In The Matter Of:

Partners Healthcare System, Inc., Determination of Need Application #PHS-19093011-HS

Department of Public Health

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COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF PUBLIC HEALTH
DETERMINATION OF NEED PROGRAM

PUBLIC HEARING RE:

Partners Healthcare System, Inc., Determination of Need Application #PHS-19093011-HS

Substantial Change in Service
Determination of Need Required Equipment
Massachusetts General Physicians Organization

BEFORE:

Margo Michaels, MPH
Director, Determination of Need Program

Held at:
Holiday Inn, Bunker Hill
30 Washington Street
Somerville, Massachusetts
Wednesday, November 20, 2019
5:59 p.m.

Alexander K. Loos,
Registered Diplomate Reporter

* * * * *

P R O C E E D I N G S

MS. MICHAELS: Hello. Good evening, everyone.

Welcome to the public hearing for the Massachusetts Department of Public Health Determination of Need program. My name is Margo Michaels. I'm the director of the program.

And the purpose of tonight's hearing, according to state regulation, is to allow any person to make their views known with respect to an application before the Department. This hearing is not one where we'll be reviewing evidence or hearing arguments. Rather, it's a public forum for the presentation of any comments that might be relevant to the consideration of an application.

For some background, although the applicant will come up first, Partners Healthcare System has filed a notice of Determination of Need for a change of service in the Massachusetts General Physicians Organization, which is a multispecialty group, and its affiliated organization of MGH. These physicians provide various services at MGH licensed facilities and operate as licensed clinics providing freestanding imaging services in Waltham and

Chelsea.

The proposed project is for the expansion of this clinic through the addition of three 3T magnetic resonance imaging units to be located at Assembly Row here in Somerville.

We look forward to hearing comments from the public as well as members of two taxpayer groups that have formed on this specific application. The application has been posted on the DPH website as well as our questions to applicant. Tonight's hearing is being recorded, and a transcript of this recording will also be posted on our website.

In order for everyone to have the opportunity to speak, I would like to ask for comments to be limited to three minutes, and we're going to have one of my colleagues here with little signs to tell you when your minutes are up. I will call each person up in the order that they have signed in. To save time, I'll also ask the next person to come up so they can sit in the front, although it looks like we're not going to be jostling for crowd control. Written comments will also be accepted as part of tonight's hearing.

Finally, before we take action, final

action on any application, we must consider any comments or specific recommendations presented here or submitted to us. Any person and any ten taxpayer group may provide written or oral comment any time during the first 30 days following the filing date of an application or, in this case, during the first ten days after a public hearing. So if you would like to comment, and you will not do so tonight, we need to hear back from you by November 29th. And Lucy, we have cards with our e-mail address and regular address if you want to send it snail mail.

So with that, I would like to ask the applicant to come up and give a presentation on the application.

DR. ROSMAN: Thanks so much. Thank you, Director Michaels and guests.

My name is David Rosman. I'm a staff radiologist at Mass. General Hospital and service chief for outpatient imaging. I'm pleased to be here today on behalf of our patients and our -- my colleague physicians who serve them to talk about their urgent need for better access to timely, cost-effective imaging. We hope to provide that for them at a physician-owned -- as you heard -- and

operated imaging satellite to be located at Assembly Row here in Somerville.

I want to thank the Department of Public Health for holding this public hearing. Thank you all for being here and -- and look forward to the conversation today.

I have some written remarks, and I will submit them, but I'll try and summarize tonight.

As a service chief of outpatient imaging, I'm responsible for the development and delivery of outpatient services for patients served at Mass. General Hospital and across Mass. General Physicians Organization's imaging centers. I speak for our entire team of clinicians, radiologists, nurses, technologists and care coordinators when I say that our mission to improve the health and well-being of our patients by delivering excellence in patient care and advancing that through innovation is a foundation for all we do. When we think about why we're here, why we're building this site, we're trying to serve our patients better.

