[redacted]

From: [redacted]noreply+4e6cec5f7616cb52@formstack.com>
Sent: Thursday, January 14, 2016 2:45 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/14/16 2:45 PM

Name (optional)::	Annie Singh
Company/Organization (if applicable) (optional)::	Justice Resource Institute
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	115 CMR secs. 9.06, 9.15, 5.05
General Regulatory Themes::	Persons with Disabilities
Please list the Agency or Agencies affiliated with this regulation::	Department of Developmental Services, Disabled Persons Protection Commission (DPPC)
Describe the regulatory issue or observation::	Issue: Interpretation of regulations regarding reporting potential or suspected abuse, mistreatment and neglect of adults with disabilities. 115 CMR 9.06 mandates reporting complaints to DPPC when service providers have "reason to believe there is a non-frivolous allegation of mistreatment, an illegal, dangerous, or inhumane condition or incident, or a medicolegal death of an individual…." MGL c. 19C defines the conditions which are mandated to be reported as, "'Abuse,' an act or omission which results in serious physical or emotional injury to a disabled person…" In practice, these regulations have come to consistently be interpreted to include the mandated reporting of all signs of accident or injury. Human service providers are routinely advised to report accidents and injuries to persons with disabilities which are outside the definitions of the regulations, including minor injuries where there is no indication of serious emotional or physical injury and where the condition does not appear to the mandated reporter to constitute mistreatment or abuse, or be illegal, dangerous or inhumane. One example of many is a situation in which mandated reporters were advised to make a DPPC complaint of potential abuse regarding the minor sunburn observed on the neck of an individual with a disability. Despite the

caregiver/parent reporting how and when the person had gotten the sunburn, and the fact that the sunburn was minor and did not appear to be causing discomfort, a 19C complaint was filed and investigated in a process which took about 5 months. The investigation resulted in the complaint being unsubstantiated, but the waste of resources for the investigating body and the provider agency were obvious. For the caregiver/parent who was referred to as the "alleged abuser' in all reports, it created a painful wedge in relationships with the state case worker and provider staff and supported their sense that the adult child's real pressing needs were being ignored in the meantime.

We have seen similar situations play out many times. Every frivolous or "cover your back" report which results in a full investigation process weakens the intent of the regulations; misdirects limited investigatory and responsive resources; lengthens the time it takes to complete complaint investigations; and provides a disincentive for people to take on the important work of caregiving for people with disabilities. A system which encourages such reports produces unreliable incidence data on abuse and neglect and diverts resources from harm reduction and response activities.

Suggestions for improvements to the regulation::

Suggestions: Restrict reporting expectations to the actual language of the regulations. Roll back the expectation that all injuries to adults with disabilities be reported, no matter how minor or where there is a known non-abusive/non-neglectful cause. Rely on existing incident reporting requirements to document the reporting and review of events which do not meet the threshold. Reduce the backlog of cases which are currently resolved well outside the regulatory timelines. Allow for more effective, efficient investigation of allegations as defined in the regulations and invest the savings in additional training and resources to support stressed caregivers and prevent real and potential harm.

Respectfully Submitted,

Deirdre Hunter, MSW, LCSW
Vice President
JRI Developing Abilities

[redacted]

From: [redacted]noreply+4e6cec5f7616cb52@formstack.com>
Sent: Thursday, January 14, 2016 2:34 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/14/16 2:34 PM

Name (optional)::	Annie Singh
Company/Organization (if applicable) (optional)::	Justice Resource Institute
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	115 CMR 8
General Regulatory Themes::	Persons with Disabilities
Please list the Agency or Agencies affiliated with this regulation::	Department of Developmental Services
Describe the regulatory issue or observation::	Issue: The licensing and certification of services contracted by DDS and provided by agencies and organizations is more extensive and burdensome than necessary to ensure the safe and effective provision of services. The preparation for and conduct of bi-annual licensing and certification surveys overuses resources of time, money and effort for the results achieved.
Suggestions for improvements to the regulation::	Suggestions: Reduce the sample size of the survey, particularly for organizations which have achieved high survey results in one or more successive surveys. Smaller, targeted surveys can be equally effective at a lower cost in time, money and effort. Expand the acceptance of accreditation or deeming by nationally recognized bodies whose standards support relevant performance outcomes. Deeming removes the expense to the Commonwealth and provides nationally benchmarked standards. Expand the term of license and certification to 3 or more years for organizations which have achieved high survey results in one or more successive surveys. Respectfully Submitted, Deirdre Hunter, MSW, LCSW Vice President JRI Developing Abilities [redacted]

