Massachusetts Department of Public Health

Public Health Council Meeting
July 12, 2023

Robert Goldstein, Commissioner

Today's presentation is available on mass.gov/dph under "Upcoming Events" by clicking on the July 12 Public Health Council listing.

Massachusetts Department of Public Health

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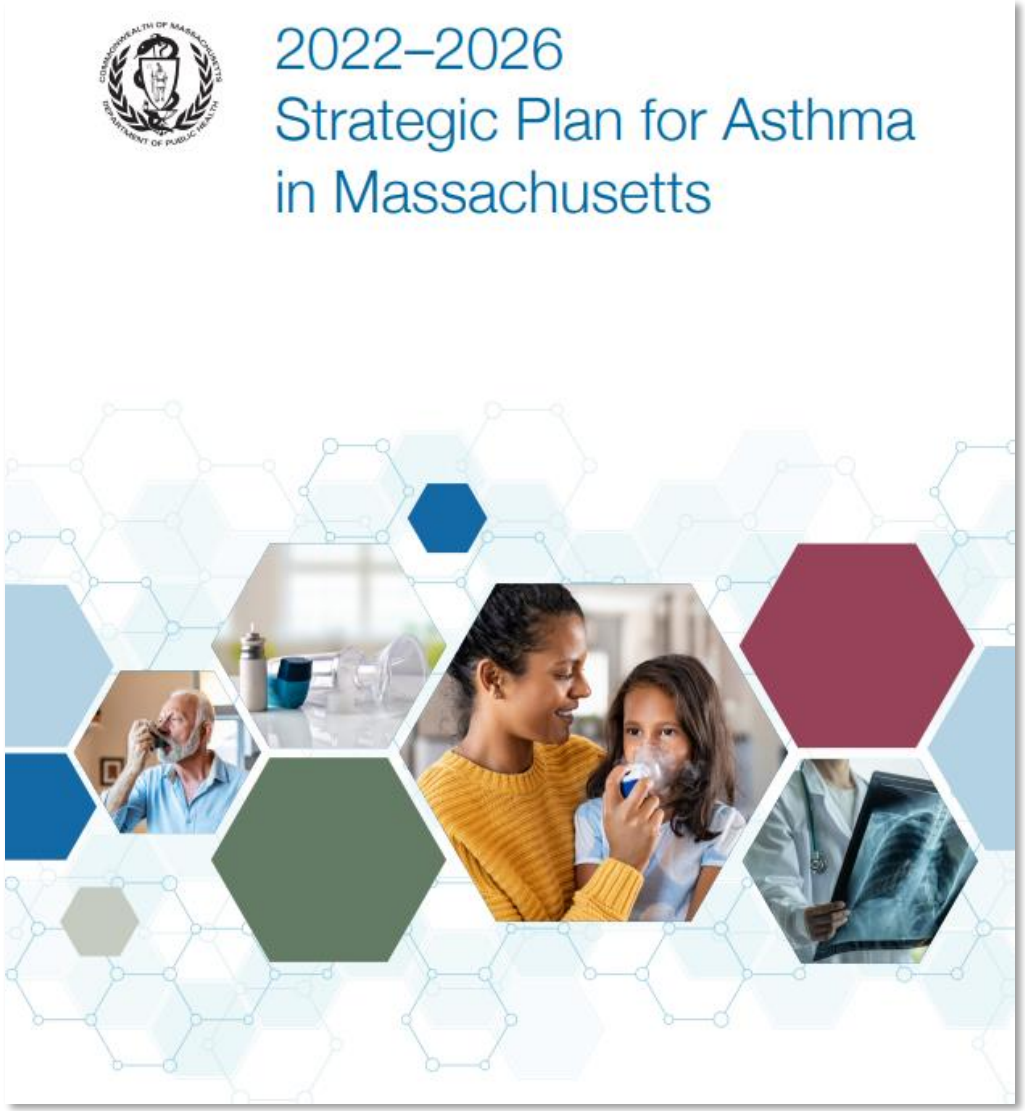
Dr. Catherine Brown – CSTE President-Elect