The proposed project will improve the health and well-being of our patients by reducing our current backlog and by improving access for our

current patients to low-cost, high-quality MRI services.

Across all our locations, we're operating at capacity. I think it's probably worth describing why that's happening. MRI technology has really advanced, even in my career. We are using MRI now to solve problems we never used to. We can now characterize lesions -- I'm an abdominal imager -- that we used to have to biopsy or operate on. We don't have to do that anymore. We know what it is, and, as a result, more MRIs means less operations. We follow patients with cancer more closely because we can see subtle changes one way or the other in their care. And what that means is a patient who is on a chemotherapeutic regimen, which can cost 200-, $300,000 a year -- a crazy place where we are in the world right now -- we can change their direction of care and say, "Stop using this $200,000 drug. It's not working." Or, "Change to a different one that works." That changes everything, and the reason that we can do that is why we're using so much more MRI than we used to.

Well, what that results in is very full capacity. So, for example, if you wanted to get an

MRI at MGH on main campus right now during normal business hours, you'd be waiting about seven weeks to book it.

Now, if you were -- had a pacemaker and wanted an MR, most patients with pacemakers can't be seen in almost any location, MR location, and we see the majority of them at Mass. General, although other sites do perform this, but we perform the majority at Mass. General, and our next available slot for a pacemaker MRI, at least as of last week, was May 2020.

So if you think about -- I mentioned before, "normal working hours." We don't operate normal work hours anymore. At least our working hours are different from normal. We open our doors at 5:45. Some of our MRs on campus operate 24 hours a day, but we open our doors at 5:45 for almost all of our locations. We see our first patient at 6:00 and the last one out the door around eleven o'clock. Even then, we're seeing waits of four weeks at the extreme hours of the day.

And I ask you to put yourself in their shoes. Faced with a possible cancer diagnosis -- you went and saw your doctor; they saw something

worrisome, and you might need an operation, or you might need chemotherapy -- the time you want to know is now. Right? Or maybe tomorrow, but certainly not January, right? Or several months away. So if we wouldn't want it, everyone here, right, we know we need to do better for our patients, and that's why we're trying to do this.

It's important to note that we wish to open these centers not to capture new patients, but rather to serve our own. We need to move our ambulatory imaging from campus to off campus, not only because it's the right thing to do, frankly, to lower total medical expense -- and I'll get there in a minute -- but also to open up space on campus for vulnerable, complex and sick patients, patients who need procedures, et cetera, that we can't get done on campus because the waits are so long. We need to make sure that we open capacity to see them and move the ambulatory patients where they should be seen, off campus in an ambulatory, lower-cost setting. The proposed project will help to alleviate some of the volume at Mass. General Hospital's main campus, and as those people are seen that way, then we open up that capacity on campus.

I want to emphasize the important -- importance of and the benefits of offering community-based outpatient care. Outpatient settings such as the proposed MRI clinic at Assembly Row are often preferred by patients, and their families, to be much more accessible, and we have some commentary from patients that indicate that. We all know getting into downtown is even more difficult than -- than getting here tonight, and then trying to park in large complexes, getting into the hospital, it's difficult; it's onerous. And when you are sick, when you are elderly, when you are debilitated, that is difficult. It's not the way that you want to get your care. And so if we can offer that to them at a more convenient location, that's what we are trying to do.

In addition to creating convenient access, the proposed Assembly Row MRIs are going to be a cost-effective setting for care. Specifically, this isn't a hospital-licensed service. Imaging is going to be at a physician-owned, physician-operated site, and thus will be reimbursed at the lower rates of reimbursement available to physician practices. That's better for the community cost. It's better

for our patients. We've been doing that in Chelsea and Waltham since 1999, and -- and wish to extend that out, and the physician care at the MPFS price point that people have seen.

Finally, I want to take a moment to highlight the continuity of care benefits for our patients that will come with this proposed project. It's what sets our services apart. All MRI results will be within our system. They'll go to our PACS; they will go to our system and -- medical record. And not only that, but they'll be seen by our subspecialty radiologists. So you know that your breast imaging is going to be read by a breast radiologist. Your head and neck tumor will be read by a head and neck radiologist.

