

## PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, May 14, 2008, 9:00 a.m., at the Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen R. Caulton-Harris, Mr. Harold Cox, Dr. John Cunningham, Dr. Michèle David, Dr. Muriel Gillick, Mr. Paul J. Lanzikos, Mr. Denis Leary, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, Dr. Michael Wong and Dr. Alan C. Woodward. Dr. Barry S. Zuckerman was absent. Also in attendance was Attorney Donna Levin, General Counsel, Department of Public Health.

Chair Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. Chair Auerbach noted changes in the agenda. Item 1b, Record of the Public Health Council Meeting of February 13, 2008, was pulled from the agenda. Item 3, Request for Final Promulgation of Amendments to Minimum Requirements for the Management of Medical or Biological Waste, State Sanitary Code, Chapter VIII – 105 CMR 480.000, was pulled from the agenda. Chair Auerbach asked the Council Members to introduce themselves to the audience.

### **COMPLIANCE MEMORANDUM:**

#### **PREVIOUSLY APPROVED PROJECT OF MERRIMACK VALLEY HEALTH SERVICES, INC. – REQUEST FOR A TRANSFER OF SITE OF A MAGNETIC RESONANCE IMAGING UNIT FROM ONE OF FOUR HOSPITAL-BASED SITES TO FREE-STANDING SITE IN NORTH ANDOVER:**

Commissioner Auerbach noted that Attorney Susan Stein would serve as alternate for General Counsel Donna Levin for this presentation. Ms. Joan Gorga, Director, Determination of Need Program, began "...Merrimack Valley Health Services (MVHS), a hospital consortium, is before you today for a Transfer of Site, to move one of its four mobile MRI's from one of its member hospitals to a suburban site in North Andover, four and a half miles away. Merrimack Valley Health Services is a regional, multi-city, multi-unit hospital sponsored consortium. Merrimack Valley Health Services was established by its member hospitals, then six in number, in 1986. It presently has three members, each of which has committed to remaining in the consortium until the end, at least, of 2011. Merrimack Valley Health Services began with one MRI unit and, over the past twenty years, has been approved by the DoN program for three additional units. Each approval has been to provide services at the member hospitals, but the approvals have never specifically linked to individual hospitals. All member hospitals were mentioned in each approval letter. Merrimack Valley Health Services was permitted flexibility in serving the

patient population. Merrimack Valley Health Services now seeks to move the unit presently located at Lawrence General Hospital to a site in the contiguous town of North Andover, leaving the unit originally used at Lowell General Hospital at Lawrence General. Because Merrimack Valley Health Services serves the entire Merrimack Valley from Lawrence and originally Lowell to Newburyport, and because its service area includes major cities, the service module for a town like North Andover appears smaller as a percent of the whole volume than it would be if the service were based at a single hospital..." Ms. Gorga continued, "For example, North Andover ranks seventh for 2007 on the total Merrimack Valley Health Services Patient Origin list; but, for the unit placed at Lawrence General, the unit which MVHS seeks to move, North Andover ranks third. Since North Andover is among the first seventy-five percent of cities and town on the Patient Origin list of Lawrence General, the applicant meets the first part of the test in the regulation that the proposed transfer will not substantially change the population served by the facility. In order to analyze the second part of the regulation, that North Andover not appear higher on the discharge list of another facility, Staff requested data from another provider in the area, Rehab Associates of New England, or RANE. North Andover ranked fifth on RANE's list and, therefore, Staff concluded that the Lawrence site of MVHS, which ranked third, met the regulatory standards. Staff did not use the data from the Lowell General unit, previously operated by MVHS at Lowell, for several reasons. It has not been in the MVHS system for almost two years. The actual equipment is parked, unused, on the campus of Lawrence General, and its data has been removed from the volume totals of MVHS. To include it in the analysis might lead to double counting, since Lowell General, through its individually licensed MRI unit, at present is serving the patients originally served by that unit."

Ms. Gorga continued, "Staff also looked at the expansion of the Lawrence unit into North Andover in another way. If the Lawrence General unit had been an individual hospital-based MRI under the license of Lawrence General, and had applied for a satellite unit in North Andover under the MRI expansion guidelines of the DoN Program, it would have been approvable. Since it was an occupancy of ninety-three percent, as well as waiting times over ten days, and a schedule of operation which included over ten hours per day, it meets the requirements of the guidelines. Instead, MVHS is seeking to use the equipment it presently owns, therefore not expanding its total supply, and to move it to a location in the center of the service area it presently serves. Staff, therefore, is recommending approval."