Commonwealth Fund 2023 Scorecard

The Commonwealth Fund

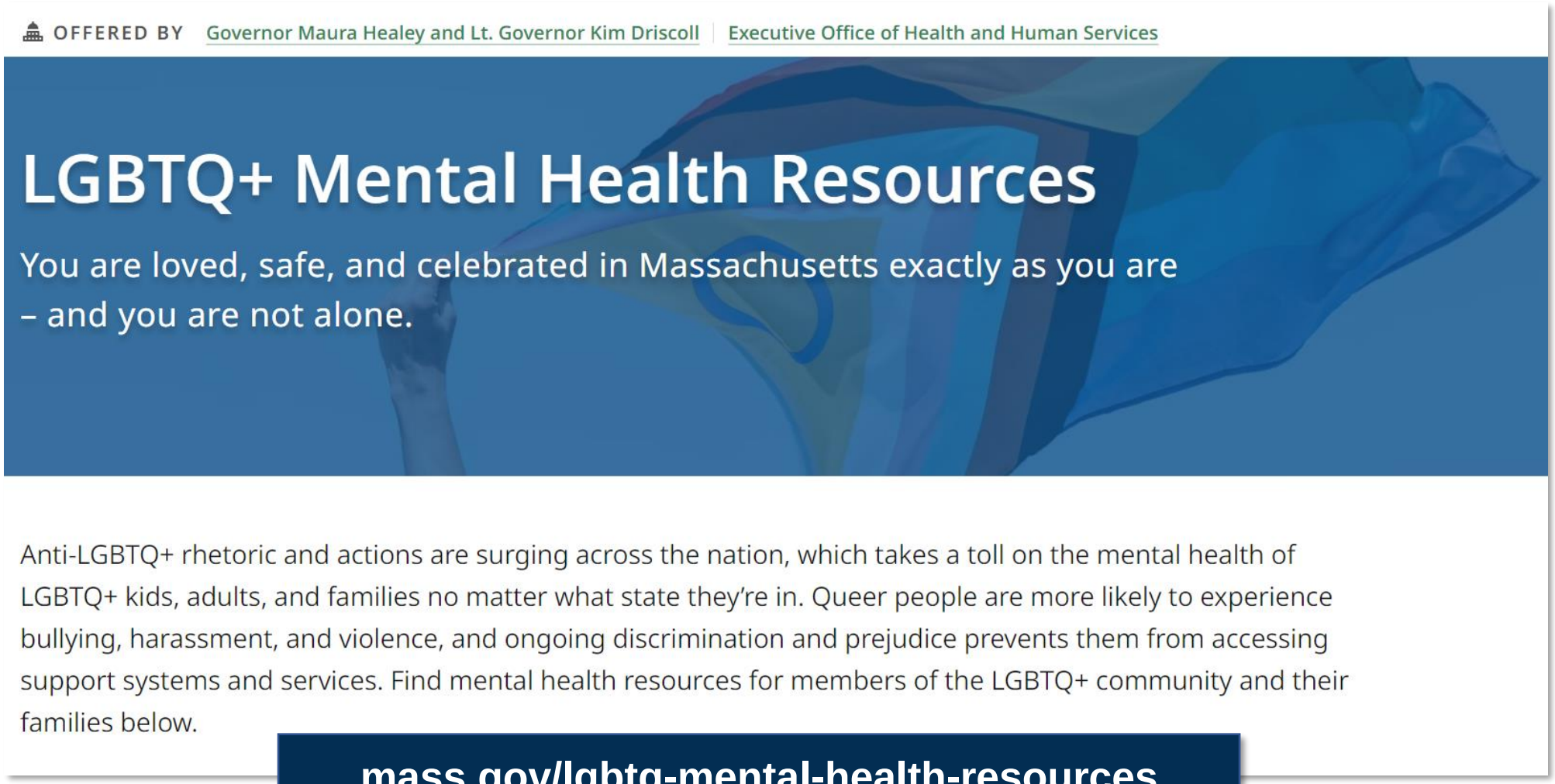
Strategic Plan for Asthma



mass.gov/asthma-prevention-and-control

Gender-Affirming Care Roundtable

LGBTQ+ Mental Health Resource Hubs



mass.gov/lgbtq-mental-health-resources

Outer Cape Visit

West Nile Virus

OFFERED BY Department of Public Health

PRESS RELEASE

State public health officials announce season's first West Nile virus-positive mosquito sample

Residents urged to use bug spray when outdoors

FOR IMMEDIATE RELEASE:
7/07/2023 Department of Public Health

BOSTON — Today the Massachusetts Department of Public Health (DPH) announced that West Nile virus (WNV) has been detected in mosquitoes in Massachusetts for the first time this year. The presence of WNV was confirmed by the Massachusetts State Public Health Laboratory in a mosquito sample collected July 6 in the town of Brookline in Norfolk County. No human or animal cases of WNV or Eastern equine encephalitis (EEE) have been detected so far this year.

Mpox


COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
mpox (monkeypox)
Get the Facts
Learn more at mass.gov/Mpox

Community Health Equity Initiative

2023 Community Health Equity Survey launching on **July 31, 2023**

For more information about Community Health Equity Initiative (CHEI) and the upcoming survey, please visit our website: www.mass.gov/CHEI

Contact the CHEI Team: CHEI@mass.gov

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The Massachusetts Public Health Data Warehouse

Highlight: An assessment of severe maternal morbidity in Massachusetts: 2011-2020

Dana Bernson, MPH

Director of Special Analytic Projects, Office of Population Health

Overview

The Public Health Data Warehouse (PHD) is a truly unique data analysis tool that links multiple datasets across state and local government to help address public health priorities with a focus on health and racial equity and the social determinants of health.

Background and context

Authorized in 2017 under **M.G.L. c. 111, §237**

> *The commissioner shall collect, record and analyze data, and shall assemble and maintain data systems, necessary to* ***analyze population health trends****. The commissioner shall give* ***priority to analyzing fatal and nonfatal opiate overdoses****. The commissioner may identify and determine additional priorities for the* ***reduction of morbidity and mortality****.*

Benefits

Linking data from across state government has allowed us to turn data into actionable insight

Results have led to ongoing commitment to tie analytics to data-driven legislation, policy, and program change and has informed clinical practice

