**MINUTES OF THE PUBLIC HEALTH COUNCIL**

**Meeting of September 14, 2016**

**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: Wednesday September 14, 2016 9:00 AM**

1. **ROUTINE ITEMS:**
2. Introductions
3. Updates from Commissioner Monica Bharel, MD
4. Record of the Public Health Council Meeting August 23, 2016 **(Vote)**

**2. DETERMINATION OF NEED**

a. Nantucket Cottage Hospital (Nantucket), application for a substantial capital expenditure and change in service Project No. 5-3C53 **(Vote)**

**3. PRELIMINARY REGULATIONS**

* 1. Informational briefing on proposed regulatory amendments to 105 CMR 130.000 – *Hospital Licensure*
	2. Informational briefing on a proposed regulatory amendments to 105 CMR 140.000 – *Licensure of Clinics*
	3. Informational briefing on rescinding regulation 105 CMR 142.000 – *Operation of Birth Centers*
	4. Informational briefing on proposed amendments to 105 CMR 145.000*- Licensing of Out-of-Hospital Dialysis Units in Massachusetts*
	5. Informational briefing on proposed regulatory amendments 105 CMR 725.000 – *Medical use of Marijuana*
	6. Informational briefing on a proposed regulatory amendments to 105 CMR 300.000 – *Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements*

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

**Public Health Council**

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

**Date of Meeting:** Thursday, September 14, 2016

**Beginning Time:** 9:28AM

**Ending Time:** 11:42AM

**Attendance and Summary of Votes:**

| **Board Member** | **Attended** | **Item 1c****Record of the Public Health Council Meeting August 23, 2016** | **Item 2a****Nantucket Cottage Hospital (Nantucket), application for a substantial capital expenditure and change in service Project No. 5-3C53 (Vote)** |
| --- | --- | --- | --- |
| Monica Bharel | Yes | Yes | Yes |
| Edward Bernstein | Absent | Yes | Yes |
| Lissette Blondet | Yes | Yes | Yes |
| Derek Brindisi | Absent | Absent | Absent |
| Harold Cox | Absent | Absent | Absent |
| John Cunningham | Yes | Yes | Yes |
| Michele David | Yes | Abstain | Yes |
| Meg Doherty | Yes | Yes | Yes |
| Michael Kneeland | Yes | Absent | Absent |
| Paul Lanzikos | Yes | Yes | Yes |
| Lucilia Prates-Ramos | Yes | Abstain | Yes |
| Michael Rigas | Absent | Absent | Absent |
| Alan Woodward | Yes | Yes | Yes |
| **Summary** | **9 Members Present, 4 Members Absent** | **7 Members Approved, 2 Members abstain, 4 Members Absent** | **9 Members Approved, 4 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, September 14, 2016 at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108.

Members present were: Monica Bharel, MD, MPH; Edward Bernstein, MD; Lissette Blondet; John Cunningham, PhD; Michele David, MD; Meg Doherty; Paul Lanzikos; and Lucilia Prates-Ramos, Alan Woodward, MD.

Absent member(s) were: Derek Brindisi; Harold Cox; Michael Kneeland, MD; and Michael Rigas

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

Commissioner Bharel called the meeting to order at 9:28AM and made opening remarks before reviewing the agenda.

**ROUTINE ITEMS**

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

Commissioner Bharel began the meeting by apologizing for the late start due to morning traffic. She then noted that there was a change in the order of the preliminary regulations on the docket, stating that the Council would hear proposed changes to 105 CMR 145, 142, 130, 140, in that order, in addition to the other regulations on the agenda.

The Commissioner updated the Council on the PMP online system (“MassPAT”). She shard that the system continues to work well with access to data at about 1.5 seconds per search. The Commissioner also mentioned that New York, along with Connecticut, Rhode Island, and Vermont, had been added as data-sharing partners, and that the system continued to be used for over 10,000 searches a day.