[redacted]

From: [redacted]oreply+4e6cec5f7616cb52@formstack.com>
Sent: Thursday, January 14, 2016 2:30 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/14/16 2:29 PM

Name (optional)::	Annie Singh
Company/Organization (if applicable) (optional)::	Justice Resource Institute
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	115 CMR 5.04(2)
General Regulatory Themes::	Persons with Disabilities
Please list the Agency or Agencies affiliated with this regulation::	Department of Developmental Services
Describe the regulatory issue or observation::	Issue: Formal written consent is required for each use of an image of adults receiving services. As the use of social media has expanded, the requirement for written consent for every social media post is an unreasonable restriction of individual's access to participate in self-advocacy, community engagement and communication activities and places an unnecessary burden on staff time.
Suggestions for improvements to the regulation::	Suggestion: Revise the regulation to allow an annual consent for use of images and participation in specific social media, with the right to rescind at any time. Respectfully Submitted, Deirdre Hunter, MSW, LCSW Vice President JRI Developing Abilities [redacted]

[redacted]

From: [redacted]noreply+4e6cec5f7616cb52@formstack.com>
Sent: Wednesday, January 13, 2016 11:58 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/13/16 11:57 AM

Name (optional)::	Annie Singh
Company/Organization (if applicable) (optional)::	Justice Resource Institute (JRI)
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	
General Regulatory Themes::	Persons with Disabilities
Please list the Agency or Agencies affiliated with this regulation::	DPH Lead Agency; administered by DCF, DMH and DDS
Describe the regulatory issue or observation::	DCP MAP Policy Manual 01/01/15, Policy No. & Issue:13-5 Health Care Provider's Orders via Fax. Medication Administration Policy (MAP) accepts only an electronic signature which is an image of their signature (a photographic image) on doctors' orders from Health Care Providers (HCP). To comply with this requirement, HCP's who use electronic health records (which have a typed signature) must produce a doctor's order with a wet signature for their patients whose medication administration is subject to MAP. This includes clients of DCF, DMH and DDS. Individual physicians, HCP practices and hospital systems balk at having to produce orders with wet signatures, resulting in unnecessary delay in care for patients. The practice required by MAP is outdated and adds to the bureaucratic burden of the HCP available to serve people subject to MAP.
Suggestions for improvements to the regulation::	Suggestion: Revise MAP to accept doctors' orders authorized with a typed signature as is common for electronic health records. Respectfully submitted, Deirdre Hunter, MSW, LCSW Vice President JRI Developing Abilities [redacted]

[redacted]

From: [redacted]oreply+4e6cec5f7616cb52@formstack.com>
Sent: Wednesday, January 13, 2016 11:37 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/13/16 11:36 AM

Name (optional)::	Annie Singh
Company/Organization (if applicable) (optional)::	Justice Resource Institute, Inc.
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (if known): :	
General Regulatory Themes::	Children and Families
Please list the Agency or Agencies affiliated with this regulation::	Department of Mental Health
Describe the regulatory issue or observation::	Justice Resource Institute (JRI) respectfully requests review and revision of two operationally challenging Department of Mental Health regulations within 104 CMR 27.12(5). Issue 1: Who may initiate restraint Issue 2: Definition of seclusion Please see below for full discussion.
Suggestions for improvements to the regulation::	JRI respectfully requests review and revision of two operationally challenging Department of Mental Health regulations within 104 CMR 27.12(5). ISSUE 1: WHO MAY INITIATE RESTRAINT DMH regulation 104 CMR 27.12(5)(e)2. requires restraint to be initiated by an authorized staff person. "Authorized staff person" is defined in 104 CMR 27.12(5)(a)2. as a member of the licensed clinical staff of the facility. Our understanding of that regulation and definition is that a restraint could only begin when and where a licensed clinical staff person was on-hand to visually

observe and direct the intervention. This requirement undermines the spirit and operation of an engaged, vibrant, therapeutic community that provides a range of activities and experiences for the youth served.

