PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Tuesday, November 14, 2006, 10:00 a.m., at the China Trade Center, Two Boylston Street, John Daley Conference Room, 5th Floor, Boston, Massachusetts. Members present were: Chair Paul J. Cote, Jr., Commissioner, Department of Public Health, Ms. Soo J. Kim, Atty. Jennifer A. Nassour, Ms. Maureen Pompeo, Mr. Albert Sherman (arrived late during the staff presentation), Gaylord Thayer, Jr., and Martin J. Williams., M.D. Absent were Clifford Askinazi, M.D and Atty. Michael C. Hanson. Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chair Cote announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. In addition, Chair Cote announced New Business Item (Informational Briefing on Proposed Amendments to 105 CMR 305.000) Confidential Birth Information was added to the docket as item 2b.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Associate Commissioner, Ms. Sally Fogerty, Center for Community Health Services; Ms. Kathy Foell, Director, Ms. Hillary Wall, Epidemiologist, Heart Disease and Stroke Prevention and Control Program; Ms. Karen Granoff, Director, Office of Patient Protection; Mr. Stanley Nyberg, Registrar of Vital Records; Mr. Grant Carrow, Deputy Director, Center for Quality Assurance and Control; Associate Commissioner Alfred DeMaria, M.D., Center for Communicable Disease Control and State Epidemiologist; and Deputy General Counsels of the Office of the General Counsel of the Department of Public Health: Atty. Carol Balulescu, Atty. James Ballin, Atty. Tracy Miller, and Atty. Kalina Vendetti.

STAFF PRESENTATION: "PUBLIC HEALTH INITIATIVES THROUGHOUT THE STROKE CONTINUUM", By Kathy Foell, Director and Hillary Wall, Epidemiologist, Heart Disease and Stroke Prevention and Control Program, DPH

Ms. Sally Fogerty, Associate Commissioner, Center for Community Health Services, made introductory remarks.

Ms. Kathy Foell, Director, Heart Disease and Stroke Prevention and Control Program, said in part, "…If you look at the stroke continuum, if you want to line up these dominos, these are the dominos that need to be in place. First of all, there is prevention, and we know that public health is all about prevention; but when you think about stroke, we are trying to control the major risk factors for stroke, which are controlling blood pressure, diabetes, cholesterol, smoking, and weight and we are doing that in many different venues and many different areas and I will highlight some of those in a minute. Secondly, once somebody has a stroke, they have to recognize they are having a stroke and often one doesn't know they are having a stroke. Their immediate response is

probably to lie down and take a nap to see if this is going to pass, and that is the worst thing to do. We need the recognition of stoke and we need to call 911."

"At 911", Ms. Foell continued, "community response, the 911 call taker needs to know that this stroke is an emergency, and they have to dispatch the appropriate equipment, and make sure that they understand it is a stroke, and they give the equipment a high priority…At the Emergency Medical Services level, the EMTs also need to recognize and confirm a probable stroke and take the patient to a hospital equipped for stroke and let the them [the hospital] know that a stroke is coming in. Once at the hospital, the Emergency Department needs to have a stroke team in place, ready to treat the stroke and the hospital needs the equipment and standing techniques to be able to respond to this in an hour. Inpatient hospital care requires prevention of complications of stroke, like swallowing the wrong way, so testing is needed for swallowing reflex and rehabilitation. After rehabilitation, the person hopefully is going back into the community with a full livelihood and the capability of caring for themselves and their families. People who have had a stroke are also at highest risk for having another stroke so that we have to start prevention all over again."

Ms. Foell noted that many interdepartmental programs are working on this issue together: the Massachusetts Tobacco Control Program, the Diabetes Control Program, the Women's Health Network, the Men's Health Partnership, Division of Health Care Quality and the Office of Emergency Medical Services. External partners are: the American Heart Association, the American Stroke Association, and well as the statewide Emergency Telecommunications Board.

Other notes include:

- People with diabetes are at the highest risk for stroke so they need to control their diabetes and monitor their blood pressure and cholesterol (lifestyle counseling).

- Sixty-eight of seventy-two hospitals, about ninety-four percent of hospitals, are in the process of becoming primary stroke service designated hospitals in Massachusetts (hospitals equipped to deal with stroke in an emergent situation).