Commissioner Bharel announced that the Bureau of Infectious Disease and Laboratory Sciences, in collaboration with Bureau of Environmental Health Food Protection Program and the Bureau of Health Care Safety and Quality, Healthcare Associated Infections Program were awarded over $5 million for a range of epidemiologic, laboratory, and policy initiatives by the CDC’s Epidemiology and Laboratory Capacity (ELC) grant. This award increases last year’s grant by over $2.5 million, and contains important new components linked to fighting the Zika virus, the detection and response to antibiotic resistant organisms, biosafety training, and advanced genomic laboratory testing.

She also announced that the Bureau of Infectious Disease and Laboratory Sciences, Division of Global Populations and Infectious Disease Prevention has also been awarded $500,000 by The CDC’s Division of Tuberculosis Elimination (CDC/DTBE). This is the first year award of an anticipated three-year cooperative agreement to demonstrate a feasible, scalable program for expanding inactive tuberculosis (TB) infection testing and treatment. DPH will partner with the Lynn Community Health Center to implement accessible latent TB infection testing, treatment, and adherence support services. Local partnerships will support community engagement to address latent TB infection and reduce the stigma of TB. Education for health care providers will focus on testing and treatment advances and the opportunity to reduce the burden of TB in the community.

Commissioner Bharel then informed the Council that tomorrow (September 15, 2016), the Governor’s Working Group on Opioids would be reconvening, at which time the Department would be releasing the updated Chapter 55 data report (see <http://www.mass.gov/eohhs/docs/dph/stop-addiction/dph-legislative-report-chapter-55-opioid-overdose-study-9-15-2016.pdf>). She informed the Council that they would receive a copy of that data.

The Commissioner asked if Council members had any questions or comments on these updates. Seeing none, she proceeded with the agenda.

**1. ROUTINE ITEMS**

**c. Minutes**

Commissioner Bharel asked if any members had any changes to be included in the August 23, 2016 meeting minutes. Seeing none, the Commissioner asked for a motion to approve minutes.

Dr. Woodward made a motion to approve, and Mr. Lanzikos seconded the motion. All approved, except Dr. David and Ms. Prates-Ramos who abstained from the vote, as they were not present at the August meeting.

**2. DETERMINATION OF NEED**

**a. Nantucket Cottage Hospital (Nantucket), application for a substantial capital expenditure and change in service Project No. 5-3C53 (Vote)**

Ms. Doherty arrives at 9:43am.

The Commissioner invited Nora Mann, Director of the Determination of Need Program, and Rebecca Rodman, Deputy General Counsel to present on a Determination of Need for Nantucket Cottage Hospital, which had applied for a substantial capital expenditure and change in service. Dr. Margot Hartman, President and CEO of Nantucket Cottage, along with several members of her team, were also available to answer questions following the presentation.

Upon the conclusion of Ms. Mann’s presentation, the Commissioner asked if the Council had any questions for Ms. Mann, Ms. Rodman, or the applicant’s representative.

Dr. Woodward noted there is a prediction of a growing population and asked if there is a provision or capability to expand if necessary in the design.

Dr. Hartman responded that they have incorporated the potential to expand in their conversation with their architect and by establishing other areas in infusion and elsewhere for an emergency surge they feel they are prepared to care for patients in a more efficient way.

In regards to the ICU, Dr. Woodward noted that the discharges in 2012 and 2013 were 3 and then 2, but had risen to 10 and then 9 in the last two years. He inquired about the elimination all ICU capacity.

Dr. Hartman responded that they routinely care for patients matching demand and resources. She explained that they have found that keeping a patient in the emergency department pending transfer to a higher level of care often is the best way to serve that patient, depending on weather conditions and medflight availability.

Dr. Woodward asked how many beds are in their new emergency department.

Frank Kovac, Project Executive and Director of Facilities of Nantucket Cottage Hospital responded saying that they have 10 treatment beds and two trauma rooms.

Dr. Hartman added that it is increase over the current 7.

