MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of October 9, 2024

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, October 9, 2024 – 9:00AM**

***Note: The October 9 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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Passcode: 679438

1. **ROUTINE ITEMS**
	1. Introductions.
	2. Updates from Commissioner Robert Goldstein.
	3. Record of the Public Health Council Meeting held September 11, 2024 **(Vote)**.
2. **PRELIMINARY REGULATIONS**
	1. Overview of proposed amendments to 105 CMR 130.000, *Hospital Licensure.*
	2. Overview of proposed amendments to 105 CMR 140.000, *Licensure of Clinics.*
	3. Overview of proposed rescission of 105 CMR 142.000, *Operation and maintenance of birth centers.*
3. **INFORMATIONAL PRESENTATION**
	1. Overview of Healthcare Associated Infections, 2023.

*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: October 9, 2024

Start Time: 9:03 am. Ending Time: 10:47 am.

| **Board Member** | **Attended** | **First Order:****Approval of****September 11, 2024 Minutes (Vote)** |
| --- | --- | --- |
| **Commissioner Robert Goldstein** | Yes | Yes |
| **Edward Bernstein** | Yes | Abstain |
| **Lissette Blondet** | Yes | Yes |
| **Kathleen Carey** | Yes | Yes |
| **Emily Cooper** | Yes | Yes |
| **Harold Cox** | No | Absent |
| **Alba Cruz-Davis** | Yes |  Yes |
| **Michele David** | Yes | Yes |
| **Robert Engell** | Yes | Abstain |
| **Elizabeth Evans** | Yes | Abstain |
| **Eduardo Haddad** | Yes | Yes |
| **Joanna Lambert** | No | Absent |
| **Stewart Landers** | Yes | Yes |
| **Mary Moscato** | No | Absent |
| **Gregory Volturo** | Yes | Yes |
| **Summary** | 12 Members Present;3 Members Absent | 9 Members Approved;3 Members Absent;3 Members Abstained |

**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, October 9, 2024, by the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts 02108.

Members present were: Commissioner Robert Goldstein; Edward Bernstein, MD; Lissette Blondet; Kathleen Carey; Emily Cooper; Alba Cruz-Davis; Michele David, MD; Robert Engell; Elizabeth Evans; Eduardo Haddad, MD; Stewart Landers; Gregory Volturo, MD.

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*

**Indigenous Peoples Day**

Commissioner Goldstein reminded the council that on October 14th, we honor Indigenous Peoples Day, an opportunity to celebrate the cultures and contributions of Indigenous people throughout the Commonwealth, and to recognize all that they have endured throughout the history of the state and nation. The following day, on October 15, in collaboration with Tribal and Indigenous partners and Boston Veterans Affairs, DPH’s Division of Community Engagement is hosting the second annual Tribal and Indigenous Health Summit. The summit, themed “Advancing Health Equity for Indigenous Peoples,” will bring together Tribal and government representatives to collaborate on how to address challenges to COVID-19 vaccination and other Tribal public health priorities.

**New Xylazine Infographic**

Commissioner Goldstein said a new infographic produced by DPH’s Bureau of Community Health and Prevention and Bureau of Substance Addiction Services (BSAS), highlights the impact of xylazine on overdose deaths in Massachusetts between 2019 and 2022. Overdose deaths involving xylazine surged in 2022 and likely doubled in 2023. The use of drugs with xylazine added, often without users’ knowledge, may cause skin ulcers, wounds, and heavy sedation, and often makes it harder to treat overdoses. He encouraged everyone to share this infographic with their networks to raise awareness of the impacts of xylazine in the drug supply.

**Globe Article: Bird Flu in Dairy Cows**

Commissioner Goldstein stated that the prior PHC meeting last month had emphasized the Department’s emergency preparedness and response efforts. Those efforts include the Department’s collaboration with the Massachusetts Department of Agricultural Resources to address the risk of highly pathogenic avian influenza, also known as HPAI, or the strain H5N1. Last month, DPH, MDAR, and the Broad Institute at MIT and Harvard worked with local dairy farmers throughout the Commonwealth to test the state’s dairy cows for HPAI. On September 16, DPH announced that all 95 licensed herds in Massachusetts tested negative for the virus, making Massachusetts the only state to report no evidence of the virus after such extensive testing. This collaboration across government agencies, communities, and the Broad Institute is a terrific example of a One Health response to an emerging infectious disease which supports better human and animal health and maintains the integrity of the state dairy industry at no cost to local farmers.