Next, Attorney Peter Braun, Legal Counsel for Merrimack Valley Health Services, addressed the Counsel. He said in part, "...It was established by community hospitals, all of which are non-profit...This was formed back in the 1980's because of the MRI guidelines that were then in effect...MVHS is one of several of those that were formed among community hospitals, and what they chose to do was form a separate legal entity called Merrimack Valley Health Services and get a tax exemption and run it as a non-profit, as a separate organization from the hospital, and they have stuck together through more than twenty years now. Even though the guidelines no longer require it, they basically invested themselves in good planning and good regional

cooperation among these hospitals...What they started was the concept of having a freestanding facility in North Andover and that was viewed as a regional approach that was going to be a central location that would serve inpatients as well as outpatients...Amidst planning for that and realizing the costs that were involved, and their own uncertainties about MRI, they decided to use a brand new technology of mobile units and not build a freestanding facility at that time...Soon after that, they realized they needed two, so they got a second DoN very quickly, and then ten years later received a DoN for a third, about five years later, a fourth, and that is where it stands today; four mobile units, all conceived as a regional approach, but the sites for the services stayed at the hospital campuses. With Lowell dropping out, it meant that they had three sites and still have four units... So, what they are seeking now is a site back in the suburbs...It will alleviate some serious problems that have occurred with the mobile units particularly on the Lawrence General Campus, as well as some on the Saints campus. Both of those are full. They are basically in the ninety percent plus utilization level that would entitle them, if they were solo, to expand; but, in addition, inpatient volume is extraordinary, particularly on the Lawrence campus, exceeding thirty to thirty-five percent on some days, which creates tremendous complications in terms of people's convenience in being able to schedule...So, this is meant to be a convenient location for the service area that the organization has always provided, as well as to attempt to alleviate some of the volume problems created by the inpatient volume..."

Next, Phillip Katz, Director of Development for Rehabilitation Associates of New England, addressed the Counsel. He said in part, "I am here in opposition to Merrimack Valley Health Services' transfer of site request, which I believe should be denied for several reasons. First, and most importantly, the application before you today is not consistent with what MVHS even applied for. In both its Public Notice and its submitted request, MVHS states the following: "MVHS requests the transfer of its Lowell General Hospital campus site to a suburban office park located in North Andover, Mass. MVHS clearly requested a transfer of site for its Lowell General unit. However, Staff has analyzed this request as if it was a transfer of the Lawrence site, and this is flawed...The staff summary states that MVHS seeks to relocate the unit currently at Lawrence General to a suburban office park in North Andover 4.5 miles away from Lawrence...leaving the unit previously used by Lowell General at the Lawrence General site. However, the Lawrence location is not closing. This is simply a reshuffling of the MRI devices in an effort to support the so-called transfer of site and with it the authorization for services. DPH should not encourage what can be construed as a shell game by MVHS...Moreover, the request filed by MVHS says nothing about transferring the Lowell scanner to Lawrence and then transferring the Lawrence scanner to North Andover. The DoN regulations are clear. The Department must analyze the discharge data for the facility that is proposed to be transferred. No analysis of the discharge data for the Lowell facility has occurred. Why not? We suspect that it is because it would not support approval of the request."

“Second,” Mr. Katz continued, “This proposal is not consistent with what MVHS has received DoN approval for, namely mobile MRI at a hospital consortium site. I was at the original hearings regarding MVHS years ago, and I can assure you that MVHS was approved for a mobile, hospital-based model. The free-standing model proposed here is clearly a new DoN for a fixed site, in a new market, that requires full review. Third, and perhaps most importantly for DPH as a policy matter, approval of this request will set a bad precedent. Let’s consider the facts. At its height, MVHS had 6 hospital members and 4 MRI units. It now has only 3 hospital members, but it still has 4 MRI units. Therefore, the request before you raises this important question: If the 3 remaining members of MVHS all do what Lowell General did, i.e., leave the consortium and get their own MRI scanners, would the MVHS entity still control four MRI approvals? In other words would the system end up with three additional hospital-based MRIs as well as the four more units that MVHS could place elsewhere?”