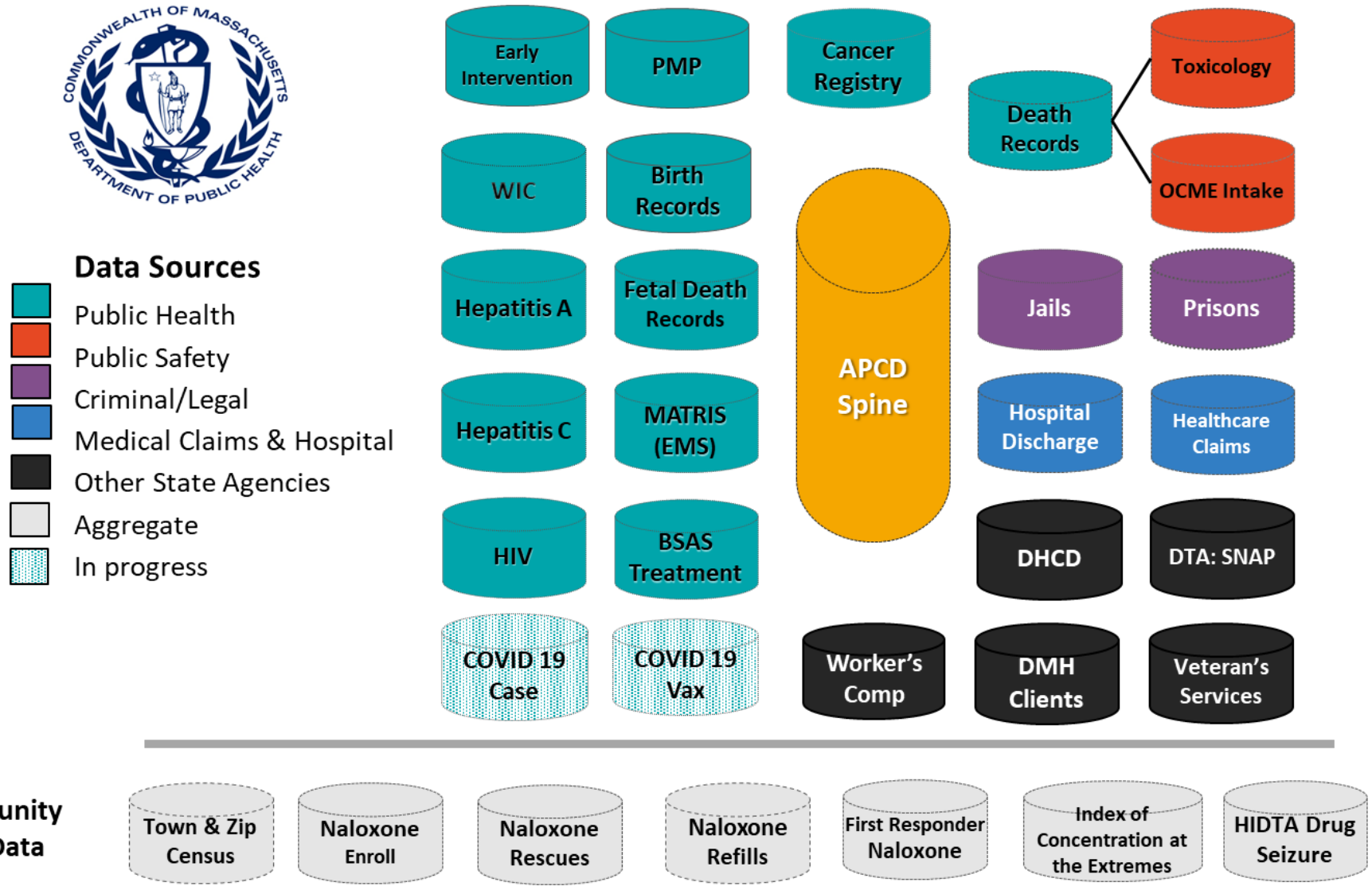
Benefits

- Insights about high-risk populations now **drive our programming** allowing us to tailor interventions to become more effective at eliminating disparities
- We created this tool to help address the opioid crisis, but we designed it as a **scalable, sustainable, and flexible** model that positions us to address other priority issues.
- This tool has become a **national model** that other states can use to better understand public health priorities.

Current State: Public Health Priorities

- Trends among the population of persons affected by **substance use disorders** and specifically opioid use disorder, including fatal and nonfatal opioid overdoses.
- Trends related to **maternal and child health** in the Commonwealth.
- Trends related to the impact of **COVID-19** on morbidity and mortality in the Commonwealth including intersections with other PHD Priorities.
- Trends related to the impact of **climate change** on morbidity and mortality in the Commonwealth including intersections with other PHD Priorities.

Current State: Data



Technical Implementation

Technical Implementation

- **Data Use Agreements**: go above and beyond legal requirements to protect the data
- **Matching process**: modified spine and limb, with MA All Payer Claims Database as spine
- **Split Files**: direct personal identifiers and analytic data never stored with the same ID
- **Minimum necessary:** limited datasets
- **Secure analytic environment:**
  - Analysts cannot see the data
  - Linkage done on the fly and temporary work files are deleted at end of session
  - No write access
  - Automatic suppression of small cell sizes
  - Full auditability of all data operations
  - Data encrypted in transit and at rest

Dissemination

3 Data briefs
4 legislative reports

27 Peer reviewed publications

Conferences

Presentations & Webinars

Podcasts

Peer to peer technical assistance

Public/Private partnerships

18
local, state, and federal agencies

11
healthcare delivery systems

33
academic institutions

11
consulting agencies, foundations, private companies, & think tanks

Selected Highlights: *An assessment of severe maternal morbidity in Massachusetts: 2011-2020*

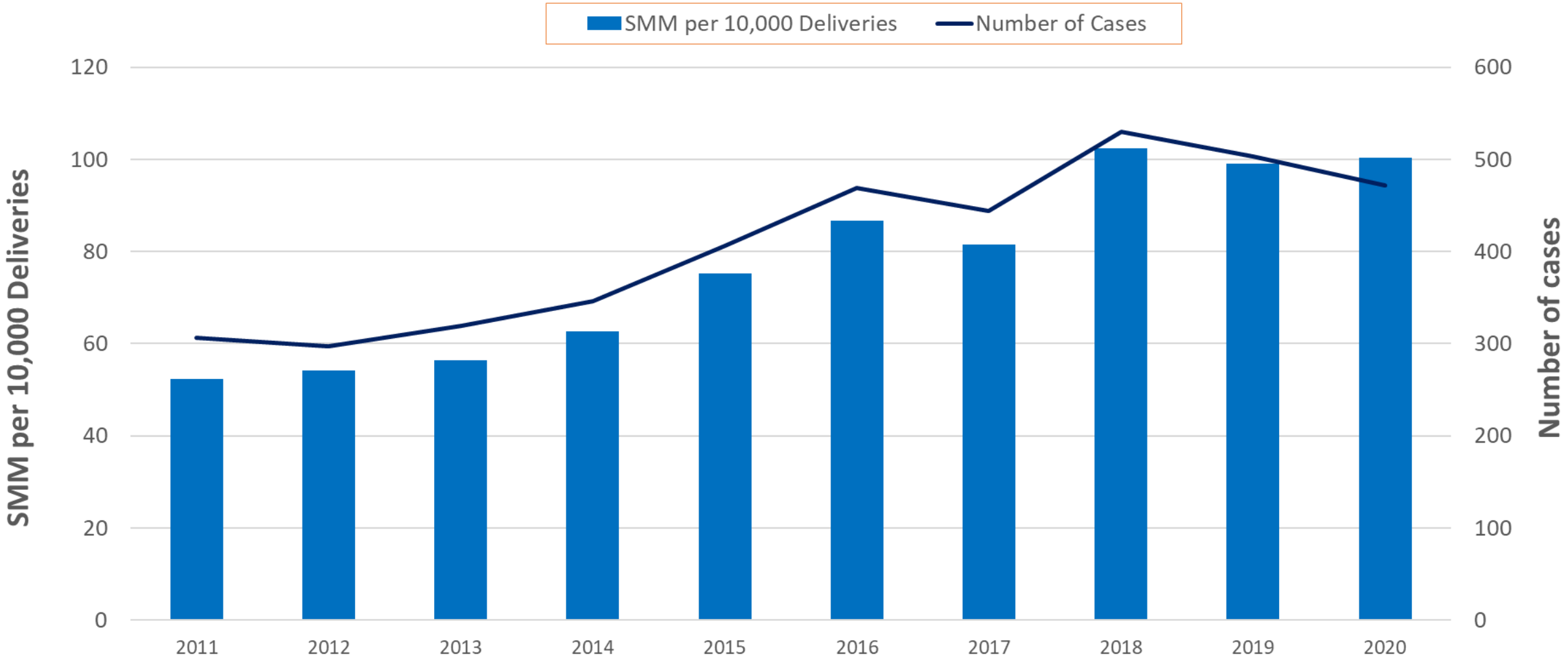
Acknowledgement:

