-2866

Webinar ID: 999 3557 3977

1. **ROUTINE ITEMS**
2. Introductions.
3. Updates from Commissioner Robert Goldstein.
4. Record of the Public Health Council Meeting held April 9, 2025 **(Vote)**.

1. **INFORMATIONAL PRESENTATIONS**
2. Update on the DPH Data Front Door.
3. Update on the DPH Heat Education Alert Tool.



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



Attendance and Summary of Votes:

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

Date of Meeting: May 14, 2025

Start Time: 9:04 am. Ending Time: 10:34 am.

| **Board Member** | **Attended** | **First Order:****Approval of****April 9, 2025 Minutes**  **(Vote)** |
| --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes |
| **Craig Andrade** | Yes | Abstain |
| **Damien Archer** | Yes | Yes |
| **Lissette Blondet** | Yes | Abstain |
| **Kathleen Carey** | Yes | Abstain |
| **Emily Cooper** | Yes | Yes |
| **Robert Engell** | Absent | Absent |
| **Marcia Hams** | Yes | Yes |
| **Stewart Landers** | Yes | Yes |
| **Tom Mackie** | Yes | Abstain |
| **Mary Moscato** | Yes | Yes |
| **Ellana Stinson** | Yes | Yes |
| **Ram Subbaraman** | Yes | Yes |
| **Gregory Volturo** | Yes | Yes |
| **Aria Zayas** | Yes | Abstain |
| **Summary** | 14 Members Present1 Member Absent | 9 Members Approved;5 Member Abstained; 1 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, May 14, 2025, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

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

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

Commissioner Goldstein called the meeting to order at 9:04 am and made opening remarks before reviewing the docket.

Lissette Blondet joined at 9:18 am.

**1. ROUTINE ITEMS**

*a. Introductions*

Commissioner Goldstein welcomed three new members to the Council: Aria Zayas, Craig Andrade, and Thomas Mackie. All council members then introduced themselves to one another.

*b. Updates from Commissioner Robert Goldstein*

**A Department of Public Health Primer**

Reviewed the basics about the Department of Public Health and reflected on the scope and magnitude of what we do, and why it matters. He said that Massachusetts has built a legacy of confronting health challenges head-on. Our state was the first to establish a childhood lead poisoning prevention program and a universal newborn screening program. We were early leaders in responding to the HIV/AIDS crisis with science, and with compassion. We acted decisively in the face of the COVID-19 pandemic. We have invested in preventing chronic disease, addressing mental health, and combatting substance use disorders. We are a national leader in supporting and protecting reproductive health. And we have long recognized that social determinants of health; housing, education, food access, transportation, job opportunities, shape lives and drive outcomes as much as, or perhaps more than, biology or behavior. Our Strategic Plan to Advance Racial Equity challenges us to look far beyond symptoms to the root causes. It pushes us to use data to drive decisions and resources where they are needed most. It reminds us to listen deeply to the communities most impacted by disparities.

In just the past year, the Department of Public Health has:

* Delivered more than 200,000 WIC benefits to families
* Supported more than 40,000 babies and toddlers through early intervention
* Maintained more than 20 million vital records – births, marriages, deaths
* Answered nearly 73,000 crisis calls through the 988 Suicide and Crisis Lifeline
* Investigated more than 1,000 food-borne illnesses and outbreaks
* Assessed more than 7,000 homes for lead paint
* Conducted more than 360,000 infectious disease lab tests,
* Tested water from 40 rivers, ponds, and lakes and 1,100 beaches for harmful levels of chemicals and bacteria
* Distributed more than 400,000 naloxone kits and 365,000 fentanyl test strips
* Issued and maintained nearly 445,000 health care personnel licenses
* And kept millions of patients safe by inspecting health care facilities across the state.

The Department is powered by a mission-driven team of 3,200 employees. They are epidemiologists and analysts, nurses and lab techs, social workers and community health workers, administrators and office staff, all united by a shared public service calling. He reminded members that they play a vital role in this undertaking.

**National Nurses Week**

Commissioner Goldstein said Nurses Week ended May 12 on the birthday of Florence Nightingale, the founder of modern nursing. He took the opportunity to extend thanks to the extraordinary nurses who work in many capacities at the Department of Public Health. Nurses make up 20% of the workforce at DPH and are the backbone of health care and public health, whether they are caring for patients in our public health hospitals, investigating outbreaks, educating communities, or quietly keeping everything running smoothly behind the scenes.