Mr. Katz concluded, “Finally, contrary to what is stated in this application:

- MVHS is not the primary provider of MRI scans in the North Andover area (RANE is).
- The service area is being changed (because the scanner in question comes from Lowell) and there will be a significant duplication of services if this request is approved.
- Moreover, the site to which MVHS proposes to transfer the Lowell MRI is not viable – either from a clinical or siting perspective.
- How will radiologists interpret studies – will they be on site to interpret studies and to administer contrast?
- This is an existing office building. How will shielding, cryogen vents, and other siting requirements be installed?
- Also from a clinical and need perspective, the largest medical group in the area, Pentucket, opposes the project.
- Let’s also consider the history here. A “significant amendment” was required in 1988 to convert the original MVHS approval from a fixed freestanding MRI to a mobile MRI service based on hospital campuses. Why isn’t a “significant amendment” and full DoN review now required to reverse this?”

Mr. Katz said, “I appreciate your consideration of the points I have raised. For all these reasons, the present request should not be approved.”

Ms. Gorga responded. She said in part, “It is true that this is a reshuffling, but as I indicated in my prior remarks, they have been awarded, in approved Determinations of Need, without hospital specificity. So they have a flexibility to reshuffle the units. That was the idea in giving them that permission. They don’t have to ask to put two units now at Lawrence, for example. They moved the Lowell unit to Lawrence because that is their entire service area, and they have that flexibility...”

After consideration, upon motion made and duly seconded, it was voted: (unanimously; Dr. Barry Zuckerman not present to vote) **to approve Previously Approved DoN Project Merrimack Valley Health Services Transfer of Site of Magnetic Resonance Imaging (MRI) Unit.**

**PROPOSED REGULATION: INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO MINIMUM STANDARDS GOVERNING MEDICAL RECORDS AND THE CONDUCT OF PHYSICAL EXAMINATIONS IN CORRECTIONAL FACILITIES – 105 CMR 205.000:**

Ms. Suzanne Condon, Director, Bureau of Environmental Health said in part, "...As some of you may be aware, one of the important programs that are part of the Bureau of Environmental Health is the Community Sanitation Program...Our Bureau and our Community Sanitation Program are responsible for insuring that minimum health standards are met in correctional facilities, as they relate to a range of issues for the inmate population. Dr. DeMaria approached us several months ago with some interest in modifying the regulations based on what he saw was really a declining level of concern about certain outcomes amongst the prison population and his capacity to meet all of the standards and ensure that the best available health care was being provided to the inmate population. And so, for that reason, any change in the minimum standards does require amendment to our regulations; and so we very much support Dr. DeMaria and the Bureau of Communicable Disease Control in this request."

Dr. Alfred DeMaria, Director of Communicable Disease Control, said in part, "...At the beginning of the year, the staff of the Bureau of Communicable Disease Control and the Bureau of Laboratory Sciences were asked, as an exercise, to review all of the activities we were involved in, to see where we were getting value for the resources expended, and one of the results of that analysis was word from the STD Prevention Division that we were doing thousands of syphilis serologies on inmates in the state and county facilities, but we were not finding cases of syphilis...The incidence of syphilis has gone down markedly and the epidemiology has changes substantially and we were not getting the yield that we had been getting back in the early nineties. One of the correlatives of this exercise is that we would actually take action and do something about what the Staff identified in activities that we did not feel were giving us value for the resources. Then we had a meeting between STD Division and the laboratory and looked at what we were doing, how much it was costing, how much time it was taking and where those resources could be better applied, and proposed to discontinue this. We surveyed our partners in Corrections, and they also were spending significant resources, collecting the specimens and transporting them to the State laboratory outside of their usual laboratory system. So, taking all that together, we proposed to stop doing the test and asked the Division of Community Sanitation if we could move forward and amend the regulations so that the corrections facilities would then be able to discontinue doing the testing within the bounds of their regulatory requirements."

Chair Auerbach commented, "...Just to quantify that according to the memo we have, it looks like the cases of reported syphilis have dropped from eleven hundred seventy-five in 1990 to, in terms of those identified in correctional screenings in the most recent calendar year, only four. So, a very significant decrease. Just to clarify, what we are talking about at this point is putting out for public comment a proposed change to a regulation. So, this would probably come back within thirty to sixty days for a final vote."

Dr. Michèle David, PHC Member, said in part, "I was looking at the whole minimum standard, and I was wondering if there is one other area we might be able to amend, and that is the area where it talks about females having to have a pap smear at every check up since every inmate is required to have a physical exam within three months. I am wondering if they should have a pap smear if they have not had a pap within the previous twelve months."