With due regard to the severity of the manifestation of mental illness that has brought these youngsters into a secure intensive residential treatment setting, we provide numerous group and individual pursuits to challenge and promote individual competence and achievement of mental health and wellness. Residents are working on academic, vocational, and career goals; talent and leisure skills; and clinical and social goals on and off the unit. As these youngsters explore their mental health capacities and emotional reserves, they can be challenged beyond their current levels of stability and can require the external support and containment of specially trained staff. This can occur very quickly or even spontaneously, until triggering provocations are fully explored, identified, and addressed over time. For example, a student can be triggered by another student's careless comment in a classroom or a teacher's instruction and react with anger and physical aggression. Staff on hand may need to step in quickly to prevent harm to the other student or the initiating student who may harm him/herself or assault a teacher. It is not practical nor is it financially feasible to ensure that a licensed clinical staff is available in every classroom, on grounds, in the gym, bedrooms, activity and art rooms, etc., to serve to initiate the unusual event of a restraint.

We respectfully submit that the Joint Commission provides for the opportunity for specially trained direct care staff members to initiate a restraint – with authorization to continue provided by a licensed staff person or Registered Nurse within 15 minutes and a physician's order within one hour. We request that the staff requirements for initiation and the definition of "authorized staff person" be changed to reflect that standard and that Registered Nurses be included in the definition of licensed clinical staff.

Please note that even with the addition of RNs to that definition, which we consider essential, we would not seek to limit our youngsters' access to a wide range of on- and off-unit activities where the RN and/or clinician may not be immediately available to authorize initiation of a restraint. Thus we are requesting both the addition of the RN to the definition of licensed clinical staff AND that initiation of a restraint may take place by specially trained staff per the Joint Commission standard (CTS.05.06.05) with authorization within 15 minutes by a licensed clinical staff.

ISSUE 2: DEFINITION OF SECLUSION

DMH regulation 104 CMR 27.12(5)(a)4. defines seclusion as occurring when a patient is involuntarily confined to a room and is prevented from leaving, or reasonably believes that he or she will be prevented from leaving. It does not include voluntary, collaborative separation from a group or activity for the purpose of calming the patient.

Again, we respectfully submit that this definition is more restrictive than that in current use by the Department of Elementary and Secondary Education (DESE), as re-drafted in the updated and more comprehensive regulations to be fully adopted in January, 2016. Under the DESE regulations, 603 CMR 46.02 defines seclusion as "the involuntary confinement of a student alone in a room or area from which the student is physically prevented from leaving." The primary distinction between prohibited seclusion and permissible exclusionary time-out is that under seclusion, the student is left alone. We would agree with that definition and would not request to use seclusion as defined by DESE. However,

exclusionary time-out, as defined by DESE, is a useful alternative to seclusion and restraint for many youngsters, both in public school and in DMH IRTPs, as well as a useful tool for families to reduce disruptive behavior in the home. We respectfully request that DMH adopt similar definitions and procedures for the use of exclusionary time-out as described in DESE Technical Assistance Advisory SPED 2016-1, which can be found at http://www.doe.mass.edu/sped/advisories/2016-1ta.html and is excerpted below:

"2. The use of exclusionary time-out in educational settings

"Exclusionary time-out as a staff-directed behavioral support should only be used when the student is displaying behaviors which present, or potentially present, an unsafe or overly disruptive situation in the classroom. Staff-directed exclusionary time-out should not be used as a method of punishment for noncompliance, or for incidents of misbehavior that are no longer occurring.