**National Hospital Week**

Commissioner Goldstein mentioned this week is National Hospital Week. He highlighted the four public health hospitals, Lemuel Shattuck Hospital, Tewksbury Hospital, Western Massachusetts Hospital, and Pappas Rehabilitation Hospital for Children. He thanked all their dedicated staff. He said hospitals never sleep, operating 24 hours a day, seven days a week. They rely on the expertise of thousands of professionals including nurses, physicians, aides, therapists, IT staff, engineers, food service workers, security officers, administrators, clerical staff, medical records staff, and many others. DPH public health hospitals, in particular, serve as safety nets for some of the most medically complex individuals in our state. We provide care to those with acute and chronic disease and significant medical, behavioral, and social needs. Many of our patients have been turned away from multiple other facilities, and often they have nowhere else to go. He thanked all those working in the public health hospitals and the greater hospital community for helping to make Massachusetts number one in the nation for healthcare.

**Women’s Health Month**

Commissioner Goldstein said that May is also Women’s Health Month and a time to highlight the hard-won progress and persistent challenges to women’s health, particularly reproductive autonomy. Massachusetts stands as a national leader in reproductive health. In response to the erosion of reproductive rights following the Supreme Court’s 2022 decision overturning Roe v. Wade, Massachusetts has continued to strengthen its legal protections for abortion providers, patients, and advocates. Just last month the Legislature introduced a bill to shield personal information from those who prescribe, deliver, receive, or support reproductive and gender-affirming health care services. And this week, DPH launched a health information campaign to raise awareness of the ACCESS law, which enables eligible individuals to get prescription contraceptives and access to emergency contraception at no cost.

**Mother’s Day / Implementation of Maternal Health Bill**

Commissioner Goldstein said advancing health equity means providing access to high-quality care and support to all mothers and birthing people, regardless of race, income or background. Since the signing of the Maternal Health Bill into Law in August 2024, the Department has been working to expand access to community birth in Massachusetts, through the establishment of the Board of Midwifery that is preparing licensure for Certified Professional Midwives, as well as the revised birth center regulations that were approved in February. Acknowledging that we still have important work to do to improve the experience and outcomes of maternal health care, the Department has launched the Maternal Health Task Force with the Health Policy Commission and other partners to analyze maternal health access and birthing patient safety.

**Measles**

Commissioner Goldstein said DPH and the Centers for Disease Control and Prevention continue to monitor ongoing measles cases and outbreaks in various states around the country. According to [CDC](https://www.cdc.gov/measles/data-research/index.html), as of May 8, 2025, a total of 1,001 [confirmed measles cases](https://chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https%3A/ndc.services.cdc.gov/wp-content/uploads/NNC_2025_Notificaition_Requirements.pdf) were reported by 31 jurisdictions so far this year. The majority of the cases are associated with an outbreak that began in West Texas that led to the deaths of three unvaccinated people. There continue to be no recent measles cases reported in Massachusetts. We continue to advocate for immunization with the widely available, safe and effective measles vaccine. Two doses of MMR vaccine are about 97% effective at preventing measles, and protection is long-lasting. For this highly contagious disease that can cause serious complications, particularly in children, getting vaccinated for measles is the most effective way to protect individuals and communities.

**Federal Impacts**

Commissioner Goldstein said the Trump Administration recently released a proposed budget for FY 2026 and a series of executive actions that, if enacted, could significantly impact the Department’s ability to promote health, safety, and well-being across the Commonwealth.

The Administration is proposing a 23% cut to non-defense discretionary spending, with sweeping reductions to core public health agencies. Notably, the Centers for Diseases Control and Prevention would see its budget slashed by more than half, from $9 billion to $4 billion, with elimination of key centers including those focused on chronic disease, environmental health, injury prevention, and emergency preparedness. Vital programs in sexually transmitted diseases, tuberculosis, substance use disorders, and viral hepatitis would be rolled into one $300 million grant initiative, a consolidation that would mean severe cuts. Similarly, the Health Resources and Services Administration (HRSA) would be cut by $1.7 billion, impacting programs that serve some of our most vulnerable populations, including those focused on HIV/AIDS, maternal and child health, and family planning. The Substance Abuse and Mental Health Services Administration (SAMHSA) would face a $1 billion cut, eliminating regional programs targeting addiction and behavioral health. Cuts to the Administration for Strategic Preparedness and Response call for sunsetting the Hospital Preparedness Program, with the expectation that states would absorb these costs independently. The Administration’s budget also proposes eliminating federal support for teen pregnancy prevention, sexual risk education, and environmental justice, and it significantly reduces public health grants from the National Institutes of Health and the Federal Emergency Management Agency. Congress ultimately controls federal spending, and we expect months of negotiations and revisions before any federal budget is finalized. In the meantime, we are working closely with the Executive Office of Health and Human Services, the Governor’s Office, and with our federal and regional partners to assess potential impacts and prepare responses. Maintaining sustainable and predictable funding for core public health services remains our priority.