Xiaohui Cui, Fifi Diop, Fareesa Hasan, Malena Hood, Jiankun Kuang, Sarah L. Stone

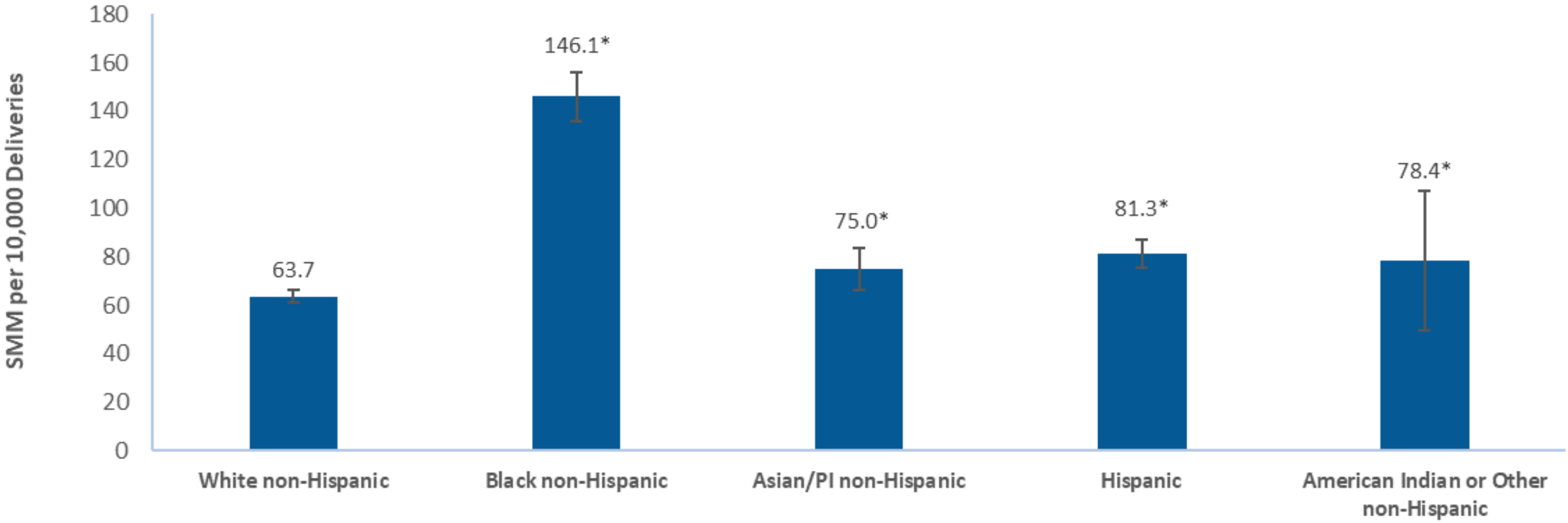
Severe maternal morbidity

- Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a birthing person's health.
- SMM rates are calculated per 10,000 deliveries
- In United States, for every maternal death, approximately 100 birthing people suffer severe morbidities related to pregnancy
- SMM is increasing in Massachusetts and US