"During an exclusionary time-out:
• The student must be continuously observed by a staff member;
• Staff must be with the student or immediately available to the student at all times;
• The space used for exclusionary time-out must be clean, safe, sanitary, and appropriate for the purpose of calming;

"Exclusionary time-out must cease as soon as the student has calmed.

"When a student is separated from the learning environment in an exclusionary time-out, s/he must be in a safe and calming environment. For any exclusionary time-out that may last longer than 30 minutes, programs must seek approval from the principal for the continued use of time-out. The principal may not routinely approve such requests but must consider the individual circumstances, specifically whether the student continues to be agitated to determine whether time-out beyond 30 minutes is justified. If it appears that the use of exclusionary time-out exacerbates the student's behavior, or the continuation of the exclusionary time-out beyond 30 minutes has not helped the student to calm, then other behavioral support strategies should be attempted.

"Exclusionary time-out is an intervention that should be reserved for use only when students are displaying behaviors which present, or potentially present, an unsafe or overly disruptive situation in the classroom. In such circumstances, the student may either ask to leave the classroom, or the student may be directed to a separate setting for the purpose of helping the student to calm. Unless it poses a safety risk, a staff member must be physically present with the student who is in an exclusionary time-out setting. If it is not safe for the staff member to be present with the student, the student may be left in the time-out setting with the door closed. However, in order to ensure that the student is receiving appropriate support, a school counselor or other behavioral support professional must be immediately available outside of the time-out setting where the individual can continuously observe and communicate with the student as appropriate to determine when the student has calmed. Students must never be locked in a room. For students displaying self-injurious behavior, a staff member must be physically present in the same setting with the student. Exclusionary time-out must end when the student has calmed."

We would ask that the Program Director of an IRTP be substituted for the principal in DESE's advisory as the administrator who authorizes exclusionary time-out beyond 30 minutes to one hour. We would further request the adoption of existing language in DMH regulations to require physician approval if the

exclusionary time-out lasted beyond one hour, thus reverting to the existing regulation on seclusion and restraint and that the doctor's order would not last longer than 2 hours, and so forth.

Thank you for your consideration of these two changes in regulation.

[redacted]

From: noreply@formstack.com
Sent: Friday, January 08, 2016 2:14 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/08/16 2:13 PM

Name (optional)::	
Company/Organization (if applicable) (optional)::	
Address (optional)::	
Primary Phone (optional)::	
Email (optional)::	
CMR Number (If known): :	345 CMR 4.00
General Regulatory Themes::	State/Local Government Relations
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health
Describe the regulatory issue or observation::	Outdated regulation. The regulation references the "the Board", which does not exist. DPH charges licensees a low level waste fee. What is the purpose of the fee? The Commonwealth does not have a low level waste disposal site.
Suggestions for improvements to the regulation::	Eliminate 345 CMR 4.00.

[redacted]

From: [redacted]<noreply+2c3fca0708b53c05@formstack.com>
Sent: Thursday, January 07, 2016 2:06 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/07/16 2:05 PM

Name (optional)::	Debra Vescera
Company/Organization (if applicable) (optional)::	BSN RN Public Health Nurse for 8 Towns in Central and South Central MA
Address (optional)::	[redacted]
Primary Phone (optional)::	
Email (optional)::	[redacted]
CMR Number (If known): :	105.5
General Regulatory Themes::	Building Codes/Accessibility Standards
Please list the Agency or Agencies affiliated with this regulation::	Massachusetts Department of Public Health Division Infectious Disease Surveillance and Tuberculosis Control.
Describe the regulatory issue or observation::	Public Health Budget Cuts continue to be problematic. Lack of appropriate Staffing at both State and Local levels is making it much more difficult to contain and control Reportable Contagious Diseases. Layoffs of Public Health Nurses at Local and State levels are leading to increased workloads and RN's having to cover multiple Cities and Towns. I currently cover 8 Towns (Charlton, Dudley, Southbridge, East Brookfield, West Brookfield, Brimfield, Holland and Wales) While some of these towns are smaller in population than others, it takes a great deal of time to travel to and from the more rural areas. Public Health RN's are barely keeping up with disease surveillance requirements, TB Cases who require daily Direct Observational Therapy Visits (D.O.T.) can be very challenging (especially when only employed 24 hours to cover all 8 towns). Perhaps MDPH should look at cutting some of their "Chiefs" and let us "Indians" be able to do our jobs in a much more timely and efficient manner. Cuts in Public Health Funding/Budgets over the last several years have led to increase in the spread of contagious diseases like measles, pertussis and tuberculosis control due to increases in multi-drug resistant tuberculosis cases. Public Health Nurses (as well as the Epidemiologists who work for the State Lab, Microbiologists, etc). are at the forefront of contagious disease prevention. Many politicians have no idea that we have been containing and controlling the spread of infectious diseases since 1890. Just because a disease is percieved as "irradicated" doesn't mean that it has been???