That subspecialty care does two different things: One for the patient, and for the physician it's piece of mind of where they are going. But for the healthcare system, it's actually less cost. We've seen Walmart actually now demand that their -- or incentivize, at least, that their patients go to subspeciality imaging practices for exactly that reason. They've seen 25 to 35 percent decreases in cost, of downstream medical costs because of

accurate diagnosis up front.

In closing, this is a project designed to help and serve our current patients. We are trying to solve an access problem. Our physician referrers are concerned with the impact of wait times for imaging on their patients, and our patients are suffering physically and emotionally, waiting too long for the image that they need. We've proposed this project to meet the demands of our current patient panel for more timely access to MRI imaging and provide increased access to high-quality, low-cost services in a community-based outpatient care setting that is more convenient for many of our patients.

For these reasons, I respectfully ask the DPH to recommend approval for this proposed project. And again, I thank you very much for your time.

MS. MICHAELS: Thank you.

Now I would like to call Mary-Theresa Shore.

MS. SHORE: Good evening, everyone.

My name is Mary-Theresa Shore, and I'm the senior director of clinical operations and the director of quality and safety for the Department of

Radiology at Mass. General Hospital.

In my role, I'm responsible to ensure high-quality, safe and timely imaging for all of our patients in radiology. One of the biggest challenges we face today is providing access to MRI services in a timely manner.

As previously described by my colleague, Dr. Rosman, despite our best efforts by expanding operational hours into the wee early mornings of the hours and the late, late evenings, the demand for MRI services continues to increase. Patients are forced to take scheduled appointments that are not convenient for them at all. Many of the patients who take our 5:45 a.m. slots leave their homes at four o'clock in the morning to make sure that they can arrive for their appointment on time and have their imaging performed. And the same remains true for those patients who have appointments late in the evening, traveling home at eleven o'clock or twelve o'clock at night. Many of these patients are elderly or very sick, but they will take any appointment available to them to get their scan done.

I personally receive many phone calls every

day from patients, physicians, administrative staff asking me can I do them a favor? Can I squeeze them in? Can I find a gap in the schedule? Anything that I could do.

Because of these escalating requests, the department did develop a program called urgent, or expedited, imaging to assist in finding gaps in schedules to help accommodate these patients that simply just cannot wait seven weeks for an appointment. Although helpful to a small subset of these patients, it does not solve our other overall problem for access for MRI services.

And those are just services for our outpatients. MGH is a thousand-bed hospital with ER visits exceeding 100,000 and inpatient admissions exceeding 50,000 annually. A large percentage of those patients would benefit from MR imaging, but given the current MRI access restrictions, when emergency or inpatients exceed our capacity in those resources, outpatients will be delayed, in many instances hours from their scheduled appointment. Inpatients are often needed to be scanned late in the evening or in the middle of the night. That causes challenges for our nursing staff but, more

importantly, it causes challenges for the care of that patient and the well-being of that patient being brought down at one o'clock in the morning for their MRI scan. It's a delicate balancing act to ensure all patient types can be accommodated based on the acuity of their imaging needs.

By expanding services to Assembly Row, those patients who do not require hospital services can obtain appointments in a timely manner as well as reducing the chance that they will be delayed once they actually arrive for their appointment. They will not have to worry about traffic and congestion of downtown Boston and also navigating the expansive campus at MGH.

Once we can triage patients to the appropriate locations for their imaging based on their condition and their clinical needs, new interventional procedures using MRI can be implemented. These procedures can profoundly have an impact on the quality of so many patients' lives.

For these reasons, I respectfully ask the Department of Public Health to recommend approval for this project.

Thank you.

MS. MICHAELS: Thank you.

Now I would like to ask, is it Eleanor Moresco?

DR. MORESCO: Moresco, yes.

MS. MICHAELS: Moresco.

DR. MORESCO: Thank you.