SMM in Massachusetts: 2011-2020

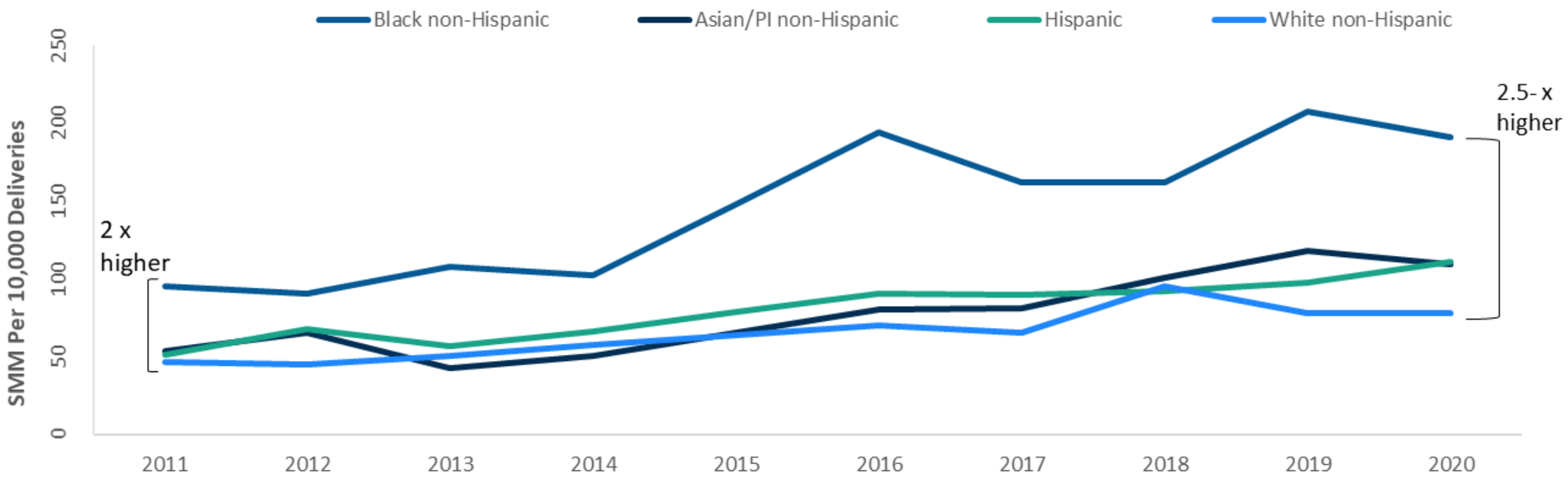


SMM by race and Hispanic ethnicity, MA: 2011-2020



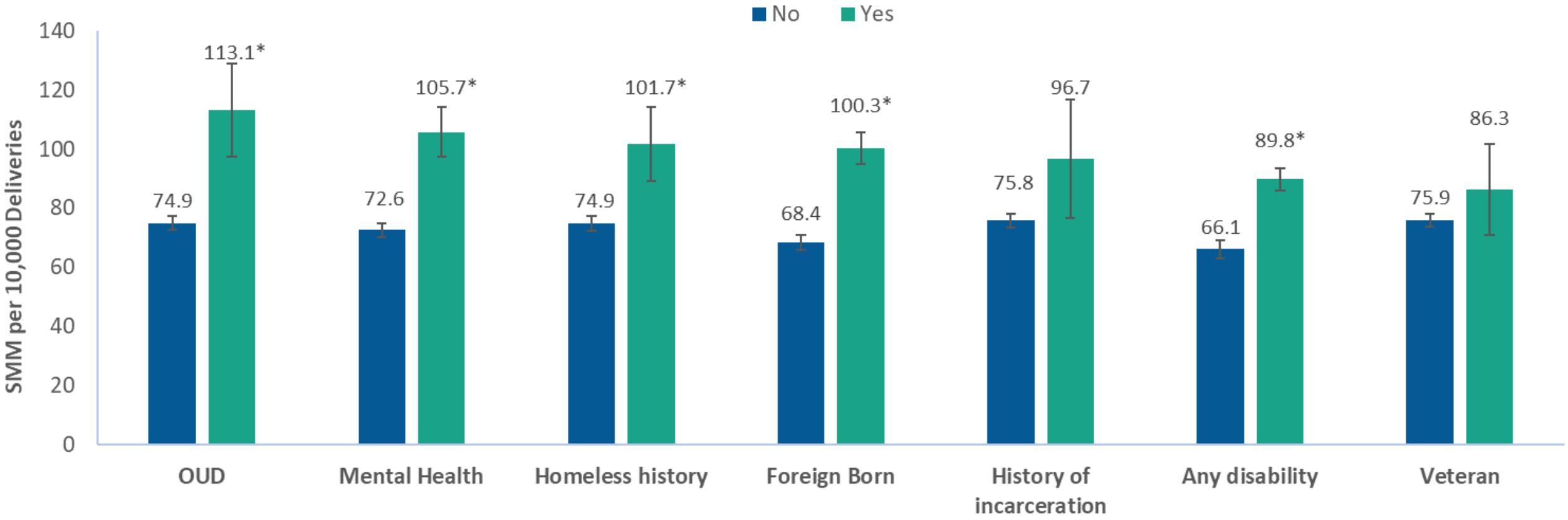
*Denotes rate is statistically significantly higher than White non-Hispanic

SMM by race and Hispanic ethnicity, MA: 2011-2020



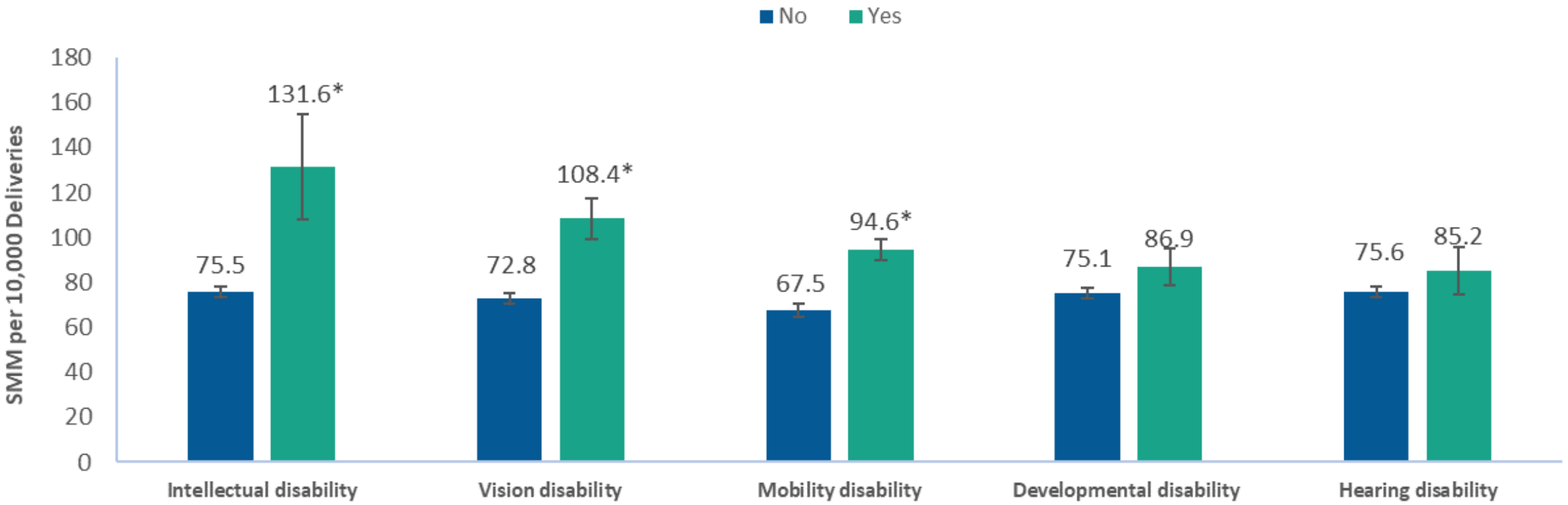
Note: Rates for American Indian and Other non-Hispanic birthing people are not shown because these are based on a total of 39 events ranging from 1-4 for all years except for 2 where the counts were 6.

SMM by priority populations, MA: 2011-2020



*Denotes rate is statistically significantly higher for members of the specified priority population

SMM by disability status, MA: 2011-2020



*Denotes rate is statistically significantly higher for people with the specified disability

Conclusions

- The prevalence of SMM nearly doubled in Massachusetts from 2011 to 2020.
- Black non-Hispanic birthing people have consistently experienced the highest SMM rates among all race/ethnicity groups, and those rates more than doubled in this time-period, widening an already large racial inequity gap.
- These findings reveal significant inequities experienced by birthing people with disabilities, which have not been previously addressed in statewide SMM reporting and which require ongoing attention.

Thank you for the opportunity to present this information today.

Please direct any questions to:

Dana Bernson, MPH

Director of Special Analytic Projects

Office of Population Health

Dana.Bernson@mass.gov

Racial Inequities in Maternal Health:

Recommendations from the Maternal Health Commission

Hafsatou Diop, MD, MPH

Director, Division of Maternal and Child Health Research and Analysis

Outline

- Purpose of the Racial Inequities in Maternal Health Commission
- Highlight key recommendations from Racial Inequities in Maternal Health Commission Report
- Highlight accomplishments to date

Racial Inequities in Maternal Health Commission

- Commission was established by Chapter 348 of the Acts of 2020, An Act to reduce racial inequities in maternal health
- Commission was tasked with seeking out steps to address racial inequities in maternal health and provide guidance and advice to the Governor, the General Court and the Secretary of Health and Human Services relative to reducing racial inequities in maternal deaths and severe maternal morbidity
- Make comprehensive recommendations to reduce or eliminate racial inequities in maternal health

Working Groups

- **Family and Community Engagement**: Investigated the social, structural, and contextual factors that influence poorer maternal health outcomes for Black birthing people and their families, along with strategies to eliminate those factors.
- **Public Health Infrastructure**: Investigated and studied the public health systems factors that influence poorer maternal health and pregnancy-associated deaths including pregnancy-related deaths among people of color and their families, specifically Black birthing people, along with strategies to address those factors.
- **Healthcare Systems**: Investigated the factors that influence poorer maternal health care delivery for Black and Brown birthing individuals and their families and strategies to mitigate those factors.