**Laboratory System Improvement Program**

Commissioner Goldstein said that last month, the State Public Health Laboratory underwent a daylong assessment with the Association of Public Health Laboratories. Back in 2000, the Association recognized the need to make the 10 essential public health services more tangible and more specific to public health laboratories and to promulgate the core functions of a public health laboratory. This led to an assessment process, developed by the Association with the help of CDC, to initiate overall system improvement within state and local laboratory systems. In 2008, Massachusetts was selected as one of 26 pilot sites for the Assessment, and since that time, there have been significant changes in science and public health that now warrant a need for a new assessment. This Assessment will result in a report, which will enhance our understanding of our current public health hazards and emerging threats and provide recommendations which will strengthen the Massachusetts Laboratory networks systems. It will develop and strengthen Laboratory compliance and practices within the system that contribute to data driven policy decisions, and it will strengthen partnerships across the public health systems. He thanked the diverse group of partner organizations who showed up to participate in the 2024 Massachusetts Laboratory Systems Improvement Program Assessment: from the FBI, the 1st Civil Support Team, the Indiana Department of Health Laboratory and the Vermont Department of Health Laboratory, the Vermont Agriculture and Environmental Laboratory, the Broad Institute, Biobot, Analytical Chemistry, Boston Medical Center, MGH, Harvard Medical School, and the UMass Chan Medical School.

**Respiratory Illness Season/Vaccination**

Commissioner Goldstein said the DPH lab system and collaborations are critical as we move into the respiratory virus season. It is officially Fall and well into the new school year, and respiratory illness season is fast approaching. COVID-19 activity continues to drop from the summer wave we experienced, but we expect to see increases in influenza and RSV in the coming months and should expect another COVID wave this winter. In the spirit of the Federal Department of Health and Human Services nationwide “Risk Less. Do More” campaign, DPH is amplifying the message that getting vaccinated today will benefit you, your family, your friends and your community in the future. Vaccination against flu and COVID-19 can help keep you from getting very sick. Even if you do get sick after getting vaccinated, your symptoms are more likely to be mild. Vaccines are a safer, dependable way to build immunity; far safer than catching a virus to build immunity. The formulas for both flu and COVID-19 vaccines change each year so that they can better match against the virus strains circulating in your communities. He reminded us, COVID and flu vaccines are widely available in Massachusetts in a variety of health care settings including pharmacies, primary care provider offices, community health centers, mobile vaccination clinics and local health department and community sponsored clinics. DPH also offers an In-Home Vaccination Program for COVID-19 and Flu, which is available for anyone who has difficulty getting to or using a community vaccination location. This month and next month are the best times for most people to get vaccinated to provide protection before the start of the anticipated respiratory virus season. DPH and CDC recommend everyone ages 6 months and older receive a seasonal COVID-19 and flu vaccine to protect against the potentially serious outcomes of these respiratory infections this fall and winter regardless of prior vaccination status. In addition to vaccination, it’s important to remember the fundamentals during respiratory season. If you’re sick, stay home and get tested for COVID and flu. Once again, all US households are now eligible to order four additional over-the-counter COVID-19 tests for free. These tests are intended for use throughout the 2024 holiday season to detect currently circulating COVID-19 variants.

**Introduce Angela Fowler, MD**

Commissioner Goldstein introduced Dr. Angela Fowler, Associate Medical Director for Vaccine Preventable Diseases in our Bureau of Infectious Disease and Laboratory Sciences to provide additional information on the importance of vaccination.