- The Department is working with the Paul Coverdell National Acute Stroke Registry. The Paul Coverdell National Acute Stroke Registry is a quality improvement registry and initiative to improve stroke care. SCORE, the combined American Heart and American Stroke Association and the Massachusetts Department of Public Health quality improvement collaborative, has been meeting with hospitals since November 2005. Approximately 76% of eligible hospitals participate in the SCORE collaborative.

Ms. Hillary Wall, Epidemiologist, Heart Disease and Stroke Prevention and Control Program, followed with information on how the program is educating the community about stroke. She said in part, "…To respond to lack of symptom recognition of a stroke and to assist community hospitals with their education requirement, the

Department has initiated a project to increase knowledge of stroke signs. We call it the Boston Operation Stroke Scale. So, EMTs can assess facial droop, arm weaknesses and paralysis, and speech difficulties. There is the F, A and S. And then, the University of Cincinnati folks, for community education purposes, added a T for "Time to call 911" so that community members would be able to recognize those three signs; but, because they are not clinicians, they need to know what to do after that. So they are trying to teach them to call 911."

Ms. Wall continued, "Out of a literature search came the message that television or video are the most effective ways to convey health messages and to change people's knowledge and behavior. The Department's vendor created an animation with a catchy song that includes the FAST acronym and the three objectives of the animation are some of the things I just talked about."

Ms. Wall spoke about a comprehensive educational kit developed by a media vendor (The Stroke Heroes Act Fast Kit) which includes versions of the animation, brochures and posters. It has Power Point presentations on stroke and the associated risk factors. There is a long and short version to meet the educators' needs and an educator's guide that walk an educator through the kit. Ms. Wall also said that the kit was designed with the Train the Trainer model in mind because the Department of Public Health staff cannot reach the entire community through education. The Department reached out to community organizations, primary stroke service hospitals, community health centers, councils on aging and trained members of their organizations, who have then gone out and provided education to the community. Over 350 kits have been distributed since October 2005. Based on an evaluation form included in the kits, the feedback has been positive and the kit has been very successful.

In summary, Ms. Wall stated, "Based on the feedback, we are very confident that we have given stroke educators the tools that they need to reach the public for stroke recognition…We started with surveillance data to inform us which population was at risk (was there even a problem in our state). We used that to form an animation, which then branched off into an educational kit. We also did a media campaign back in May, which we will be repeating and, currently, we are working on culturally adapting the educational kit animation, and the media campaign for Spanish speakers in our state, and we will soon be starting work for Portuguese speakers."

In closing, Ms. Wall said, "I hope in our talk today, Kathy and I have shown you that synergies can arise from internal DPH and external collaborations, and that, when we are dealing with a disease entity, we really need to address it across the stroke continuum of care. A great way to do that is by collaborating with our partners, and lastly, effective initiatives to address diseases should be evidence-based, and data driven, and have an evaluation component to them."

PROPOSED REGULATIONS: NO VOTE

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 128.000, HEALTH INSURANCE CONSUMER PROTECTION:

Ms. Karen Granoff, Director, Office of Patient Protection, presented the proposed amendments to 105 CMR 128.000 to the Council. She said in part, "…We wanted to inform the Council of the Department's intention to promulgate amendments to 105 CMR 128.000, Health Insurance Consumer Protection. The proposed amendments make minor changes to the regulation to reflect the recently enacted c.58 of the Acts of 2006 (Health Care Reform Act) which creates a new type of health plan that will be subject to the consumer protection provisions of M.G.L.c.176O."

Ms. Granoff continued, "Under c.118H, the only entities that may initially offer Commonwealth Care products are those that currently contract with Medicaid as managed care organizations (MCOs). There are four current Medicaid MCOs ("MMCOs"). Two of them, Fallon Community Health Plan and Neighborhood Health Plan, are licensed as HMOs and are therefore already subject to oversight by OPP pursuant to M.G.L.c.176O. As HMOs, both are also subject to regulation and accreditation by the Division of Insurance ("DOI") pursuant to M.G.L.c.176G and M.G.L.c.176O. The other two MMCOs are Cambridge Health Alliance, which offers coverage through its Network Health plan, and Boston Medical Center, which offers coverage through its Boston HealthNet plan. These two plans were exempt from any oversight by either DOI or OPP pursuant to section 28 of c.47 of the Acts of 1997." She noted:

Section 4 of c118H includes the following provision:

"Notwithstanding any general or special law to the contrary, all eligible individuals on whose behalf premium assistance payments are made, including those enrolled in plans offered by Medicaid managed care organizations referenced in section 28 of chapter 47 of the acts of 1997 shall under this section be entitled to consumer protections as described in chapter 176O.