Kimberly's Story as told by her sister, Donnette McManus

"After Kimberly's death, I realized that she is among the many African American mothers who died due to negligence, bad healthcare, and a lack of understanding.

What questions should mothers ask? Why don't healthcare providers listen? Who is ultimately responsible? What could have been done to prevent our loss and other families' losses?"

"And there is this issue of trust, where no matter what you say as a Black woman, the doctors who are the people who are supposed to help you, don't trust you. They don't listen to what you're saying. So, it feels like there are different levels or a double standard between the way women of color are treated during these scenarios."

-CHARLES MUHUI, HUSBAND AND HOLBROOK RESIDENT

Call to Action: Public Health Infrastructure

- Establish a statute and provide state funding to MMMRC's operations
- Provide funding to support the quality improvement efforts led by PNQIN
- Establish legislation to develop a doula workforce and provide state funding support doula certification/credentialing pathway
- Provide funding to support statewide expansion of the Welcome Family Program-a home visiting program- to additional communities
- Mandate education regarding stigma, bias, trauma, diversity, mental health, and substance use disorder (SUD) among DCF staff

Call to Action: Health Care Systems

- Support perinatal quality improvement efforts to have all birth facilities participate in implementation of patient safety bundles
- Promote group prenatal care models through enhanced reimbursement for group prenatal care or other incentives
- Increase access and efforts to better integrate and expand midwifery model of care for labor and delivery as well as integration of home birth for uncomplicated pregnancies
- Expand access to birth centers and doula care
- Require provider-based trainings on implicit and explicit bias, discrimination, and trauma informed care

Accomplishments to Date: Maternal Health Task Force

- Established a statewide Maternal Health Task Force (MHTF) comprised of 25 community partners including 3 people with lived experience representing 20 organizations
- Convened MHTF meetings on March 24, 2023, and May 26, 2023
- Role of MHTF is to develop a draft strategic plan for the state by September 2023 and a final draft by September 2024

Accomplishments to Date: Perinatal Neonatal Quality Improvement Network (PNQIN)

- Launched the Maternal Equity Bundle in October 2022 to reduce overall rates SMM and to close the Black-White gap in SMM
- DPH provided funding for the SPEAK UP against racism training offered by the Institute for Perinatal Quality Improvement; we have trained over 500 providers across 34 birthing hospitals to dismantle racism, provide respectful care that is equitable and high-quality, and eliminate perinatal health inequities.

Accomplishments to Date: Promote and Execute Innovation in Maternal Health Service Delivery

Direct Clinical Care: Strategy 1

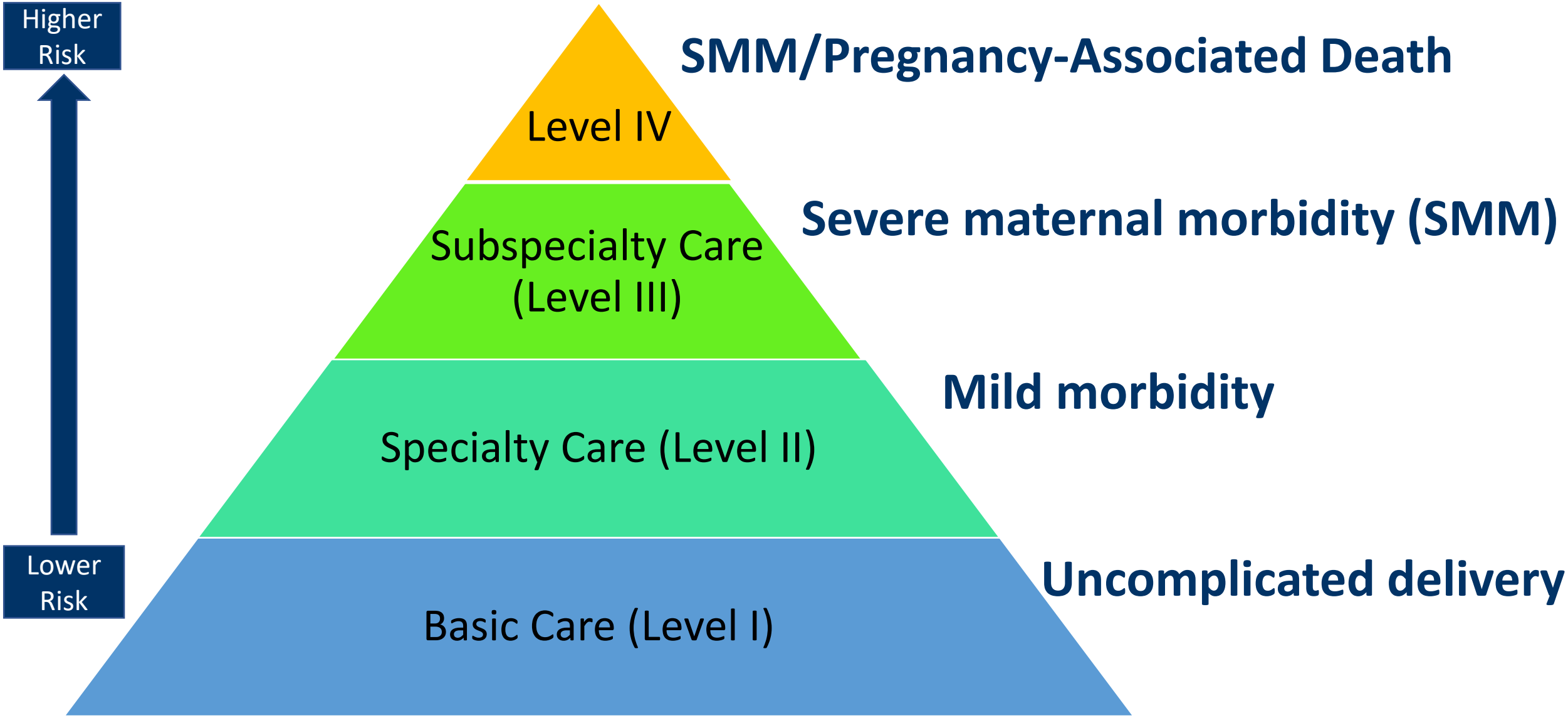
- Implemented remote blood pressure (BP) monitoring programs at Baystate Medical Center in Western MA using Babyscripts, and at Brigham and Women's Hospital in Boston using a Bluetooth-enabled BP monitor to improve awareness of obstetric warning signs for patients with hypertensive disorders of pregnancy in the postpartum period
- More than half of maternal deaths occur during the postpartum
- 35% of pregnancy-associated deaths with medical causes had documented hypertensive disorders, and Black non-Hispanic had the highest percentage of deaths due to a medical cause at 70.6% and the highest percent of documented hypertension on birth and death certificates at 47%.