**Mosquitos/Ticks**

Commissioner Goldstein said that this year’s mosquito season has been more severe than we have seen in the past few years. He said the good news is that as we get deeper into the fall, the risk of mosquito-borne illness decreases. And mindful of that lower risk, last week DPH announced the risk level for Eastern Equine Encephalitis is no longer considered high or critical anywhere in the Commonwealth. Surveillance data and past patterns of disease have led to this decision, as most cases of EEE occur by the end of September. In addition, mosquito behavior changes as those mosquitoes most likely to spread EEE are present in much smaller numbers. Their activity is now driven more by temperature and humidity and less by time of day. This year so far, Massachusetts has reported four human cases of EEE, three horse cases, and 96 EEE-positive mosquito samples. There were no cases of EEE last year. The last outbreak of EEE occurred in 2019-2020, resulting in 17 human cases with seven deaths and nine animal cases. Mosquito season is not over, and, in fact, just last Friday, DPH reported two new human cases of West Nile Virus, bringing the total number of human cases this year to 15. There have been 333 WNV-positive mosquito samples detected from counties across the state so far this year. Last year we reported six human cases of West Nile, with the last one in November. That should serve as an important reminder that there is a risk of mosquito-borne disease until the first hard frost which is defined as a temperature of 28 degrees Fahrenheit or below sustained for several hours. We continue to remind people, for just a bit longer, to keep taking precautions to prevent mosquito bites. He said when outside, use repellent, wear long sleeves, especially between dusk and dawn, and be sure to empty standing water in containers, birdbaths, and wheelbarrows to limit mosquito breeding areas.

**Baxter IV Supply Chain Interruptions**

Commissioner Goldstein said the Department continues to monitor the situation regarding the supply concern at Baxter International's North Cove plant, which manufactures 60% of the domestic supply of IV solutions, producing 1.5 million bags per day and dialysis supplies. This North Carolina plant is currently closed for production as the company assesses the damage from the impacts of by Hurricane Helene. Given the potential of this event to have a significant impact on supply chains, last week the Department asked Emergency Preparedness and Supply/Logistics staff across all health care systems (including hospitals, long-term care facilities, clinics, dialysis, and EMS) to consider strategies and planning to minimize effects on patient care and shared examples of action steps that may be appropriate for organizations to take. The Department is actively engaging with providers across health care to proactively plan for any issues. In addition, we continue to reiterate the urgency of this situation to federal partners and have asked that it be given the highest priority to reduce supply chain disruptions.

**Steward Health Care**

Commissioner Goldstein said much has happened since last month when he provided the Council with an update on where DPH stood with Steward Health Care’s exit from the state.

Commissioner Goldstein asked if any of the Council members had questions.

Mr. Landers commented on the infographic from BSAS regarding the xylazine situation and commended them for including race and ethnicity. He was sorry to see that Latinos had a higher rate than white and white non-Hispanics. He was curious about the other category because he thinks when talking about racial equity in the substance use field, people would be curious where the Black population is and whether the other somehow masked that number. He realizes this is still kind of early in the phase of the expansion of xylazine into the drug pool but wanted to make that comment.

Commissioner Goldstein said to highlight the work that is happening through BSAS, we try to transparently present the data and present data that are disaggregated by race, ethnicity, geography, age, and begin to look at all of the different pieces here, xylazine exposure, substance use, other substances that folks are using. He said he’s optimistic about the ability to disentangle that “other” category and begin to look at it in a more granular way. He said they’re going to try to present that in new ways on dashboards on the website so that everyone can access it and communities can see what's happening where they are.

Dr. Volturo said we're looking at xylazine and one of the things within the past several months we've seen is much more medetomidine in the mix of drugs and it's much more potent than xylazine, requiring longer periods of supporting the bradycardia and hypotension with this. He asked are there any thoughts of seeing where we are with that in the state.

Commissioner Goldstein said a few months ago, he had a meeting with people from the federal government as well as our drug testing program here in Massachusetts trying to understand national trends of what we're seeing in drug supplies, what they're seeing coming up the Eastern seaboard and what we're seeing in our own drug testing. He expressed that we are seeing many different products that are now in the drug supply, and we want to think through if our testing is appropriate? He posed the question if they are testing enough to be able to report accurately where this is.

Dr. Evans said the early surveillance of the emergence of new substances is so important because it is a changing drug market. These are more potent substances. There are national surveillance entities as well that Massachusetts participates in. She said Massachusetts has more in different ways to detect new substances that are appearing in the drug market. So that's a great strength. She said for clinicians or others who are on the front line are often the first to see some new substance but might not always know what it is. She would be interested to hear from those who are working within healthcare organizations as to how they prepare their staff for when these substances appear, especially the emergency department or other first responder spaces. First responders are called to the scenes, and they might not be totally prepared or know what to do with that situation.

Commissioner Goldstein said we should all understand that our drug supply is poisoned.