This provision brings the two previously-exempt plans squarely within c.176O and OPP's jurisdiction for their Commonwealth Care products…The proposed amendments will simply codify the changes that have already been acknowledged by both the Connector and the two MMCOs, which are included in the Connector's contract with the MMCOs for the Commonwealth Care products and in the MMCOs' evidences of coverage for these new products."

In closing, Ms. Granoff stated, "…The proposed amendments will make the necessary changes to 105 CMR 128.000 to reflect the fact that the MMCOs are subject to c.176O and 105 CMR 128.000 for the Commonwealth Care plans and recognize the differences between the Commonwealth Care plans and those that are also licensed and accredited by DOI. OPP is also proposing two minor changes to sections that refer to the payment of the $25 fee. These changes do not affect the substance of the regulation as currently written – one merely changes the text from passive to active voice and the other simply makes it clear that the fee does not have to be enclosed if OPP waives it based on financial hardship." Specifically, OPP is proposing the changes below:

Section	Purpose
128.020	Adds MMCOs to the definition of "carrier," Adds the Connector to defined terms; Amends the definition of "service area" to reflect the fact that the term is defined differently by the Connector.
128.402	Change from passive to active voice.
128.404	Explicitly states that the fee does not have to be enclosed if waived by OPP.
128.600	Requires filings to OPP by the MMCOs that don't currently file with the DOI to be concurrent with submissions to the Connector.

Staff noted that OPP is required (§1(d) of chapter 141 of the Acts of 2000) to submit any proposed regulations to the Managed Care Advisory Committee (MCAC) for review and comment at least 60 days prior to final promulgation. Therefore, OPP will provide these amendments to the members of the MCAC concurrent with this notice to the PHC. The Department plans to hold a public hearing on December 15, 2006. Following the hearing, OPP will return to the PHC to provide a review of the testimony, to present any changes proposed in response to the testimony, and to request approval for promulgation of the amendments.

No Vote/Information Only

NEW BUSINESS: INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 305.000 (CONFIDENTIAL BIRTH INFORMATION):

Atty. James Ballin, Deputy General Counsel, Department of Public Health, presented the informational briefing on proposed amendments to 105 CMR 305.000 (Confidential Birth Information) to the Council. He said in part, "The proposed amendments to the Confidential Birth Information regulations are primarily intended to clarify and expand

the permitted use and disclosure of confidential birth information and to make the regulations consistent with the Department's Confidentiality Policy and Procedures regarding access to confidential Department data." The amendments specifically do the following:

1. Clarify existing regulatory requirements;

2. Revise the definitions for "de-identified data" and "limited data sets" to make the regulations consistent with the Department's Confidentiality Policy and Procedures;

3. Allow the sharing of confidential birth information that is not otherwise restricted by law or court order with other government officials in other vital records jurisdictions pursuant to a data exchange agreement. This will allow, for example, the interstate exchange between Massachusetts and Rhode Island of newborn hearing screening information in the birth record of Rhode Island residents who gave birth in Massachusetts and Massachusetts residents who gave birth in Rhode Island. The data exchange agreement explicitly restricts the use to only the authorized purposes and prohibits further disclosure of any confidential birth information provided to another state; and

4. Permit the sharing of confidential birth information with the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention, which funds the Registry of Vital Records and Statistics through a cooperative grant. NCHS would be permitted to use and disclose confidential birth data with appropriate restrictions (see 105 CMR 305.040(H) on page 7) for:

a. Its own use in generating national statistics on births;

b. Providing data to researchers;

c. Publishing de-identified public use data files; and

d. Sharing with other federal agencies as authorized by federal law.