Good evening. My name's Eleanor Moresco. I'm a primary care physician who's practiced for the last 33 years in the Medford community, and I'm here on behalf of the physicians, the community physicians affiliated with MelroseWakefield Healthcare, what was originally known as Hallmark Health Systems.

You may or may not be aware that over the past three years our community hospital, our physicians and our collaboration and partnership with Tufts Medical Center have started to create a really gelling and effective low-cost healthcare network located on the North Shore of Boston. This started at the end of 2016 when our hospital went into partnership with Tufts Medical Center, and, as a result of that partnership and joint venturing between our hospital, MelroseWakefield Hospital, and Tufts Medical Center, Tufts has sent their tertiary

providers out into our community, not only with the convenience of providing care and visits for those patients in their own community, but these specialists are actually doing the patient surgeries and procedures and hospitalizing these patients at MelroseWakefield Hospital whenever this is possible.

As the result of this collaboration between Tufts and our own hospital, the physicians, the independent practice association of physicians affiliated with the hospital also decided at the end of 2016 to leave their contracting affiliation with Partners Healthcare network and join an alternative contracting network that was also centered around Tufts Medical Center as a very high-quality, high-patient-care mixed acuity and a very low-cost tertiary care hospital in the Boston area. It is actually the lowest of the tertiary care hospitals in cost, and for every hospital event that we move to Tufts Medical Center away from events that are happening in the Partners network, there's about a 30 to 40 percent cost savings to the healthcare system.

As part of getting involved -- as part of our support in getting into this new contracting

network, the physicians have taken on and accepted very aggressive pay-for-performance contracts. We're being held to extremely high standards of quality performance, but extremely high metrics for lowering the cost of health care in our patient populations.

One of the incredible successes of this joint venturing and this collaboration between physicians, our hospital and Tufts Medical Center in this lower-cost contracting network, is that we have reduced our overall tertiary care hospitalizations for certain medical conditions and disease states by keeping those patients in our community for all parts of their care; and, in addition, we've shifted 34 percent of our patients out of the Partners network and into Tufts Medical Center as their tertiary care hospital, which has created a huge savings in the healthcare economy in our population.

So that brings me to the second thing that I would like to talk to you about tonight, which is that, as a community physician, I have a concern that licensing this huge site with three powerful magnets in what has traditionally been considered our own primary and secondary service area could

become a destabilizing force to our emerging low-cost healthcare network. My concern as a physician leader is that this magnet is not just an issue of diagnostics and access, but it may represent the leading edge of a larger programmatic approach to the community where subspecialists who rely heavily on MRI for the diagnosis and management of patients will be brought out to the community into subspecialty clinics. Those are traditionally -- those types of subspecialties are particularly very procedure-based specialties, like orthopedics, cancer care, spine surgery, neurosurgery. The concern is that our patients will be looking to access based on availability and branding, will be looking to access this facility for care, and rather than staying in the community and getting their total care in the community, or at our lower-cost tertiary care partner, that their inpatient care will be channeled into the higher-cost Boston facility for their surgeries, for their procedures and their hospitalizations.

So finally, this brings me to the third thing that I would like to say.

MS. MICHAELS: Please wrap it up.

DR. MORESCO: Pardon me?

MS. MICHAELS: Please wrap it up.

DR. MORESCO: Yes. It's the last thing I'm going to say.

Which is that I would -- what the physicians in the community would request of the DPH is that before you grant this license, that you please inquire and investigate into the long-term plans that MGH has for developing other healthcare facilities on this site.

Thank you very much.

MS. MICHAELS: Thank you.

Next we have Natalie Egan.

Oh, Jeremy Herrington and then Natalie? Okay.

MR. HERRINGTON: Thank you to all in attendance tonight.

Good evening. I'm Jeremy Herrington, clinical director of MRI and off-campus imaging at Massachusetts General Hospital. In my current role, I oversee the daily operations of all MRIs at the main campus as well as the ambulatory care centers in Chelsea and Waltham. In my role, I ensure that there is MRI access within an appropriate time frame

based on the acuity of care, site to site.