No matter where you are, no matter what type of clinician, when you are seeing an individual who's experienced an overdose, it should be expected that the supply was adulterated and that there are other things that are there beyond what someone might think they are using.

Dr. Bernstein wanted to follow up on this discussion looking at the flow of the adulteration and the contamination. He asked if there is any way of detecting whether the fentanyl is contaminated or the cocaine.

Commissioner Goldstein said they reported this back in June looking at the annual opioid overdose report and seeing an increasing number of overdoses with cocaine present and also that fentanyl is often present. He said it is hard to understand through the data whether it is intentional co-use of cocaine and fentanyl or if that is poisoning of the cocaine supply with fentanyl. There is some work that's being done to try to disentangle those two, but it is very challenging in the overdose death reporting to understand if this was an intentional use or not.

Dr. Bernstein suggested whether there can be teams looking at death reports and the reporting system so that you can do a social autopsy on a selection of deaths.

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

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

*c. July 17, 2024 Minutes* ***(Vote)***

Commissioner Goldstein asked if there were any changes to the September 11, 2024, minutes. There were none.

Commissioner Goldstein asked if there was a motion to approve the September 11, 2024, minutes.

Mr. Landers made the motion, which was seconded by Dr. Haddad. Dr. Bernstein, Mr. Engell, and Dr. Evans abstained. All other present members voted to approve the minutes.

**2. PRELIMINARY REGULATIONS**

*a. Overview of proposed amendments to 105 CMR 130,00, Hospital Licensure.*

*b. Overview of proposed amendments 10 105 CMR 140.000, Licensure of Clinics.*

*c. Overview of proposed rescission of 105 CMR 142.000, Operation and maintenance of birth centers*

Commissioner Goldstein said that the next docket item is to hear about some proposed regulatory amendments that we think at the department will improve the quality and accessibility of healthcare for people across the state. These include amendments to how our state emergency medical services and hospitals respond to strokes and how we can encourage the development and the sustainability of birth centers, an evidence-based setting for pregnancy related care that has the potential to improve health equity and reduce severe maternal morbidity and maternal mortality. He first addressed proposed changes to our stroke care requirements in hospitals.

He said acute stroke remains a leading cause of morbidity and mortality in Massachusetts and Black and Indigenous people are disproportionately impacted by the condition. In 2023, there were almost 16,000 acute strokes reported by hospitals across the state, and the acute stroke rate in black residents was 369.3 per 100,000 residents, while among white residents it was 294.6 per 100,000 residents. In the most recent Massachusetts death report, highlighting data from 2021, stroke was the 6th leading cause of death across all age groups and was represented in the top ten causes of death in every age group from 15 years old and up. He stated that there's an opportunity to reduce stroke, death and disability by fostering timely access to high quality stroke care.

The second set of amendments is focused on access to pregnancy related care. Currently in Massachusetts, we have just one birth center. This is despite evidence that birth centers provide excellent care to many birthing people, and they could be especially beneficial to those who have experienced stigma or discrimination in traditional hospital settings. Structural barriers and regulatory burdens have prevented birth centers from opening and sustaining overtime in our state. By changing how birth centers are regulated, we're acknowledging the unique model that birth centers provide and the impact that they can have on outcomes in our state.

He highlighted a large study published in 2018 that looked at outcomes from 47 of the 400 birth centers in the country. The study focused on analyzing results for patients on Medicaid that received care in several settings, including birth centers. Compared with individuals who had a similar level of risk and gave birth in hospitals, those who received care in birth centers had a 25% lower risk of preterm birth, a lower rate of caesarean section, and the gestational age of the baby was approximately half a week longer. Even individuals who received care at a birth center and later gave birth at a hospital, both those who plan to transfer and those who required transfer during labor, had better outcomes, including lower rates of low birth weight babies. In fact, in the study, the percentage of babies with low birth weight among Black birthing people who had received care at birth centers was only 6%, compared to the national average rate of 13.7%.

These outcomes illustrate the positive impact the care in a birth center setting can have on birthing people and their children, helping to reverse the trends of increasing rates of severe maternal morbidity and maternal mortality, and addressing the alarming racial disparities that we have in this state.