Dr. Woodward asked for clarification if they would use a trauma room to maintain a patient in an ICU situation until they could be transferred.

Dr. Hartman said that is correct.

Dr. Woodward noticed they are expanding from one to two operating rooms so there is some surge capability there. He asked if they could staff two operating rooms in a crisis situation.

Dr. Hartmann said they are working on plans for that and that this is key to managing a high fixed cost low volume small hospital.

Dr. Woodward noted that they obviously deal with a unique set of circumstances in their environment and noticed their population increases to approximately 55,000, not including weekly visitors, which may push numbers to 70,000-80,000. He further commented that it is a small facility to care for so many patients and asked what their surge plan is and how many people can they accommodate within the facility and what is there disaster plan for an additional facility.

Dr. Hartman explained that it has been observed by the Joint Commission that they are in emergency preparedness mode at almost all times. She informed the Council that they have lots of planning with local agencies on the island as well as Region 5 for all kinds of challenges and that drill these challenges regularly. Dr. Hartman also explained that they have plans for expanding into the high school if necessary to accommodate appropriately triaged surged patients and if you count all infusion bays and increased emergency department and 10 med surge beds they actually have more capacity than they currently do.

Mr. Kovac also commented that that doesn’t include the clinic space that is joined to the hospital.

Dr. Woodward asked for clarification if there were some clinic beds that could be used in an emergency situation.

Dr. Hartman said this is correct and that they are incorporating all of these things in their planning.

Dr. Woodward thanked Dr. Hartman and Mr. Kovac.

Mr. Lanzikos commented on some of the very special challenges that exist on an isolated environment such as Nantucket and expressed concern for lower wage health workers, whether they are facility-based or community-based. Mr. Lanzikos stated he hopes as the community and the facility are looking at ways to utilize these initiatives, that some proportion is being used to support and advance the number of community health workers. He is particularly concerned about patients who need the assistance of these workers so that they can stay in their homes.

Dr. Hartman thanked Mr. Lanzikos for his comment and informed the Council that they consider access and housing, for example, to be health issues and that they will be very focused on in their community health needs assessment.

Ms. Blondet requested demographics on the percentage of people of low socioeconomic status on the island. She also asked what are the languages spoken other than English spoken on the island that there might be a need for interpreter services.

Dr. Hartman replied that their primary population for English as a Second Language is Spanish, followed by Portuguese. They also have a Nepalese, Bulgarian, and strong Irish population year round. Live interpreter services are available.

Ms. Blondet asked about individuals living at or below poverty level on the island.

Dr. Hartman does not have the statistic available at the moment but would be happy to provide Ms. Blondet with it. She further stated that they are certainly aware that, despite their reputation as a location of high net worth, there is a vast and diverse demographic that they serve and they are committed to providing access regardless of ability to pay.

Ms. Blondet replied that she was certain that will be an important statistic for their community health initiatives.

Mr. Lanzikos questioned the increase in fertility listed on page 4 and believed it should be 1500.

Dr. Hartman stated that they would check and confirm.

Commissioner Bharel asked if there were any additional questions from the Council. Seeing none, she asked for a motion to accept the staff recommendation for approval of the Nantucket Cottage Hospital’s Determination of Need.

Dr. Woodward made a motion to approve; Ms. Prates-Ramos seconded the motion. All present members approve.

**3. PRELIMINARY REGULATIONS**

**a. Informational briefing on proposed amendments to 105 CMR 145.000*- Licensing of Out-of-Hospital Dialysis Units in Massachusetts***

Commissioner Bharel invited Lauren Nelson, Deputy Director for the Bureau of Healthcare Safety and Quality and Sherman Lohnes, Director of the Division of Health Care Facility Licensure and Certification, to discuss proposed regulatory amendments to 105 CMR 145 *- Licensing of out-of-hospital dialysis units in Massachusetts*. She also asked Kate Fillo, Quality Improvement Manager for the Bureau of Health Care Safety & Quality, and Rebecca Rodman, Deputy General Counsel to join for any questions after the presentation.