Accomplishments to Date: Promote and Execute Innovation in Maternal Health Service Delivery

Direct Clinical Care: Strategy 2

- Implement the Levels of Maternal Care using the CDC's Levels of Care Assessment Tool (LOCATe) and MA equity focused-questions
  - Does your hospital provide implicit bias and anti-racism training for physicians, nurses, and staff?
  - Does your hospital provide education on peripartum racial and ethnic disparities?
  - Does your hospital have a dedicated system or process for patients and families, and/or for staff to report discrimination, racism, and bias; and addressing social determinants of health?
- Established and convened a multi-disciplinary Implementation Steering Committee including 40 members representing 23 organizations to develop a plan to sustain the Level of Maternal Care model in MA

Establishing the Levels of Maternal Care



Current Status of Recommendations

Recommendation	Status
Doula Workforce Development	Not started; legislation would be needed to support a voluntary certification pathway; DPH has been engaging a doula partner advisory group (DPAG) to build relationships and prepare for this possibility.
Maternal Mortality Review Committee	DPH received three years of partial funding from the CDC; future state could include full and ongoing operations and legislative authority.
Perinatal Neonatal Quality Improvement Network	FY24 H1 budget includes $500k; implemented equity bundle in 22 out of 40 hospitals.
Home Visiting Program	Welcome Family Program available in 8 communities through federal funding; future state could include statewide expansion.
Department of Family and Medical Leave Data Collection	Collecting disaggregated data by race/ethnicity to monitor inequities; future opportunity to collect additional disaggregated data by veteran and disability status.
Telehealth Remote Blood Pressure	Currently in 3 hospitals; future opportunities for growth could include expansion to all hospitals and MassHealth reimbursement.
Provider Training	DPH-funded SPEAK UP against racism training offered by the Institute for Perinatal Quality Improvement; 500 providers trained across 34 birthing hospitals

Summary

- Recommendations made by the Commission are not a cure-all solution for addressing racial inequities in maternal health, but an attempt to begin the actions necessary for change in a more optimal direction for the Massachusetts birthing persons and their partners who may be most vulnerable to maternal health inequities.
- Reducing SMM and maternal mortality among people of color will be dependent upon the redesigning of health delivery infrastructures and standardized collaboration within and across community settings.
- Enforcements towards racial equity may significantly improve overall maternal health outcomes for Massachusetts residents.

Thank you for the opportunity to present this information today.

Please direct any questions to:

Hafsatou Fifi Diop

Director

Division of Maternal and Child Health Research and Analysis

Hafsatou.Diop@Mass.Gov

Proposed Revisions to Health Care Facility and EMS Licensing Regulations

Marita Callahan

Director of Policy and Health Communications, Bureau of Health Care Safety and Quality

Summary of Regulations

DPH proposes revisions to the following regulations. These regulations set forth standards governing health care facilities and emergency medical services, to provide high quality of care, industry standardization, and strong consumer protection to the residents of Massachusetts.

Regulation	Description
105 CMR 130.000, *Hospital Licensure*	Sets forth standards for the maintenance and operation of hospitals
105 CMR 140.000, *Licensure of Clinics*	Sets forth standards for the licensure, maintenance and operation of clinics
105 CMR 141.000, *Licensure of Hospice Programs*	Sets forth standards for hospice services, which may be offered in multiple types of health care settings and in the community, including a patient's home, a nursing home, or a free-standing hospice facility operated by a hospice program.
105 CMR 150.000, *Standards for Long-Term Care Facilities*	Sets forth standards governing long-term care facilities, including nursing homes and rest homes
105 CMR 158.000, *Licensure of Adult Day Health Programs*	Sets forth the licensure requirements for all Adult Day Health Programs
105 CMR 170.000, *Emergency Medical Services System*	Establishes a statewide Emergency Medical Services (EMS) system to properly train and certify EMS personnel and establish standards for licensure of ambulance services.

Background: CMS COVID-19 Requirements

Beginning in February 2022, the Centers for Medicare & Medicaid Services (CMS) required all **CMS-certified providers** (including personnel in healthcare facilities) to have completed the COVID-19 primary series vaccine.

On May 31, 2023, CMS rescinded this requirement effective August 2023, and communicated that it will not be enforced in the interim.

Background: COVID-19 Vaccination Requirements

Currently, Department regulations require **hospice** and **long-term care facilities** to mandate that all personnel have received COVID-19 vaccination.

- Exemptions have been allowed for individuals for whom the vaccination is medically contraindicated or against an individual's sincerely held religious belief.
- Individuals receiving an exemption must be able to perform their essential job functions with reasonable accommodations that do not place an undue burden on the facility.
- Guidance implementing this vaccination requirement requires personnel to receive only the primary series of the COVID-19 vaccine.

Background: Influenza Vaccine Requirements

Most Department-licensed health care facilities (**hospitals, long-term care facilities, clinics, and adult day health**) have had longstanding requirements around seasonal influenza vaccine.

- Staff may be exempt, including the ability to decline for any reason (not limited to medical or religious reasons).
- Facilities must report annual personnel vaccination rates to the Department, in accordance with guidelines and maintain a system to track personnel vaccination status.