Birthing people in our state currently only have one option if they want to seek access to high quality birth center care in the community - Seven Sisters Midwifery and Community Birth Center in Northampton. Despite the evidence, there is only one option and it's time to change that.

He also took the opportunity to mention that last week he was able to visit with the team from the Neighborhood Birth Center in Roxbury where they're hoping to build on over two decades of work to open the state's second birth center. What he learned in meeting with these advocates was the power of community in driving progress. The team at Neighborhood Birth Center is being intentional in the design of a space where health, families, birth and babies are celebrated and where dignity, justice and power are provided to those who are served. As a physician, he was struck by the profound impact that the care we provide in hospitals can have. While we hope to always center share decision making, racial justice, and honoring people's choices, that's not the experience for all people in hospitals. Too often, Black birthing people in this country are harmed. The insights and experiences shared by the team at the Neighborhood Birth Center cemented his commitment to bring birth and reproductive healthcare back into communities and to center justice, equity and dignity. He looks forward to returning to the Birth Center on opening day.

Commissioner Goldstein emphasized that these proposed amendments are part of the Department's broader work and our commitment to improving maternal health. It's reflected in the DPH strategy map, in our support of the recently passed maternal health bill, in our actions in response to the maternal health report that we released last year, and then the work of the Executive Office of Health and Human Services advancing HealthEquity in Massachusetts initiative.

Commissioner Goldstein invited Dr. Cristina Alonso, Director of Pregnancy, Infancy and Early Childhood for the Bureau of Family Health and Nutrition, to talk about some recently released grants for birth centers.

Following Dr. Alonso’s updates, Commissioner Goldstein asked that as the Council hears about the proposed changes to our regulations, to keep in mind the profound impact we can have on the delivery and the accessibility of healthcare, on maternal health outcomes, and importantly, on racial equity.

Commissioner Goldstein then invited Marita Callahan, Director of Policy and Health Communications for the Bureau of Health Care Safety and Quality, to present an overview of proposed amendments to the Department’s regulations regarding hospital licensure, clinic licensure, and birth centers.

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

Dr. Haddad said speaking from the point of view of collaboration, he understands that there is resistance in the obstetric community to allow for the centers to be present and to serve their function, which is necessary. But the remedy here is not necessarily to distance one group from another as the regulations specify. Now you do not have an obstetrician connected to the center as a friendly liaison into a hospital, which may be required if there are significant complications. The transfer process now becomes a bit less well-oiled. The hospital may have an agreement, but the hospital doesn't practice medicine, physicians practice medicine, and it will end up with an obstetrician on call in that particular emergency room. care of those babies. That would be the worst result. He said he would favor some sort of dialogue, to at least have a friendly agreement where they are willing to create a call schedule.

Commissioner Goldstein noted there is extensive evidence from other states that have aligned with national standards to have an agreement with the hospital, and not with the individual physician and have shown no change in birth outcomes or in quality and safety in the birth center, so we are doing this in an evidence-based way. He said having spoken to the team at Seven Sisters out in the western part of the state and the team at the Neighborhood Birth Center, they all strive for a friendly relationship with their obstetricians, family medicine providers and hospital-based midwives. But they recognize that the current regulations are quite dependent on an individual person as opposed to a system. This change, if it goes through, will allow for a relationship with the hospital rather than an individual veto by one clinician at that hospital.

Dr. David said that this is one of the systems we can leverage to improve equity, given the increase in maternal black mortality and infant mortality. She read the regulation and was glad we are proceeding the way we are. She asked if the second attendant must have labor and delivery (LND) experience, given we already have a certified nurse mid-wife in the room, and given our nursing shortage, it might make it difficult for them to find personnel for the birthing centers.

Commissioner Goldstein said as the regulation is written right now, that nurse does need to have LND experience within the past year. What they are trying to do with these amendments is broaden that and say that experience does not need to be within the last 12 months. There will still be nurses who have had experience and have been in the labor and delivery room but perhaps weren't doing that over the past 12 months because of workforce concerns.

Dr. Alonso said that they’re trying to enable the opening and the operation of birth centers and trying to be realistic about what that looks like given the workforce that we have and also given that system as they’re integrating certified professional midwives into the healthcare well. They're taking a measured approach and looking to other states to understand what's worked well and what can they learn from them. For example she said, specific to the transfer issue, they are looking into two programs that are having great results nationally in working with both hospitals and birth centers in establishing not just agreements, but also scripts, drills, policies and protocols that ensure that everybody knows what is happening in a transfer, so that both the midwives at the birth center, the person who's being transferred and their family and the receiving hospital is as informed and as respected and dignified as possible.