Year over year, it has become more challenging to provide this care within a reasonable time frame for our inpatients, ED patients, outpatient -- and our outpatient population. Furthermore, some of our outpatients with implanted devices, such as pacemakers, require additional services in order to perform their exam, and thus must be performed at the hospital.

At MGH and through the MGPO, we have internally increased access to MRI through expanding hours and reducing time slots through -- for our imaging through new technologies. We currently open our doors at 4:45 in the morning and receive outpatients on the main campus, with the last outpatient appointment at 10:15 at night. All of this, while managing higher-acuity inpatients and ED patient care in the safest manner possible.

MRI has increasingly become a vital diagnostic tool for inpatients and ED patients, and we must provide access to this tool within a reasonable time frame in the increase in length of stay at the hospital. As inpatient volume increases, we have been left with little choice but

to open sporadic overnight shifts to meet the inpatient MRI demand.

Ultimately, achieving high-priority care for our inpatients and ED patients inherently limits the number and type of outpatient appointments the hospital can offer. As access channels continue to grow, managing the MRI schedules has become increasingly untenable.

Within the department local MRI managers and supervisors receive constant calls to assist with patients who need an MRI but cannot wait through our current backlog. Systematically local managers must triage outpatient appointments based on acuity, safety screening and care coordination.

As a clinical director, myself and the MRI leadership team receive phone calls and pages related to urgent add-on requests or requests that must be done sooner than the first available appointment at the main campus. Clinicians and patients alike are astounded when they discover the wait times, which often lead to frustration and dissatisfaction.

This topic is particularly true with regard to management of pacemakers and other

electronically-implanted devices that require oversight during imaging. Based on our current access, as of today, we are booking patients who need MRI and have a pacemaker in May 2020.

In addition to the hospital, we are fully booked at our off campus sites. Our Chelsea and Waltham sites operate 16 hours a day, seven days a week. There are currently no urgent or immediate appointments available across all off-campus sites. As a result, this leads to frustration for patients, clinicians and staff looking for semi-urgent patient care or -- or to potentially avoid an admission to the ED.

In conclusion, the MRI leadership team has performed heroic efforts, but as the acuity of patients and the complexity of medical implants increases, scanning routine outpatients at the hospital continues to become increasingly challenging. The scanners at Assembly Row will allow us to reduce our outpatient backlog while further assisting with managing the more acute cases at the hospital in a timely manner.

I want to thank the Department of Public Health for holding this hearing and considering this

important DoN request on behalf of Massachusetts General Hospital and the Massachusetts General Hospital Physician Organization.

MS. MICHAELS: Thank you. I keep doing that every single time. Thank you.

Now Natalie Egan. Thank you.

MS. EGAN: Jeremy's tall.

Thank you, Director Michaels, for allowing me to speak tonight.

My name is Natalie Egan, and I am a practice support manager for Mass. General imaging. I'm the liaison between the referring offices, their physicians and staff, and the department of radiology. I'm their advocate.

The biggest challenge I face, which you probably know, is MRI access. It affects nearly every group at MGH. I hear stories every day from my offices. When they call me, it's my job to help them solve their problem.

I'm not going to repeat what's already been said. Rather, I'm just going to tell you about a situation that really affected me as a practice support manager.

I received a call from my pediatric

neurosurgery office. A patient, who was about ten years old -- and my son was ten at the time, so it really struck me -- he came to the physician's office with headaches and vision changes. The physician told the mom that they suspected a brain tumor and wanted to get an urgent MRI. Of course the parents were very nervous, very concerned, and their entire world had been turned upside down.

I got a call, and the scheduler said, "Natalie, these patients are right" -- "the parents are right in front of me. Is there anything you can do?"

There was nothing available. Of course, I had to call the MRI operations manager and my MRI staff and say, "Hey, is there anything you can do? Can you squeeze this patient in, please?"