Atty. James Ballin, Ms. Sally Fogerty and Mr. Stanley Nyberg answered questions from the Council about confidentiality of birth information. Staff noted that a public hearing will be held in December to solicit comments on the proposed amendments. After the hearing and following the end of the comment period, the Department will review comments, revise the regulations if it deems appropriate based on public comments, and then present the proposed final amendments to the Public Health Council for final approval.

No Vote/Information Only

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Note: For the record, Ms. Soo Kim, Council Member, left the meeting at approximately 10:50 a.m.; therefore she did not participate in the discussion or vote on the two regulations that follow.

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REGULATIONS:

REQUEST FOR APPROVAL TO PROMULGATE EMERGENCY AMENDMENTS TO 105 CMR 300.000: REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS TO INSTITUTE THE REPORTING OF CASES OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION BY NAMES:

Associate Commissioner Sally Fogerty and Attorney Tracy Miller presented the emergency amendments to 105 CMR 300.000 to the Council. Ms. Fogerty noted that staff is asking the Council to allow them to change how they collect HIV data. "At the present time and since 1999, when HIV infection was made reportable, the Department promulgated regulations requiring reporting by a coded unique identifier in response to the stigma and discrimination associated with HIV/AIDS and the fear of breaches in confidentiality. However, AIDS cases have always been reported by name to the Commonwealth and the information is kept in a separate secure room on a non-network unique password protected server at the State Laboratory. This information has never been disclosed to anyone."

She also said, "Substantial federal funding for clinical care, medication support, and support services is provided by the Health Resources and Services Administration (HRSA) under the Ryan White Care Act of 2000. $20.1 million is currently provided in the form of grants to the Commonwealth under Title II of this Act, and an additional $13.4 million is provided to the City of Boston under Title I. Other direct grants to Massachusetts hospitals, community health centers, training organizations, and other community-based organizations constitute approximately $15.5 million in added federal support. These grants consist of a combination of formula-driven and competitive awards, many of which were historically tied to the prevalence of AIDS in the Commonwealth. Historically, the prevalence of HIV cases was not utilized in these calculations."

Staff noted further, "The Ryan White Care Act of 2000 instructs HRSA to include cases of HIV infection in addition to AIDS in consideration of formula and competitive awards starting in 2007. The Commonwealth was aware of this legislative language; however, the law does not specify the requirement of reporting HIV cases by name. Since the Department has maintained an evaluated quality code-based HIV reporting system for years, it considered itself prepared to maintain its funding base in future years by means of its code-based system. Massachusetts is one of 14 states with a code or name-to-code system, including all of the New England states. Massachusetts is one of the two last states to indicate its intent to change its HIV reporting system. To date, the CDC has refused to accept any reporting of HIV

cases for the national HIV/AIDS Reporting System (HARS) except by name, regardless of the validity of the design of other reporting conventions. CDC has repeatedly stated that it considers name-based surveillance systems to be the "gold standard", and has desired a single, uniform national HIV reporting system. In July 2005, the CDC Director, Dr. Julie Gerberding, recommended to the governors of states with non-name systems that they adopt a names-based HIV reporting system. Subsequent communications from senior CDC officials continued to emphasize this change, and linked a failure to change to a names-based reporting system to a risk of losing federal funding."

Staff's memo to Council, dated November 14, 2006, further clarifies, "The Ryan White Care Act of 2000 technically expired September 30, 2005, yet remains in effect pending reauthorization. Congress drafted new legislation, which passed in the House of Representatives. This legislation proportionally penalizes states with code or name-to-code surveillance systems, and further stipulates that states receiving Ryan White Care Act funding must fully implement name-based HIV reporting by April 1, 2008 to be eligible for future funding. While the congressional action remains incomplete, it is virtually certain that the CDC will not change its position regarding HIV reporting systems and that federal funding will increasingly be tied to the implementation of a name-based system in every state. The Department is convinced that given these threats to the financing for the HIV medical and public health infrastructure, implementation of a names-based HIV surveillance system must proceed expeditiously. To convert from a code to a name system requires revising instructions to medical providers, updating information technology systems, and educating the public. Disease incidence is tracked on an annual basis; therefore any change in the HIV surveillance system must be initiated by the first of the year to insure a complete and accurate count. For these reasons the Department must promulgate emergency regulations to initiate these steps as soon as possible to avoid near-term and future loss of essential funds. Massachusetts requires at least a year to implement and mature its revised reporting system in order to have its data accepted as timely by the CDC and to maximize the completeness of the case data reported by name as well as the funds available to the Commonwealth."