Upon the conclusion of Ms. Nelson and Mr. Lohnes presentation the Commissioner asked if the Council had any questions.

Dr. Woodward asked the group why staff eliminated the minimum of 110 square feet per dialysis station, he inquired if there was a push from clinics to do this and if there was an AIA minimum standard.

Mr. Lohnes replied that this change is consistent with federal requirements and takes into account changes in technology equipment. Rather than having a set standard to reevaluate periodically this proposed change is tied to outcomes to ensure quality of care and patient safety.

Dr. Woodward asked if it would be acceptable to have a 60 square foot room to dialyze patients.

Mr. Lohnes stated that the requirement is that there is sufficient space to safely access and care for patients; it’s likely that smaller space would present difficulties for patients.

Dr. Woodward asked if the AIA has a standard regarding this.

Mr. Lohnes stated that it was not something he knew off hand but that he would certainly check on it.

Mr. Lanzikos stated that he understands the value of eliminating the described dimensions; however, he was concerned that unless we have objective measures, there are some providers who might try to minimize the appearance. Mr. Lanzikos suggested adding the type of emergency equipment to avoid back and forth with providers.

Mr. Lohnes stated that in the regulation itself they do mandate that a minimum 4 foot distance be maintained between sides of dialysis chairs and beds, in the regulation itself, as opposed to the slide, there is additional guidance as to minimum distance.

Mr. Lanzikos asked for what type of emergency medical equipment would be expected to be available.

Mr. Lohnes informed Mr. Lanzikos that it would be crash carts.

Ms. Fillo stated that consistent with other types of health care facilities regulation of automatic external defibrillators, would need to be available. DPH has provided sub regulatory guidance for other facilities such as nursing homes as to the types of medications that must available depending on the population.

Commissioner Bharel then asked if there were any further questions, seeing none she asked Ms. Nelson and Mr. Lohnes to remain at the table to brief the Council on a proposal to rescind 105 CMR 142, relative to the Operation of Birth Centers.

**b. Informational briefing on rescinding regulation 105 CMR 142.000 – *Operation of Birth Centers***

Upon the conclusion of Ms. Nelson and Mr. Lohnes presentation, the Commissioner asked the Council if there were any questions.

Mr. Lanzikos asked how many birth centers are currently operating and what is the trend in operation.

Mr. Lohnes replied that other than those associated with a hospital, there are no free standing birth centers. It is not an area they have seen much change in.

Mr. Lanzikos asked if the hospital affiliated birth centers are on the campus or typically within the hospital building.

Mr. Lohnes replied that if the centers are not within the building itself they would be located on the campus.

Mr. Lanzikos asked for clarification whether currently within the Commonwealth there are only hospital related birth centers.

Mr. Lohnes confirmed that is true.

Ms. Nelson further stated there are currently only two.

Commissioner Bharel asked if there were any other questions. Seeing that there were none, the Commissioner asked Ms. Nelson and Mr. Lohnes to present the proposed amendments to 105 CMR 130 – Hospital Licensure.

**c. Informational briefing on proposed regulatory amendments to 105 CMR 130.000 – *Hospital Licensure***

Upon the conclusion of Ms. Nelson and Mr. Lohnes presentation, the Commissioner asked if the Council had any questions.

Dr. Kneeland asked if health care associated infections are synonymous with nosocomial infections. For example, a patient has an out-patient procedure that resulted in an infection that then requires in-patient care.

Ms. Fillo replied in the affirmative, and further stated that health care associated infections are generally acquired in the hospital setting or health care setting, as an example they collect data on surgical site infections, laboratory events such as Methicillin-resistant Staphylococcus aureus, infections related to catheters etc.

Dr. Kneeland asked if it includes all or if it’s specific.

Ms. Fillo responded noting that it is specific. What is currently collected are examples; however, the regulation is broad enough that in sub-regulatory guidance and in accordance with federal Centers for Medicare and Medicaid Services that we have alignment.