Dr. DeMaria said, "I think this is an unusual circumstance because there is statutory requirement for us to have regulations around admission physical examination, and originally the intent was to have a baseline health evaluation of inmates on entering the system...Public Health felt, at some point probably in the late seventies and eighties, that this was an opportunity to promote improved public health screening and public health intervention....going beyond just making sure that people had a baseline health status evaluation on admission to doing things like pap smears and screenings for various communicable diseases as those screening methodologies became available. So, I think it is just an unusual circumstance."

Dr. Alan Woodward said, "I think one way you could do it is at the end, you could say, as appropriate. They could have had a CBC a week ago, also. If there is recent lab that has been acquired through another mechanism, and you have a way to verify it, then the redundancy on any of these things seems inappropriate."

Dr. Meredith Rosenthal, PHC member, said, "For covering part of these, could we say, consistent with Preventative Health Task Force recommendations?"

Dr. Muriel Gillick, PHC member, said, "There is another one which seems to require pregnancy tests of all women, regardless of age, which seems a little bit out of line, but has nothing to do with preventative guidelines."

Chair Auerbach said, "I see a grudging willingness to allow that language which maybe we can clean up when we get the final because I think that the idea here is to have something that we feel comfortable with..."

Dr. Michael Wong, PHC member, said, “Since we are talking about public health, and trying to take things into the twenty-first century..., what about some language on certain types of screening on discharge or release from corrections facilities? Much of this has been focused on entry into facilities and the concept that inmate health is going to be maintained, but we certainly know certain behaviors and risk activities occur within the walls, and in many cases, many inmates, upon release, don’t know that they have acquired something.”

Mr. Paul Lanzikos, PHC member, said, “I think the notion is admirable...I would suggest though, rather than us trying to formulate public policy in the space of these meetings, that we would direct Staff to more thoughtfully consider, analyze this, have dialog with the Department of Corrections and other appropriate entities...”

Comment [KOG1]: Did he say minutes or meetings?

Dr. Rosenthal, PHC member, commented, “...As we go forward and contemplate final roles here...I think there is a real distinction between infectious disease, communicable disease and some of these other things...There are lots of opportunities for people to have different preferences, particularly people who don’t have access to regular health care once they are out of the prison system. So I would like us to think a little bit harder about what must be done and what must be offered. I think there is a very clear case for having to do testing for communicable disease in the prison system. I think there is much less clear case of requiring a CBC [complete blood count], for example, if a patient does not want it.”

Next, Chair Auerbach said, “We had talked earlier about having the language that talked particularly about having the test performed as appropriate or consistent with the established national guidelines. All in favor of making that language change for the release? Do I have a motion to make that?” Council Member Lanzikos moved. Council Member Rosenthal seconded. All public health council members voted in favor. Public Health Council Member Zuckerman absent. Chair Auerbach continued, “...The suggestion was also not to have specific language, but to say that we are also soliciting from people their comments or thoughts about the balance and steps that might be appropriately taken to ensure that there is voluntary agreement to proceed with the tests, among the patient population, consensus that it is fine to do.” All Public Health Council members were in agreement. Public Health Council Member Zuckerman absent.

**PROPOSED REGULATIONS: INFORMATIONAL BRIEFING ON PROPOSED REGULATIONS FOR THE CONGENITAL ANOMALIES REGISTRY – 105 CMR 302.000:**

Ms. Sally Fogerty, Director, Bureau of Family Health and Nutrition, said, “The purpose of this memorandum is to inform the Council of the Department’s intention to hold public hearings to receive comments on proposed Congenital Anomalies Registry Regulations (105 CMR 302). Congenital anomalies, also called birth defects, affect one in 33 babies nationwide, are a leading cause of infant mortality, and contribute substantially to the burden of medical costs, disease and

disability. The proposed regulations, mandated by M.G.L.c.111 § 67E, standardize definitions, delineate the scope of required reporting and describe the conditions for confidentiality protection and release of the data. In April 2002, the Massachusetts Legislature amended the state law that provided for mandated reporting of birth defects (M.G.L.c.111 §67E). The revised law: (1) requires physicians to report a congenital anomaly, birth defect or birth injury to the Department within 30 days of diagnosis; (2) increases mandated reporting of a diagnosis in a child up to age three; (3) sets our requirements for the use of this data for the purpose of reducing morbidity and mortality from birth defects in the Commonwealth; and (4) requires the Department to promulgate regulations governing the operation of the Birth Defects Monitoring Program. The proposed regulations represent the collaborative efforts of the Department's Bureau of Family Health and Nutrition working with an Advisory Committee established for this purpose. The Department has been working with clinicians, hospitals and professional organizations to develop regulations that are consistent with our goal to monitor patterns and trends of congenital anomalies in Massachusetts, link families with services, and assess service needs."