Specifically these emergency amendments do the following:

- Delete 105 CMR 300.180 (D), which specifies a non-name HIV surveillance system;

- Integrates laboratory tests for HIV infection into the reportable disease list of 300.180 (C);

- Updates language in a reportable disease list, specifically allowing for clinical or laboratory diagnostics for AIDS to be reportable. This section is further updated to eliminate references to household members and laboratories as reporting agents, limiting this function to health care providers. It further specifies that reporting will be by written or electronic formats designated by

the Department, eliminating outdated references to telephone, facsimile and 'other electronic means'. The section is amended to specify the minimum data requirements for reporting diseases on this list, indicating case name, address, date of birth, gender, and contact information of the reporting individual. These changes bring HIV reporting into line with the reporting of AIDS and all of the other diseases on the list;

- Reference to a non-name reporting system for HIV infection is deleted without replacement in section 300.020;

- Two minor wording changes are made to clarify section 300.120. A reference to 'such identity' is changed to 'this information,' and 'the Commonwealth's' is inserted to insure any disclosures are to further the Commonwealth's interest.

- And a new paragraph (B) is added to 300.120, to allay any concerns that any names of individuals reported with HIV or AIDS would be reported to the federal government, the Commonwealth, or any of its political subdivisions (or agency, agents, or contractors of these entities). It reads:

  (B) Notwithstanding 105 CMR 300.120 (A), the Department shall not disclose to the federal government, the Commonwealth or any of its political subdivisions or any agency, agent, or contractor of said Commonwealth or federal government, the identity of any individual with HIV or AIDS reported to the Department under 105 CMR 300.000.

After consideration, upon motion made and duly seconded, it was voted unanimously [Ms. Kim not present to vote] to approve the **Request for Promulgation of Emergency Amendments to 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements to Institute the Reporting of Cases of Human Immunodeficiency Virus (HIV) Infection by Names**; that a copy be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy of the emergency regulations be attached and made a part of this record as **Exhibit No. 14, 868.** The Department will hold a public hearing on these amendments in December. Following the hearing, Department staff will return to the Council with the public comments and any further recommended revisions.

REQUEST FOR EMERGENCY PROMULGATION OF PROPOSED AMENDMENTS TO 105 CMR 150.000: LICENSING OF LONG TERM CARE FACILITIES, RELATED TO EMPLOYEE INFLUENZA VACCINATIONS:

Dr. Grant Carrow, Deputy Director, Center for Quality Assurance and Control, Department of Public Health, presented the request for emergency promulgation of amendments to 105 CMR 150.000. He said in part, "…The Department is proposing

amendments to the long term care facility licensure regulations (105 CMR 150.000) to require long term care facilities to offer employees annual vaccination against the influenza virus. In an effort to lessen the health and economic impacts of the influenza virus on Massachusetts residents, one of the precautions that can be taken is vaccination against the influenza virus for health care workers. Vaccination is the primary method for preventing influenza and its severe complications."

Dr. Carrow continued, "In January 2005, a report prepared by the George Washington University School of Public Health and Health Services analyzed state immunization laws for staff and residents of long term care facilities (LTCFs). According to that report, 21 states had no law or regulation. Thirteen states had laws or regulations requiring long term care facilities to distribute influenza vaccine to their employees; 27 states required LTCFs to distribute influenza vaccines to their residents.[1] Although the Centers for Disease Control and Prevention (CDC) has recommended influenza vaccination for all health care workers since 1981, in 2005, the CDC's Advisory Committee on Immunization Practices emphasized in its recommendation that all health care workers should be vaccinated annually against influenza."