Dr. Kneeland asked for clarification if it is only inpatient.

Ms. Fillo stated that they are emergency department, observational stay and inpatient admission measures.

Mr. Lanzikos referenced the closing of essential services and recommended adding the Joint Committee on Public Health to the 30 day notice group. Mr. Lanzikos asked if they require a published legal notice when the hospital proposes to close essential services.

Mr. Lohnes responded that there is a requirement for public notice prior to the hearing and that the Department publishes the notice.

Mr. Lanzikos asked when the public hearing has to be scheduled.

Mr. Lohnes replied that the public hearing has to be scheduled at least 60 days before closure and there has to be at least 21 days’ notice of the public hearing.

Mr. Lanzikos asked if the Department publishes the notice.

Mr. Lohnes confirmed that.

Dr. Woodward inquired about the cardiac catheterization and the volume minimums for the facility as well as for the providers. He then asked if the volume minimum is determined by various entities.

Ms. Fillo explained that the three organizations together publish the consensus document and the one document is based on research. The specific volume numbers are proposed to be removed from regulations due to the fact that the consensus documents are published approximately every two years.

Dr. Woodward asked if that number has been somewhat consistent with what we’ve had previously.

Ms. Fillo said that there are different numbers for facilities depending on whether a facility performs diagnostic procedures or diagnostic and interventional procedures. The numbers in the consensus documents are lower than the standards DPH has had in the past.

Dr. Woodward asked if they have consensus on institutional or provider minimums on the national level.

Ms. Fillo stated that the provider and institutional minimums included in similar consensus documents are generally accepted at the national level.

Dr. Woodward stated that he viewed that as a problem in smaller hospitals and suggests that we look at adopting the same standards for providers as well as institutions.

Ms. Fillo clarified that while previously the consensus documents had strong statements about individual provider minimums, they have backed off on their language and the current consensus documents look not just to volume minimums but also to competency and outcomes. DPH looks at operator outcomes and service or hospital based outcomes.

Dr. Woodward suggested that we add the words “consistent with” the triad of national organizations and thought that would provide guidance and reassurance that the granting of privileges at smaller institutions would have some basis in science.

Dr. Kneeland agrees.

Ms. Blondet leaves the room at 10:35am and returns at 10:42am.

Dr. Woodward shared his concerns that by eliminating a lot of criteria we will see a significant expansion in an expensive service when there is underutilization and hoped DPH would not eliminate a lot of the protections we are trying to achieve.

Ms. Fillo stated that the proposed amendments add a standardized process for application and that DPH anticipates having a robust application process for licensure of these services. Staff plan to look at access and quality of the program.

Dr. Kneeland asked if there were many places that did diagnostic only and don’t have approval for diagnostic plus PCI.

Ms. Fillo said the Commonwealth does have a handful of hospitals that provide diagnostic only services and no interventional services.

With no further questions, the Commissioner asked Ms. Nelson and Mr. Lohnes to remain at the table to present 105 CMR 140.000 – Licensure of Clinics.

1. **Informational briefing on a proposed regulatory amendments to 105 CMR 140.000 – *Licensure of Clinics***

Upon the conclusion of Ms. Nelson and Mr. Lohnes presentation, the Commissioner invited the Council to ask questions.

Ms. Doherty asked about patients in underserved geographical isolated areas. Would the definition in geographical challenged areas be changed?

Ms. Nelson stated that the definition will allow for the expansion of services into all areas. If those areas are isolated or underserved they will benefit from the expansion of those services.

Dr. Cunningham asked about the sharing of facilities. He asked what do they mean exactly by another entity is it a physically separate company or organization or can it be a drugstore that has a clinic inside the pharmacy.

Ms. Nelson stated it could be both; it would depend on what type of clinic he is referring to. If discussing a mobile clinic or a minute clinic service.

Dr. Cunningham asked if that counts as another entity or a single one that has two components.

Ms. Nelson said the CVS and the clinic services that are provided within it are licensed as a limited service clinic.