Suggestions for improvements to the regulation::

Politicians at Local, State and Federal levels should be educated on the role of the Public Health Nurse (at all levels of government). Where there is smoke, there is fire. In MA, we have had an increase in TB Cases (as well as an increase in multidrug resistance cases, outbreaks of measles, outbreaks of pertussis and increase in morbidity and mortality rates for vaccine preventable diseases such as influenza. We are barely able to provide "tertiary" levels of prevention to reduce the spread of potentially dangerous infectious diseases. Secondary interventions for early diagnosis and prompt treatment of diseases is now a "gift" if we can reach the patient/population in a timely manner. Primary Intervention to Promote health, prevent illness, and provide communities with protection is non-existent for many of us who cover multiple towns (both Part-time and Full-time). It is only a matter of time before we have another contagious disease outbreak...and pray that "small-pox" doesn't return to this planet (which is the only contagious disease that has be alledgedly "irradicated")

[redacted]

From: noreply@formstack.com
Sent: Monday, January 04, 2016 8:45 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/04/16 8:44 AM

Name (optional)::	
Company/Organization (if applicable) (optional)::	
Address (optional)::	
Primary Phone (optional)::	
Email (optional)::	
CMR Number (If known): :	105 CMR 460.00
General Regulatory Themes::	Environmental Protection
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health (DPH) and Department of Labor Standards (DLS) for de-leading implementation under 454 CMR 22.00.
Describe the regulatory issue or observation::	The Department of Public Health (DPH) regulations have very specific purpose of testing for purposes of lead compliance and de-leading in child occupied housing. The DPH policies however are far more reaching. The DPH interprets activities not involving their DPH such as RRP (Lead Safe Renovation) which is covered by 454 CMR 22.00 as potential illegal de-leading. The DPH has implemented many, many policies without public comment. These policies are provided only to the licensed lead inspectors with whom they enforce. This gives no opportunity for the public for whom these policies affect to review or participate in such implementation. The licensed inspector community are the mechanism to deliver such policy to the public when performing services. Also many policies prohibit sound construction practices and dictate whom performs certain actions. This is related to the former DPH CLPPP 9 policy on renovations. The DPH process for waivers of policies prevents timely completion of work and often no guarantee will receive such waivers. This can impact receipt of compliance documents and can put a financial burden on property Owner's. The interpretation and implementation of policies and regulation is ambiguous by the leadership of the DPH.
Suggestions for improvements to the regulation::	Eliminate the separate regulatory agency (DPH) and place with the DLS where the de-leading procedures are in place. Controlled by a single entity which would license both the inspectors and contractors, would allow for standards to be consistent within one agency. This is not unlike asbestos

where both the inspector and the contractor are licensed by a single agency. More recently dialogue has started to take shape due in part to the persistence of groups such as Lead and Environmental Hazards Association (LEHA) MA Chapter, which includes licensed inspectors and contractors frustrated by the inconsistency in regulations, to request joint meetings with the DLS and DPH.