Dr. Grant stated further, "Extrapolating from national estimates, in any given year in Massachusetts 2600 residents are hospitalized and 800 residents die from complications of influenza. Again extrapolating from national estimates, the cost of a severe influenza season in Massachusetts can be as high as $280 million. In addition, to the direct medical cost of treating influenza, for each episode of influenza in healthy young adults an average of 2.8 work days are lost. Studies have shown that influenza vaccine is cost-effective." Further information and statistics from staff's memorandum of November 14, 2006 to the Council states:

- Epidemiological data suggest that health care workers can spread highly contagious influenza to patients in their care. Unvaccinated health care workers can be a key cause of influenza outbreaks in health care settings. There is broad recognition of the seriousness of this issue among health care-related professional organizations and government agencies (National Foundation for Infectious Diseases).

- Estimated rates of influenza-associated pulmonary and circulatory-related deaths are highest among people ≥ 65 years of age. Deaths in older adults account for 90% of deaths attributed to pneumonia and influenza (CDC.MMWR 2005; 54 (No.RR-8);1-40).

- It is currently estimated that fewer than 40% of health care workers are vaccinated against the influenza virus each year. The Joint Commission on

[1] It should be noted that some states, including Massachusetts, offer the vaccine to LTCF residents without a regulatory requirement but consistent with the recommendation of the Centers for Disease Control and Prevention.

Accreditation of Health Care Organizations (JCAHO) has recently approved a new infection control accreditation standard, to be implemented beginning January 1, 2007, for Critical Access Hospital, Hospital and Long Term Care accreditation programs. Under this standard these organizations must offer influenza vaccine to all staff, including volunteers, and licensed independent practitioners with close patient contact. However, JCAHO accreditation is voluntary and not all health care facilities seek this accreditation.

In closing, Dr. Carrow made the request, "To protect the employees and residents in long term care facilities and avoid influenza outbreaks as much as possible, the Department therefore is proposing through these amendments to require that all long term care facility employees be offered annual vaccination against the influenza virus. The proposed amendments also include language regarding the provision of information to every employee regarding the risks and benefits of the vaccine, recordkeeping, and the opportunity for an employee to refuse vaccination and, in the case of such a refusal, documentation that the employee has received information about the vaccine and declined to receive the vaccine. We are requesting emergency promulgation of these proposed amendments. With the Council's approval, the amendments will become effective immediately. Although the flu vaccine requirement will not be in effect until the 2007-2008 flu season, as indicated in 105 CMR 150.002 (D)(8)(a), emergency promulgation will allow long term care facilities to plan and in January 2007 order sufficient vaccine for the next flu season. The Department has worked closely with the LTCF industry in the development of these regulations and will conduct a public hearing/comment period on the amendments. Subsequent to consideration of comments received, staff will return to the Public Health Council with a recommendation concerning the amendments and final promulgation."

After consideration, upon motion made and duly seconded, it was voted unanimously [Ms. Kim not present to vote] to approve the **Request for Emergency Promulgation of Proposed Amendments to 105 CMR 150.000: Licensing of Long Term Care Facilities, Related to Employee Influenza Vaccinations**; that a copy of the emergency regulations be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy be attached and made a part of this record as **Exhibit No. 14, 869.**

Council Member Sherman asked Dr. Alfred DeMaria about the status of the various pandemics that we are expecting in the next 90 days. Assistant Commissioner Alfred DeMaria responded, "Well, in the next 90 days, I think the likelihood is relatively low, although it is possible. Everything we know about the Influenza A virus suggests that a pandemic will occur, but there is no way to predict when it will occur. Right now, H5N1 is what we are concerned about in Asia, but there is a variety, literally dozens, of not hundreds of potential flu viruses that could become a pandemic virus. I think we are in a much better place now than we were a year ago or two years ago, in terms of preparation. I think we have made enormous progress in a lot of areas. It will never be done. In terms of vaccination, there will be more flu

vaccine for this season than any time in history….And the investment now in newer ways of producing influenza vaccine will have an enormous impact in the future because it will allow us, someday, to vaccinate every single man, woman, and child and actually prevent influenza, rather than just control it." It was noted that the price of a flu shot can range from $10.00 to $30.00. Council Member Thayer asked Dr. DeMaria if there have been any confirmed cases of human to human transmission. Dr. DeMaria replied, "Very limited and very unusual circumstances. There is no sustained human to human transmission of H5N1 reported. There have just been a couple of cases where there was extraordinary exposure. It really has not adapted to human transmission."

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The meeting adjourned at 11:25 a.m.

LMH/lmh

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Paul J. Cote, Chair