The parents had to go home. There was no MRI appointment. There was no follow-up physician appointment. They basically had to go home with this child that was potentially diagnosed with a brain tumor.

After a few calls, the MRI staff worked their magic. They were able to get this patient an appointment, and it was great. The patient had the

MRI. Fantastic. Unfortunately, it didn't align with when the physician was available for their appointment. So they had to go home again, no results, and they had to come back for their physician's appointment to learn the fate of their child.

I think that, you know, we need additional MRIs. The only thing we can do -- like we're doing everything possible to fit these patients in, but the only thing that we can do at this point is add more MRI machines. When we move a patient or squeeze a patient in, we're adversely affecting other patients. So somebody's getting bumped, or someone's getting moved. And it's not fair. We should be able to take care of our own patients.

And I'm not talking about this as a single occurrence. I actually had at least, like, 15 examples I could have brought up. I could really go on and on, but I'm not going to do that tonight. I'm just going to respectfully ask that you consider to add the additional MRIs to the Assembly Row area.

Thank you.

MS. MICHAELS: Thank you.

Okay. Next up we have Ryan Fuller.

DR. FULLER: Good evening. Thank you for allowing me to submit my comments. I'll be providing written comments as well.

Like Dr. Moresco, I have concerns about the project's impact on existing community providers and its ability -- and the applicant's ability to compete on the basis of price, total medical expense and provider cost, or meaningfully contribute to the Commonwealth's goal of improved public health outcomes and delivery system transformation.

Community providers like MelroseWakefield Healthcare have continued to demonstrate that we were committed to the communities that we serve by relentlessly focusing on delivering high-quality care and value-based health care. Two examples of this: Our recently-approved ambulatory surgery center where we are committed to providing lower-cost surgeries in the communities that we serve, in the communities that we live in, and our increase in inpatient case mix over five percent over the last two years by partnering with our Wellforce colleagues, specifically Tufts Medical Center.

This application, in addition to the

multiple other DoNs recently filed by Partners Healthcare, threaten work and access to high-value community health care. I would like to focus my remarks tonight on the ways in which the application fails to provide sufficient data to illustrate the need for three MRIs in Somerville.

In its application, Partners Healthcare repeatedly states that the current fleet of MRIs is operating near capacity. However, the application does not provide enough evidence to support this claim. At the very least, the Department should consider asking for additional data. And my remarks, that I will submit, outline those data requests.

I believe this information will illustrate that there is not a need for three MRIs, and new -- new, costly imaging machines to this market. I believe that the Department should also inquire as to whether Partners will be willing to repurpose any of its existing more costly MRIs to serve the application's stated purpose. As you know, a report by HBC last year detailed how Massachusetts stands out the fourth highest in -- highest in the nation for spending on imaging services.

The application asserts that it will be increasing the need for imaging services in the growing population of people aged 65 and up. While that logic makes sense, it fails to take into account that Medicare, the predominant payer of medical services to the elderly population, has been highly critical of the skyrocketing rates for imaging services, and is implementing the new Medicare appropriate use criteria program. This program is intended to curtail inappropriate advanced diagnostic services provided to Medicare beneficiaries and will undoubtedly curb the rate of utilization in this population.

Furthermore, it is our understanding that, if approved, Partners will have a total of 55 MRIs across its system. Table 1 of the application identifies 1.5 million unique patients. Using some industry standards that -- using industry standards, we believe that equals 150,000 scans per year. If we assume one scan per patient, that would mean -- that would mean Partners would be running its machines at 34 percent capacity.

Specifically to the Somerville market, Table 3 of the application identifies only 9,139

unique patients in this service area. Assuming, again, 8,000 scans as a capacity, the applicant is far from demonstrating the need for three MRIs to serve this patient panel.

In closing, I would like to thank the Department for allowing me to raise my concerns. Approval of these three additional machines within the state's highest health -- highest-cost healthcare system will undermine much of the hard work that has gone into strengthening in the existing community providers and ensuring patients have access to lower-cost choices.