[redacted]

From: noreply@formstack.com
Sent: Wednesday, January 06, 2016 10:33 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 10:33 AM

Name (optional)::	Randall Phelps
Company/Organization (if applicable) (optional)::	Phelps Food Service Consultants
Address (optional)::	
Primary Phone (optional)::	
Email (optional)::	
CMR Number (If known): :	
General Regulatory Themes::	Other
Please list the Agency or Agencies affiliated with this regulation::	All MA BOH
Describe the regulatory issue or observation::	Adoption of the most current Federal Food Code is crucial. Regulatory agencies throughout the Commonwealth are enforcing varied editions of the code blended with 105 CMR 590. Consistency is needed!
Suggestions for improvements to the regulation::	

[redacted]

From: [redacted]noreply+09f621abec398b53@formstack.com>
Sent: Wednesday, January 06, 2016 10:43 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 10:43 AM

Name (optional)::	Donna Moultrup
Company/Organization (if applicable) (optional)::	Massachusetts Health Officers' Association
Address (optional)::	[redacted]
Primary Phone (optional)::	
Email (optional)::	[redacted]
CMR Number (If known): :	Chapter 2, State Sanitary Code
General Regulatory Themes::	Housing
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health, Community Sanitation Division
Describe the regulatory issue or observation::	The State Sanitary Code needed updates many years ago. A new code is ready to go but there hasn't been the staffing or political will on the part of State government to see that it happens. This code is about health and safety and many of the updates have to do with clarifying enforcement. It may cost the landlords a few more dollars but they are collecting considerably more than they are spending on housing and it is middle to lower income families who are suffering. This needs to get done!
Suggestions for improvements to the regulation::	Adopt the updated version of the housing code.

[redacted]

From: [redacted]noreply+09f621abec398b53@formstack.com>
Sent: Wednesday, January 06, 2016 10:56 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 10:55 AM

Name (optional)::	Donna Moultrup
Company/Organization (if applicable) (optional)::	Massachusetts Health Officers' Association
Address (optional)::	[redacted]
Primary Phone (optional)::	
Email (optional)::	[redacted]
CMR Number (If known): :	590.000
General Regulatory Themes::	Other
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health, Food Protection Program
Describe the regulatory issue or observation::	Mass. has always had its own Food Code. In 1999 Mass. adopted the Federal Food Code and had additional requirements in 590.000 because the State wanted some stricter guidelines than in the Federal Food Code. The official code in MA is still the 1999 code! It is so out of date from the current 2013 Federal Food Code with 2015 amendments that cities and towns are now taking it upon themselves to adopt the 2013 code. In my opinion, the entire code, inspectional training, inspections, inspection reports, ability to use available technology and any semblance of consistency is gone. We must adopt the 2013 code and restore consistency to the State. The process has begun, but a shortage in staffing in Food Protection is slowing it considerably. This should be a priority for 2016. Again, there may be some regulatory changes that will cost the food service industry some money, but we are talking about health and safety here, and in many cases, simply clarifying the requirements, and in other cases, due to the science, making some things less restrictive.
Suggestions for improvements to the regulation::	Make Food Protection a priority for 2016.

[redacted]

From: [redacted]<noreply+f30856dea3f62e92@formstack.com>
Sent: Wednesday, January 06, 2016 11:04 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 11:03 AM

Name (optional)::	Terry Gilchrist
Company/Organization (if applicable) (optional)::	Westboro Board of Health
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	105 CMR 590.000
General Regulatory Themes::	Building Codes/Accessibility Standards
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health
Describe the regulatory issue or observation::	As a regulator for my town for 24 years I am embarrassed when I go out to do my job and we are still enforcing the 1999 Federal Food Code. It is now 2016 and we should be enforcing the latest Federal Food Code which came out in 2013. There have been so many changes regarding the safety of food and also so many instances of Foodborne Illnesses that have taken place in the last 5 years, yet we are only enforcing the 1999 food code. This to me is a huge embarrassment to the regulators who are out in the field trying to keep the public safe when eating out. Please, I truly believe that we need to adopt the 2013 Federal Food Code as it is imperative that regulators have the latest Food Code when implementing or making sure that food establishments are complying with the regulations.
Suggestions for improvements to the regulation::	Please allow the DPH to adopt the latest Federal Food Code (2013)