Dr. Cunningham asked if all of that could have one shared bathroom.

Ms. Nelson stated that it could have shared toilet facilities as long as it complies with sanitary standards.

Dr. Kneeland leaves at 10:51am and returns at 10:53am.

Dr. Cunningham asked if a mobile clinic happens to do more than one day at a particular spot, yet they are prohibited from storing items overnight, is there any sort of special circumstance.

Ms. Nelson said the prohibitions against them storing medications overnight is incorporated into these regulations but it is really a product of Chapter 94C of the general laws.

Mr. Lanzikos asked for the types of dental procedures that would necessitate clinic licensure.

Ms. Nelson said that this requirement would not be applicable to simple extractions and the like which is why it still remains accessible to people who may need it like underserved populations. Specifically in the regulation applies to procedures requiring general anesthesia, advanced oral maxilla facial surgery, removal of a large tumor or major surgery to the mandible or maxilla.

Mr. Lanzikos asked if any of these procedures are now or will be performed in a dental practice that office would now have to be licensed as a clinic.

Ms. Nelson said these only apply to dental clinics so unless that dental office is also a dental clinic this will not apply.

Mr. Lanzikos asked what differentiates a dental office from a dental clinic.

Mr. Lohnes stated that under the statutory definition of clinic, a practice that is wholly under control of the licensed practitioner is exempt from clinic licensure.

Dr. Woodward inquired about the definition of urgent care. He suggested it say acute exacerbation of chronic illness.

Ms. Doherty wondered about the regulations proposed in relation to Mobile Integrated Health and whether it would apply to Mobile Health Units.

Ms. Nelson responded that the difference between a mobile clinic and mobile integrated health is primarily the involvement of paramedics. The mobile clinic would involve clinic personnel and not paramedics.

Ms. Blondet asked if these regulations would apply to mobile health units that are not affiliated with health facilities. For example, the family health van is affiliated with Harvard Medical School and to a health center.

Mr. Lohnes stated that these would apply to mobile units affiliated with community health centers.

Ms. Blondet inquired if mobile health units that are not affiliated with health facility are unregulated.

Mr. Lohnes said that the ones that they are familiar with are associated with a hospital or with a clinic.

Ms. Doherty suggested that special care assisted facilities are excluded from this grouping.

Commissioner Bharel also noted that the site would have to invite the mobile entity and that there is a relationship there.

Dr. David asked if there was a provision for privacy and how do you establish privacy of the mental health encounter.

Mr. Lohnes said that he doesn’t believe they would approve a gymnasium as a site for mental health but would expect the site to meet the regulations for privacy and sanitary and infection control.

Dr. David leaves 11:04am returns at 11:09am.

Commissioner Bharel asked if there were any further questions, seeing none, she thanked Mr. Lohnes, Ms. Nelson, Ms. Rodman and Ms. Fillo for their presentation and invited Bryan Harter, Director of the Medical use of Marijuana Program, and Kay Doyle, Deputy General Counsel to come to the table to present on proposed regulations 105 CMR 725. – Relative to the Medical use of Marijuana.

**e. Informational briefing on proposed regulatory amendments 105 CMR 725.000 – *Medical use of Marijuana***

Following Mr. Harter and Ms. Doyle’s presentation, the Commissioner asked the Council if they had any questions.

Dr. David asked if DPH is creating a regulatory environment where there is a private space for patients to use medical marijuana at a medical facility. Her concern is that some people may be allergic to the substance.

Ms. Doyle thanked Dr. David for the question and noted that the regulations recognize that certain facilities are smoke free and they don’t require caregiving institutions to accommodate the smoking of marijuana.

Dr. David asked how would the smoking of marijuana be regulated to protect others who are in the environment.

Ms. Doyle replied that that is largely regulated on the municipal level rather than the state level at this point except there is state law that regulates where smoking generally can be performed and where it can be restricted.