This is truly an unsettling time for those us who work in public health and who care deeply about the individuals, families, and communities we serve. We will continue to advocate strongly for the funding, support, programs, and services those in our Commonwealth count on and deserve.

Commissioner Goldstein asked if there were any questions.

Ms. Moscato thanked the Commissioner and noted the senior population as vulnerable regarding the potential federal cuts.

Ms. Hams thanked the Commissioner for the background of Massachusetts Public Health and said they now need to deal with the implications at the state level while working to address those impacts in the most equitable way possible.

Mr. Landers mentioned the potential harm to local public health with possible federal funding cuts.

Dr. Subbaraman said that the potential federal cutbacks may discourage the future pipeline of public health workers and may be a catalyst in losing future students of public health.

Ms. Blondet mentioned the fear that undocumented immigrants now have in leaving their houses, which is motivating new strategies being created to provide access for primary care through on-line appointments.

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

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

*c. April 9, 2025 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the April 9, 2025, minutes.

Dr. Volturo offered a technical change, which the Commissioner accepted.

Commissioner Goldstein asked if there was a motion to approve the amended April 9, 2025 minutes.

Dr. Volturo made the motion, which was seconded by Mr. Landers. Mr. Andrade, Ms. Blondet, Dr. Carey, Mr. Mackie, and Ms. Zayas abstained. All other present members voted to approve the minutes.

**2. INFORMATIONAL PRESENTATIONS**

*a. Introducing the DPH Data Library*

Commissioner Goldstein invited Carla Villacorta, Manager for Data Transformation & Partnerships to share give an introduction to the DPH Data Library, a new DPH landing page that offers a single-entry point for exploring DPH’s publicly available data.

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

Dr. Carey said this data library is very timely from the point of view of the public, regarding the mixed messages around data and public health that are out there, starting with COVID and vaccines and more recently measles. There should be an awareness and use of this tool. She hoped those who are most susceptible to misinformation could be reached by this data. She suggested several ways, including primary care providers to help disseminate this information to the general public. She also asked if users could be tracked.

Commissioner Goldstein said that there are a number of interactive dashboards that would be helpful as a practicing clinician trying to understand the community where your patient comes from. The Public Health Information Tool (PHIT) would allow a clinician to look at a particular community and know what the risk factors may be there. The Environmental Health Tracking Tool can do the same to understand what one is potentially exposed to in their community here in Massachusetts. They can track the number of clicks they get in the various dashboards.

Ms. Cooper said there is a statewide homeless data warehouse called the Rehousing Data Collective managed by the Executive Office of Housing and Livable Communities. It has data that local homeless providers are required to input, given their federal funding. She would like to see an integration of data from that site to the DPH Data Front Door.

Mr. Cyr said that they have modernized their data platforms to enable the integration from various statewide data platforms.

Commissioner Goldstein said the initial idea for this library was to pull together our DPH data. But in the process, they are working on modernizing the whole data infrastructure so that it’s possible to accumulate more data from across state government.

Mr. Mackie said in light of the alarming things that are happening federally, like the retraction of available data sets that have been historically housed on websites like Centers for Disease Control and Prevention, he applauded the state for having this additional investment to build and to use evidence in the context of making critical public health decisions and said it is even more important perhaps today than ever before. Regarding how the DPH Data Library might be integrated into clinical practice, he said he was curious around partnerships or ways to facilitate training and how to use this to inform decision making. Had there had been any thoughts about building resources that could facilitate the integration of these resources into clinical or policy practice from colleague? Or collaborations with universities to integrate into course work as the next generation is trained?

Commissioner Goldstein said this data belongs to the public and the public should have access to it. This includes schools of public health, nursing and medical schools who will engage with this data along with the Public Health Data Warehouse and MDPH Net.

Mr. Andrade suggested the local public health institute as a way to connect and tap into this data for their own regional health. He suggested that a tutorial video be created or visiting trainings from Ms. Villacorta would be beneficial.

Ms. Villacorta acknowledged that some resources such as a “What is data modernization at DPH?” video exists. These resources have been built to educate the internal audience at DPH but agreed that additional partnership could be useful.

With no further questions, Commissioner Goldstein moved to the next item on the agenda.

*b. Update on the DPH Heat Education Alert Tool.*

Commissioner Goldstein invited Darien Mather, Lead Epidemiologist and Lead for the Climate and Special Projects Unit within the Bureau of Climate and Environmental Health, to share an update on the DPH Heat Education Alert Tool. She was joined by Kate Adams, Senior Epidemiologist for the Climate and Special Projects Unit.