[redacted]

From: [redacted]noreply+0c842d1326df2c1e@formstack.com>
Sent: Wednesday, January 06, 2016 11:07 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 11:06 AM

Name (optional)::	Steve Rice
Company/Organization (if applicable) (optional)::	MA DPH Food Protection Program
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	
General Regulatory Themes::	Other
Please list the Agency or Agencies affiliated with this regulation::	Local BOH 105 CMR 590 (Food Code)
Describe the regulatory issue or observation::	retail food establishments are not required to monitor temperatures of perishable foods while in cold storage. retail food establishments that pick up perishable foods are not required to transport these foods under refrigeration (mechanical, insulated, or otherwise including use of gel packs or ice) from the supplying facility to their food establishment. All one has to do is visit any major food supplier (Food Mart Road, Southhampton Street, Boston Fish Pier, Seafood Way, Channel Street as some examples in Boston or any Restaurant Depot) and you will see perishable foods placed into common passenger vehicles or pickup trucks; there is no regulatory means to protect public safety for time / temperature abuse during this transportation period. both of these issues are coverd under wholesale regulations; why the gap for retail?
Suggestions for improvements to the regulation::	cooler logs with 2x/day record of all refrigeration units in a retail establishment if retail food establishments choose to pick up, rather than have delivered, any perishable foods, that they be done so with insulated mechanical refrigeration capable of maintaining refrigerated foods at <41*F and frozen foods at <0*F, as required under 105 CMR 500 for wholesale distribution (this may be as

simple as a cooler plugged into a power supply on the vehicle) or in an insulated cooler with sufficient gel packs or ice to maintain perishable foods <41*F during the period of transportation.

[redacted]

From: [redacted]reply+8833a3736f752e0f@formstack.com>
Sent: Wednesday, January 06, 2016 11:55 AM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 11:55 AM

Name (optional)::	Derek Fullerton
Company/Organization (if applicable) (optional)::	Massachusetts Health Officers Association-President
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	
General Regulatory Themes::	Public Safety
Please list the Agency or Agencies affiliated with this regulation::	Public Health
Describe the regulatory issue or observation::	State Food Code – Chapter 10 of the State Sanitary Code, 105 CMR 590.000 adopted by the Mass. Dept. of Public Health on 10/13/2000 to amend 1999 Food Code Currently Massachusetts Public Health Officials are regulating off an outdated Federal Food Code of 1999. The current FDA food code is of 2013 and local health departments are not able to be standardized in inspections, compliance, and enforcement in parallel fashion as the nation. In addition, operating off a previously adopted food code prohibits local cities and towns to have standardized inspections, standardized trained inspectors, and prohibits possible qualifications in funding from federal grants (i.e. FDA) .
Suggestions for improvements to the regulation::	Having the MADPH Food Regulatory Program expedite the adoption of the 2013 Federal Food Code and properly update/merge with the 105 CMR 590.000 Thank you!

[redacted]

From: noreply@formstack.com
Sent: Wednesday, January 06, 2016 12:10 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 12:10 PM

Name (optional)::	
Company/Organization (if applicable) (optional)::	
Address (optional)::	
Primary Phone (optional)::	
Email (optional)::	
CMR Number (If known): :	410.000 & 590.000
General Regulatory Themes::	Other
Please list the Agency or Agencies affiliated with this regulation::	State Sanitary Codes for the Minimum Standards for Human Habitation and Food Service Establishments
Describe the regulatory issue or observation::	Ongoing review and updating should be moved to hearing and enactment
Suggestions for improvements to the regulation::	Use the suggestions of the sitting committees for both regulations.