In terms of the workforce, she said the question alludes to the need of everybody at a community level. We need more nurses, we need more community health workers, we need more certified professional midwives. And that's something that the Department will be looking into in the next couple of years.

Dr. David said what she was concerned about is a requirement to have a registered nurse, given that we already have the midwife in the room, which might be sufficient, and we can expand the workforce that people can employ at the birthing center.

Commissioner Goldstein said it can be considered as this goes through public comment and consider if we might be able to loosen that restriction even more.

Dr. Carey said she thinks we may be looking at a very good example of an improvement of value in healthcare here in the Commonwealth. She said we're often at the forefront of these kinds of improvements, so she finds it surprising that we only have one birth center so far. We talked about improvements in equity and in outcomes, but moving services out of a hospital when services can be delivered safely outside of a hospital has really very big implications for cost, cost savings, which is the other part of the value equation, but it increases in quality. Also considering the improvements in patient satisfaction, which is an important factor in quality. She believed that many women prefer a calmer, more patient centered environment that could be outside of a hospital, and many of these women are the same women who would much prefer a certified nurse midwife to be delivering her baby rather than a busy obstetrician. The Commissioner has given us some statistics that show some numbers around improvements in specific outcomes in the birth centers that were dramatic and encouraging.

She wondered how much of this process and these improvements can be attributed to improvements in prenatal care because the delivery window itself is only two days maximum in a birth center and if there's a lot of what we're seeing here has to do with what happens before other streams of care.

Dr. Alonso said what's important about the integration of birth centers is making sure that people are at the right level at the right time. We can't integrate birth centers without also re- evaluating levels of care. Understanding that somebody who is low risk, who is healthy, who wants good information, is a great candidate for a birth center and somebody who has severe complications needs to be in a level 4. She said that what we've seen from birth centers is that for people who are at low risk and it's their first or second pregnancy, in their 20’s or 30’s, without chronic diseases, it’s a great place with great outcomes. However, we also know that some people are not great candidates for birthing at a birth center. What we found is that there are some models where birth centers are providing prenatal care to higher risk people and with a planned hospital model. That's where it’s seen that the longer prenatals, the wrap around care services, the sort of respectful, dignified, often culturally competent and matched care is leading to people coming into higher risk birthing situations with a longer gestational age. We're taking the pieces of the system that best align with the birthing person and their needs. A birth center provides the time and the space for a person to know what is going to be adequate for them at the right time.

Dr. Volturo said these are great changes that are being made and we have many obstetric deserts in the state that some of these birthing centers could help fill those areas. In many of those areas, the populations have many issues in terms of social determinants of healthcare that birth centers can often fill those voids. In terms of the transfer agreements, he doesn’t see this to be much different than what exists with ambulatory surgery centers. They are basically with the hospital and in many cases, there is a transfer agreement that has some protocols in terms of dealing with anesthesia and so forth. He congratulated DPH for making changes regarding strokes saying that it's been a long time since we initially designated stroke centers in the state. The management of stroke has changed tremendously over the past several years and making these changes will improve patient care. One of the keys in improving the care is to look at the EMS point of entry protocols and look at it very similar to the way we look at PCI for acute myocardial infarction.

Mr. Landers wanted to confirm the background being that there are currently seventy-one licensed hospitals, sixty of which are licensed to provide primary stroke services. With the new regulation, all emergency departments must be providers of acute stroke care. He asked if we have hospital ED departments now that are not licensed to provide primary stroke services and if all of the EDs and their hospitals choosing to provide acute stroke care will need to get a new certification of some kind.

Commissioner Goldstein said yes, there are hospitals right now that are not providing primary stroke services that will need to now provide services, and these hospitals won't need to go through some new certification and evaluation to make sure they're providing that.

Dr. Katherine Fillo, Director, Healthcare Strategy and Planning reinforced the Commissioner’s comments and said there are hospitals that have emergency departments that are not currently primary stroke service hospitals. By creating this expanded framework, it will be required that all hospitals at least be acute stroke ready so that they would be able to appropriately triage and then if needed, transfer to another hospital that does have a stroke center. They want to make sure that all emergency departments are able, including the satellite emergency facilities, to address the timely needs of stroke.