Dr. Woodward shared concerns about physicians who have certified large number of patients for medical marijuana. He asked of the 167 who have been registered, how many have certified more than 100 patients?

Ms. Doyle said that the Program is actively collaborating and working with the Board of Registration in Medicine and potentially soon the nursing board, as well to monitor this concern. The number of physicians who certify a large number is of patients is relatively few, and, as Bryan stated earlier, a greater number of physicians certify the medical use of marijuana for a fewer amount of patients.

Dr. Woodward asked if they have a protocol where they forward names of physicians to the board of registration who have certified over, for example, 100 patients.

Ms. Doyle said that DPH does track that information in our online registration and we work with the Board of Registration of Medicine regarding inquiries and complaints of physicians.

Dr. Woodward asked if the Department could initiate a complaint based on numbers.

Ms. Doyle informed him that we could.

Dr. Woodward stated that when we discuss an ongoing relationship he refers to care rather than a certification relationship between patients and physicians. He asked if the criteria for nurse practitioners would be similar.

Ms. Doyle said that they are similar to those required for physicians.

Dr. Woodward requested that they come before the Council for an update on the distribution of practitioners and how many are providing more than 100 certifications to determine if the process needs to be tightened somehow.

Dr. David stated that as a primary care physician it would be difficult for patients to have ongoing care for medical marijuana use, as many PCPs are not very open with prescribing it. She stated that many physicians refer their patients to a dispensary to get certified and the question is very complex and becomes more than just volume.

Dr. Woodward stated that he just wanted to make sure that we are getting a high quality evaluation of patients and that they are getting appropriate ongoing medical care. He recognizes that it is a complex issue. Dr. Woodward’s concern is that because many physicians will not certify patients we have patients that are being certified by individuals who are doing it as an avocation.

Commissioner Bharel reminded Dr. Woodward and the Council that the number of physicians prescribing to a limited number of patients is the majority of cases and that the statute requires a patient-doctor relationship.

Dr. Cunningham shares the concern that there may be more than a few who prescribe to a large number of patients.

Ms. Doherty shared that in hospice residences this is already becoming a problem especially for staff that can’t allow patients to smoke on the premises.

Mr. Lanzikos asked if the date and locations had been set for the hearing.

Ms. Doyle replied they had not yet.

Mr. Lanzikos asked if it would occur in the Public Health Council Room or in the community.

Ms. Doyle said that they would certainly consider both options.

Dr. Kneeland asked if physician assistants have the authority to prescribe.

Ms. Doyle replied that they do not. If these amendments pass, it will be physicians and certified nurse practitioners.

Commissioner Bharel asked if there were any further questions or comments from the group. Seeing none, she thanked Ms. Doyle and Mr. Harter and invited Kevin Cranston, Assistant Commissioner, and Director of the Bureau of Infectious Disease and Laboratory Sciences; Dr. Al DeMaria, State Epidemiologist, and Medical Director for the Bureau; and Gillian Haney, Director of the Office of Integrated Surveillance and Informatics Services to come to the table to present on proposed regulations 105 CMR 300, Relative to Reportable Diseases, Surveillance, and Isolation and Quarantine.

**f. Informational briefing on proposed regulatory amendments to 105 CMR 300.000 – *Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements***

Upon conclusion of Mr. Cranston’s presentation, Commissioner Bharel asked if there were any questions.

Dr. Cunningham stated there have been two diseases removed from the list and inquired if an individual would no longer be quarantined since the disease has been removed from the list.

Dr. DeMaria responded saying that the requirements were standard precautions for both diseases removed from the list. He further stated that they feel compelled to list all reportable diseases in the isolation and quarantine requirements, but a number of them would call for routine standard precautions.

Commissioner Bharel asked if there were any additional questions from the Council, seeing none, she reminded the group that the next meeting is scheduled for October 20, 2016 at 2pm. She then called for a motion to adjourn.

Mr. Lanzikos made the motion and Dr. David seconded it. All approved.

The meeting adjourned at 11:42AM.