[redacted]

From: noreply@formstack.com
Sent: Wednesday, January 06, 2016 12:06 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 12:06 PM

Name (optional)::	Marlene Johnson
Company/Organization (if applicable) (optional)::	Burlington Board of Health
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	
CMR Number (If known): :	105 CMRs: 590.000 and 105 CMR 435.000
General Regulatory Themes::	Other
Please list the Agency or Agencies affiliated with this regulation::	Local Boards of Health (all above regulations) Food Service Establishment owners/managers (590) Food Consultants and CFPM Trainers (590) Hotels, Condos, Apt. Complexes, clubs, schools with commercial swimming pools (435) Contractors/Engineers who build/plan commercial swimming pools (435) Certified Pool Operator (CPO) instructors (435)
Describe the regulatory issue or observation::	105 CMR 590.000 is outdated. The FDA 1999 Food Code was adopted in 2000 via this regulation. FDA has published most recently the 2013 Food Code and food safety instructors use tests (for required certifications) that are based on new information in the 2013 Food Code. Health Agents/Inspectors are enforcing out of date regulations and MA needs to become current with industry and national standards. 105 CMR 435.000 is unclear in many areas such as what is a "shallow end". The minimum chemical standards for pools and spas relative to Free Chlorine (FC) and Combine Chlorine (CC) need to be changed to industry standards. Types of outdoor enclosures (fencing) needs to be more defined. Log sheet at end of regulations needs to be removed or improved. Language needs to be added under enforcement that the "agent of the Board of Health" may suspend the pool permit if an imminent health hazard exists and define those in the regulations. Currently the owner/manager has to come before the Board of Health (BOH) at a meeting and the BOH must vote to suspend the permit. Health Agents/Inspectors have to persuade the operator to voluntarily close

	the pool on the spot (i.e. when chemical standards for FC and/or CC are not met).
Suggestions for improvements to the regulation::	105 CMR 590.000 - do not have a "working group" and compare the last 3 food codes. The appropriate Food Protection Program staff should just adopt a newer food code (i.e. 2009 or 2013) and then strike and modify sections within 105 CMR 590.000. Before they are finalized all Boards of Health should have adequate time to review and submit input and suggestions before final promulgation. Just read the 2013 food code and decide what stays, what goes and what you want to add. 105 435.000 - The appropriate Community Sanitation Program staff should review the Model Aquatic Health Code (MAHC) which was finalized and published by the CDC in Aug. 2014 for the latest industry and regulatory standards. Adopt sections of this code and modify where needed. Before they are finalized all Boards of Health should have adequate time to review and submit input and suggestions before final promulgation.

[redacted]

From: [redacted]<noreply+43a68dc31c501553@formstack.com>
Sent: Wednesday, January 06, 2016 12:31 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 12:30 PM

Name (optional)::	Brian LaGrasse
Company/Organization (if applicable) (optional)::	City of Methuen
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	
General Regulatory Themes::	Building Codes/Accessibility Standards
Please list the Agency or Agencies affiliated with this regulation::	Health Department
Describe the regulatory issue or observation::	State Sanitary Code, Chapter II (State Housing Code); Federal Food Code
Suggestions for improvements to the regulation::	Update State Sanitary Code; Adopt latest version of the Federal Food Code, we are currently working off the 1999 Food Code

[redacted]

From: noreply@formstack.com
Sent: Wednesday, January 06, 2016 12:40 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 01/06/16 12:40 PM

Name (optional)::	
Company/Organization (if applicable) (optional)::	
Address (optional)::	
Primary Phone (optional)::	
Email (optional)::	
CMR Number (if known): :	
General Regulatory Themes::	Children and Families
Please list the Agency or Agencies affiliated with this regulation::	
Describe the regulatory issue or observation::	I believe a lot of the staff is under qualified or simply does not care. There have been way too many cases where children who were supposed to be under the watch of the Department, had horrible things happen to them.
Suggestions for improvements to the regulation::	Lighten case loads, require all staff attend mandatory ongoing training on what to look for and how to handle cases. Make sure the staff are educated and actually WANT to do their job. Anyone who is simply clocking in for a paycheck... that is not the job for them. These are CHILDREN that they are supposed to be protecting. DO BETTER.