Mr. Landers asked what types of facilities they imagine to be at level 2 and 3.

Dr. Fillo said in the middle level, they would have hospitals that would be able to identify an ischemic stroke, a stroke caused by a clot and be able to appropriately administer medications like TPA and admit and provide care in a bed designated for stroke care. At the higher level would likely be our hospitals that are able to do clot retrieval for those large vessel occlusion strokes. If there is a large clot, that medication would not be the best option, but going in and taking out the clot through mechanical intervention, there are hospitals across Massachusetts that are able to do so.

Dr. Cruz-Davis commented that her career started working in teen pregnancy and poor birth outcomes among especially minority women. She said it’s incredibly exciting to see that you're looking at birthing centers as an opportunity to address some of these issues and the wrap around services that had been spoken of. So not only the birth outcome but making sure that the women that may not be able to deliver there can at least go to the birthing center, obtain prenatal care or the wrap around services that she feels comfortable with and then ultimately have that relationship with the hospital that will ensure that her birth outcome is the best that it can be.

Dr. Bernstein asked about the role of doulas in the birthing centers.

Maia Raynor, Maternal and Child Health Policy and Program Manager, said that Seven Sisters is the only Birth Center in operation currently in Massachusetts. They do have an in-house doula program where the doulas work with families to provide prenatal education and be a supportive presence within the labor space, but most importantly in that postpartum period, continuing to provide support to patients their families. She envisions as more birth centers are developed in the state, we’ll continue to see the collaboration between midwives and doulas in that setting.

Commissioner Goldstein commented from his time out at Seven Sisters, they have a fantastic program there, one where the doula follows the patient but not linked to the facility. It's a great way for those individuals that need to transfer from a birth center to a hospital for whatever reason, to have a member of their care team go with them. They've set up a wonderful program that allows the doula to engage in care from the moment the person arrives at the birth center all the way through the delivery and then for some time postpartum.

**3. INFORMATIONAL PRESENTATION**

*a. Overview of Healthcare Associated Infections, 2023*

Next, Commissioner Goldstein invited Dr. Kate Fillo, Director of Health Care Strategy & Planning, to give an informational presentation on healthcare associated infections in hospitals and dialysis centers. Joining her was Christina Brandeburg, Senior Epidemiologist for the Bureau of Infectious Disease and Laboratory Science, Jessica Leaf, Senior Epidemiologist for the Bureau of Infectious Disease and Laboratory Science, and Eileen McHale, the Healthcare Associated Infection Coordinator for the Commonwealth.

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

Dr. Bernstein asked how data for hospital acquired COVID and flu is being tracked?

Dr. Fillo said the Department is working to update its reporting to align with some requirements that are being reinstated by CMS. All hospitals will need to report on a weekly basis, the number of individuals who are admitted with laboratory confirmed COVID-19,influenza, and RSV which is then broken down by age groups

In terms of cluster reporting, they work with hospitals whenever there are two or more cases, reporting is required from our healthcare facilities, not just hospitals, but long-term care and other types of facilities.

Dr. Bernstein clarified that he was asking about tracking specifically hospital acquired conditions.

Dr. Fillo said if there is a cluster, that would be reported. The CMS marker is at hospital admission. CMS doesn't require reporting explicitly for hospital acquired COVID or flu.

Dr. Evans asked if it would be of interest or even possible to examine some of these metrics to see whether there's variation according to the characteristics of the patients being served. Characteristics like gender or race and ethnicity or even at the site level, the proportion of patients in different facilities that are below the poverty line. She questioned how the picture might change if some of these metrics were specified if it might help to have conversations around health equity, experiences of healthcare, and how that can be different by these characteristics.

Ms. Brandeburg said race is a very important topic that has been on their list for a while, but unfortunately, the variables addressing patient demographics like race, ethnicity are not currently required to be reported. However, that will be changing starting in 2025. She is excited to start collecting that data at least for the events that are reported into NHSN.

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 Wednesday, November 13, 2024, at 9 AM.

Commissioner Goldstein asked if there was a motion to adjourn.

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

The meeting was adjourned at 10:47 am.