Overview of Existing Requirements (1 of 2)

Facility Type	Regulation	Current COVID-19 Vaccine Requirement in Regulation – Primary Series Only	Current Influenza Vaccine Requirement in Regulation – Seasonal
Hospital	**105 CMR 130.000**	None	Yes- can exempt for any reason
Clinic*	**105 CMR 140.000**	None	Yes- can exempt for any reason
Hospice	**105 CMR 141.000**	Yes- medical or religious exemptions only; must be able to perform job with reasonable accommodations	None

**Note: The Out-of-Hospital Dialysis Unit regulations (105 CMR 145.000) refer to this section of the Clinic regulation regarding vaccine requirements. Therefore, these units' requirements always match what is in 105 CMR 140.000.*

Overview of Existing Requirements (2 of 2)

Facility Type	Regulation	Current COVID-19 Vaccine Requirement in Regulation – Primary Series Only	Current Influenza Vaccine Requirement in Regulation - Seasonal
Long Term Care Facility	**105 CMR 150.000**	Yes- medical or religious exemptions only; must be able to perform job with reasonable accommodations	Yes- can exempt for any reason; must be able to perform job with reasonable accommodations
Adult Day Health	**105 CMR 158.000**	None	Yes- can exempt for any reason
Emergency Medical Services	**105 CMR 170.000**	None	None

Overview of Proposed Revisions: Long-Term Care and Hospice

With these proposed amendments, personnel in **long-term care and hospice facilities** will need to be vaccinated with both COVID-19 and influenza vaccines, unless an individual is subject to an exemption.

- Staff may decline the vaccine for any reason (medical contraindication, religious beliefs, personal reasons, or other).
- **Staff in long-term care and hospice facilities who decline vaccination must take mitigation measures** to prevent viral infection and transmission.
- Department-licensed health care facilities must report personnel COVID-19 and influenza vaccination rates to the Department, in accordance with guidelines.

Overview of Proposed Revisions: Hospital, Clinic, Adult Day Health, EMS

With these proposed amendments, personnel **in all other settings** will need to be vaccinated with both COVID-19 and influenza vaccines, unless an individual is subject to an exemption.

- Staff may decline the vaccine for any reason (medical contraindication, religious beliefs, personal reasons, or other).
- Staff in these settings who decline **may be required by their employer** to take mitigation measures to prevent viral infection and transmission.
- Department-licensed health care facilities must report personnel COVID-19 and influenza vaccination rates to the Department, in accordance with guidelines.

Goals of Proposed Amendments

The Department approached these amendments with the following goals:

- Emphasize the importance of both influenza and COVID-19 vaccination among this workforce, due to higher risk of exposure, to prevent missed days of work due to illness, and to maximize availability to care for patients
- Reducing risk to patients of COVID-19 and influenza infection and potential serious complications
- Maximize vaccination while providing flexibility to personnel to be exempt from vaccination
- Update outdated language which currently only addresses the “primary series” of COVID-19 vaccine
- Close pre-existing gaps and inconsistencies in vaccine requirements, by including all health care facilities and Emergency Medical Service providers in this process, as all serve vulnerable and immunocompromised patients

Next Steps

- Following this presentation to the Public Health Council, staff will hold a public hearing and as required, will provide a public comment period.
- After the close of the public comment period, staff will review public comments, revise as necessary to reflect comments received, and then request approval of the final revised regulation at a subsequent meeting of the Public Health Council.

Thank you for the opportunity to present this information today.

For more information regarding health care facility and EMS licensure requirements, please find the relevant statutory language and the full current regulation here:

Massachusetts Law:

https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111

https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111C

Current Regulations:

https://www.mass.gov/lists/health-care-facility-licensure-regulations

https://www.mass.gov/lists/laws-and-regulations-for-oems

Proposed Amendments:

mass.gov/dph/proposed-regulations

Appendix: 2022-2023 HCP Influenza Vaccination Mean Percentage

Mean percentage of HCP Influenza Vaccination During 2022-2023 Season

	Acute Care Hospitals	Ambulatory Surgical Centers	Nursing homes	Dialysis Centers	Non-Acute Care Hospitals
Reporting Facilities	72	38	226	47	33
Mean HCP Vaccinated	91%	83%	62%	53%	72%
Vaccinated at Facility	54%	41%	41%	34%	42%
Vaccinated Elsewhere	37%	42%	21%	19%	39%
Mean HCP Declined Vaccination	2%	10%	12%	10%	12%
Mean HCP with a Medical Contraindication	1%	2%	2%	1%	1%
Mean HCP with Unknown Vaccination Status	6%	6%	24%	37%	15%

Appendix: Existing Requirements vs. Proposed Revisions (1 of 2)

Facility Type	Regulation	Current COVID Vaccine Requirement in Regulation – Primary Series	Current Flu Vaccine Requirement in Regulation - Seasonal	Proposed Amendments
Hospital	**105 CMR 130.000**	None	Yes- can exempt for any reason	**Addition** to flu requirement: Exempt individuals may be required to take mitigation measures **New** COVID requirement: Can exempt for any reason; exempt individuals may be required to take mitigation measures.
Clinic	**105 CMR 140.000** *Note: The Out-of-Hospital Dialysis Unit regulations (105 CMR 145.000) refer to this section of the Clinic regulation regarding vaccine requirements.*	None	Yes- can exempt for any reason	**Addition** to flu requirement: Exempt individuals may be required to take mitigation measures **New** COVID requirement: Can exempt for any reason; exempt individuals may be required to take mitigation measures.
Hospice	**105 CMR 141.000**	Yes- medical or religious exemptions only; must be able to perform job with reasonable accommodations	None	**New** flu requirement: Can exempt for any reason; exempt individuals must take mitigation measures **Updated** COVID requirement: Can exempt for any reason; exempt individuals must take mitigation measures

Appendix: Existing Requirements vs. Proposed Revisions (2 of 2)

Facility Type	Regulation	Current COVID Vaccine Requirement in Regulation – Primary Series	Current Flu Vaccine Requirement in Regulation - Seasonal	Proposed Amendments
Long Term Care Facility	**105 CMR 150.000**	Yes- medical or religious exemptions only; must be able to perform job with reasonable accommodations	Yes- can exempt for any reason; must be able to perform job with reasonable accommodations	**Updated** flu requirement: Exempt individuals must take mitigation measures **Updated** COVID requirement: Can exempt for any reason; exempt individuals must take mitigation measures
Adult Day Health	**105 CMR 158.000**	None	Yes- can exempt for any reason	**Addition** to flu requirement: Exempt individuals may be required to take mitigation measures **New** COVID requirement: Can exempt for any reason; exempt individuals may be required to take mitigation measures
Emergency Medical Services	**105 CMR 170.000**	None	None	**New** flu requirement: Can exempt for any reason; exempt individuals may be required to take mitigation measures. **New** COVID requirement: Can exempt for any reason; exempt individuals may be required to take mitigation measures.

Next Meeting:
August 9, 2023