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

Ms. Moscato said these heat alerts are very important to her work of taking care of seniors and over 300 nursing homes and community centers.

Commissioner Goldstein added that there is also the ability to look at the forecast by community.

Dr. Stinson said as an ER Physician at Boston Medical Center, these alerts are critical for the work she does. She asked if the alerts went via text on phones.

Ms. Mather said the Heat Alert Network (HAN) go out to emails, but not texting alerts. She believed the alerts are designed so community-based organizations can easily forward them through text.

Commissioner Goldstein said it would be looked into, because it’s a good idea to receive texts as most people don’t check their emails every day.

Dr. Subbaraman said his limited understanding of this literature is that a lot of the heat stress-related health outcomes may be things like heart attacks, which are essentially concealed as other types of health outcomes and not necessarily as heat stress related admissions. He asked if there are other health outcomes that if included could lead to other thresholds.

Ms. Mather said people coded as having “heat stress” are people who otherwise are healthy and would not have shown up to the emergency room. They have also expanded to look at all visits to see what the impact of heat is, which is a little less clear. When the temperature is above 78°F, about 200 more ED visits can be expected due to any cause.

Dr. Carey said it’s important to make people aware not only that a heat wave is coming and the temperatures will be high, but also to make them aware long-term of just how dangerous it can be. Some groups of people who don't have English language proficiency, or people who have mental illness, or people who are unhoused. She wants them to be able to understand just how dangerous it can be.

Ms. Mather said they are trying to create a systematic response with all systems in place so people can make healthy decisions because they understand the threat of extreme heat. For example, like understanding they can go a library or cooling center where they can stay during a heat event.

Dr. Volturo added that people don’t start thinking about heat as a problem until it starts to go over 85 degrees, but many people can’t tolerate the heat at lower temperatures, especially those on medication that is mitigating their ability to tolerate it. Additionally, he added that in the cities where the concrete mass holds the heat, the temperatures often don’t drop sufficiently at night to mitigate risk.

Mr. Andrade questioned how much information the state has on the capacities across municipalities, or lack thereof, to help mitigate a heat emergency. He wondered about people that are unhoused or who have limited resources, in events of moderate heat, let alone extreme heat, if their communities are able to offer mitigation opportunities. He was concerned that the disparity between populations of people within our community, but also the ability for their community to have systems in place so people are not left to their own devices, where they have none.

Ms. Adams said one of the things they have done is looked at crude rates of heat illness across a five-year period, across the entire state. They identified about 95 communities that had either a high numbers of cases (over 50) or very high crude rates of heat stress - they were in places in the Commonwealth they didn’t expect. Then they looked at whether or not these communities had 50% or more of their residents living in environmental justice groups or areas, and also whether or not they were communities identified by the Department’s Health Equity work. They’ve identified 37 communities that are not only stressed by heat cases or heat crude rates but also have additional socioeconomic and social determinants of health issues going on. They are working with the Office of Health Equity to make inroads into those communities. They issued them their own reports for each community, detailing why they were heat equity communities and what the details behind that were. There are also issues with working populations that they're concerned about. They are trying to loop in the occupational aspects of that both within the Bureau of Climate and Environmental Health (BCEH), and other bureaus so that they can start to tackle the issues in these communities.

Ms. Mather added that when those data briefs went out, they encouraged municipalities to use that data to include in their applications to the Municipal Vulnerability Preparedness Program through EEA, to try to get some resources to help them start mitigating heat.

Commissioner Goldstein said this is a good example, especially for those who are newer to the council and maybe aren't as aware of the structure of the Department of Public Health, of how the subject matter expertise of the bureaus is lifted up and expanded by the work of the offices.

So, the Office of the Assistant Commissioner for Health Equity, helping us think about Health Equity communities, the Office of Local and Regional Health helping us engage with the local public health workers, and the Office of Preparedness and Emergency Management that helps with the alerts and gets the messages out in a timely manner. He said this is a remarkable example of the Department breaking down the walls and getting the work done.

Dr. Archer said there is additional infrastructure in the state to help with the proactive preventive approaches that can be taken when this data becomes available. He asked, have the community health centers been connected to using these tools - because as a primary care provider in those communities, the center can make a call the list of vulnerable people that are known to be at risk. This ties in and leverages the extended network that exists.

Commission Goldstein confirmed that the community health centers are part of the state’s Health and Homeland Alert Network, and DPH can help ensure they are getting these alerts as they come out.

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 June 11, at 9:00 am.

Commissioner Goldstein asked if there was a motion to adjourn.

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

The meeting was adjourned at 10:34 am.