I appreciate the time and attention the Department of Public Health is putting into the rigorous analysis of this request. If this request is truly necessary, actually beneficial to the healthcare consumers and aligns with the state's goals of lowering healthcare costs, enhancing access to critical services throughout communities like behavioral health and -- behavioral health and primary care --

And I'm getting the hook. Thank you.

MS. MICHAELS: Thank you.

Next, and I believe last, is Abe Shoreland.

DR. SHORELAND: Good evening. Thank you, Director Michaels, for the opportunity to speak.

My name's Abe Shoreland. I'm an orthopedic surgeon working in the area. I practice on Montvale Avenue in Stoneham, which is close to the site that is proposed. I'm in a group of seven orthopedic surgeons. We order a high volume of high -- of MRIs daily of high quality. I personally have not experienced any difficulty ordering imaging services for my patients working with local providers. Additionally, I do believe that my patients have more than adequate access to high-quality, low-cost follow-up care within the community.

If approved, I worry that Partners will use these MRIs to funnel patients' care into their high-priced downtown academic medical centers for services that could otherwise be offered at a lower cost to consumers in the community. As you know, patients are often blind to the provider market share and patient referral strategies. An expansion of this type will only further guise those efforts and leave patients feeling like they're without choice in seeking more-convenient, less-costly health care services.

As the state continues to focus on delivery system transformation, I think specific attention should be paid to ensure that well-funded, high-priced providers are not creating an arms race to build new, when there are existing providers in the community that offer similar services. Without this level of review, patients like mine have a greater risk of getting pulled into higher-priced systems without any benefits of increased quality or convenience.

Thank you for the opportunity to speak.

MS. MICHAELS: Thank you. Oh, great.

Thank you. Next is Stephen Mackey.

And is there anyone else who would like to speak after Mr. Mackey?

Okay. I'll give you one more shot when he's done.

MR. MACKEY: Thank you, Dr. Michaels.

My name's Stephen Mackey. I'm president and CEO of the Somerville Chamber of Commerce. I want to thank the Department for coming here to Somerville with this public hearing, and thank you for the opportunity for brief remarks.

I am not a healthcare professional, but on

behalf of the Chamber of Commerce, and from our perspective, we wanted to be here to point out what a great addition to the community Partners Healthcare has been, and we also want to offer a little -- from our perspective, when you think about site selection in Greater Boston, in the metropolitan society in whatever dimension you think of it -- whether it's business, or healthcare, or education -- Somerville has taken advantage of and been the beneficiary of the great urban resurgence that's been going on in the world and in this metropolitan area, and it's also been the beneficiary of metropolitan and federal leaders recognizing Somerville for its location.

We succeeded a few years ago in convincing the powers that be in locating an Orange Line T station at Assembly Square. That brought us our great Partners Healthcare System and about a billion dollars in other investments that have come in and are coming along. Also our location convinced the metropolitan planning organization and the MBTA to invest a billion -- for the state to invest a billion dollars and the federal government to invest a billion dollars in establishing new stations along

the Green Line in Somerville. So from that perspective, we would suggest that if it's serving the society in metropolitan Boston in any way, Somerville, and particularly Assembly Row, is just an outstanding location. And also one that, while we've been here for forever -- literally -- it's been discovered only recently. So it's really been discovered and appreciated just recently.

Thank you very much.

MS. MICHAELS: Thank you.

All right.

With that, I have no more names on my list, so I just want to ask if people want to speak.

Going once. Going twice.

Great. Thank you all for attending. I appreciate it. If you have further comments, you can send it to us in the next ten days. That would be due back to us on November 29th.

Thank you.

(Whereupon, the proceedings were concluded at 6:35 p.m.)

C E R T I F I C A T E

I, Alexander K. Loos, Registered Diplomate Reporter, do hereby certify that the foregoing transcript, Volume I, is a true and accurate transcription of my stenographic notes taken on November 20, 2019.

Alexander K. Loos

Registered Diplomate Reporter

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