Ms. Fogarty continued, "The proposed regulations:

- Require reporting and authorize collection of information about specific congenital anomalies and significant birth injuries from any physician making such a diagnosis, including the following information: personal identifiers, demographics, diagnoses, diagnostic codes, physician identifiers, and hospital provider identifiers.
- Streamline reporting and minimize burden on physicians by authorizing medical records personnel in health care facilities (hospitals) and physician practice groups to act as agents for physicians for purposes of reporting.
- Authorize the Department to collect additional information (in addition to data items collected on the reporting form) subject to approval of a duly constituted institutional review board.
- Authorize release of data pursuant to M.G.L. c.111 §24A to researchers for approved public health studies through a duly constituted review board, whose technical and ethical research review informs the process. Researchers must provide protocols and written assurances for maintaining confidentiality.
- Establish an advisory committee to provide ongoing consultation to the Registry.

Ms. Fogarty concluded, "The proposed regulations, mandated by M.G.L. c.111§67E, establish the parameters of the Massachusetts Congenital Anomalies Registry in order to strengthen the State's ability to monitor congenital anomalies, investigate clusters of congenital anomalies,

assess need for services and link affected families to available services. The Department intends to hold public comment hearings in several locations across the state. Following hearings, we will return to the Public Health Council in the summer 2008 to provide a review of the testimony, to present any changes proposed in response to the testimony, and to request approval for final promulgation of the proposed amendments.”

**No Vote/Informational Only**

**PRESENTATION: “2007 HEALTH RISK BEHAVIORS OF MASSACHUSETTS YOUTH”, BY ANTHONY ROMAN, PH.D. AND CAROL GOODENOW, PH.D., DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION (ESC) AND DONNA JOHNSON, DIRECTOR, MDPH DIVISION OF PRIMARY CARE AND HEALTH ACCESS:**

Dr. Anthony Roman, Director, University of Massachusetts, Boston Center for Survey Research, began the presentation. He said in part, “...What we are going to talk about here today is the consolidation and the integration of two state sponsored large data collection efforts among public school students in Massachusetts...” The Youth Risk Behavior Survey has been conducted by the ESC with funding from the Centers for Disease Control since 1990...producing reports of health characteristics in the State. It is conducted in a high school, grades nine through twelve, and it is done every other year. It covers risk behaviors, tobacco, alcohol use, drug use, as well as sexual behaviors, suicidality, and other issues on top of that. The Youth Health Survey is done by the Department of Public Health. It was done several times throughout the 1990’s ...in grades seven through twelve....From a survey methodology standpoint, both were done very well....The advantages of consolidation and integration were obvious to us. It saves time and money...It increases the number of survey topics and survey questions across both surveys. We were able to increase the information that we were going to get at the same time. The methodology is now completely comparable...It also makes for a single release of data...What we have done in this first go-round is develop an infrastructure. We need to have cooperation with ESC and DPH on data sharing, data release...”

Next, Dr. Carol Goodenow, Department of Elementary and Secondary Education, said in part, “...Lots of good news. The bottom line on this is that there are a great many areas in which we have seen incremental improvement even just since 2001...Currently, drinking has dropped. Now, fewer than half of high school students report having had a drink in the past month. First drink before age thirteen has dropped down. There has not been a statistically significant drop in the binge drinking. That is five or more drinks in a row, but the general trend here is very good...Eight percent of middle school students have had a drink. Three percent have engaged in binge drinking in the past month.”

Dr. Goodenow continued, “Tobacco use is also showing some improvement. For the first time, fewer than half of Massachusetts public high school students have ever tried a cigarette. We have seen a drop and I know that this is not parallel with the national level....Smoking below age thirteen has gone down, too. At present, seven percent of high school students report having used smokeless tobacco. About fourteen percent of seventh grade students have ever smoked cigarettes. Four percent had smoked in the last month....There have been declines in a number of drug use indicators. Lifetime marijuana use is down. Current marijuana use is down, although at twenty-five percent, significantly more kids are likely to have used marijuana in the last month than to have smoked a cigarette...Ecstasy use is down. Amphetamine use is down. Kids saying that they have been sold, offered, or given illegal drugs on school property is down...Clearly, there are a significant minority of high students who are using prescription drugs that are not their own, and the same thing is showing up in middle school students. Injury-related behaviors are down. There is less physical fighting and fewer kids reporting that they were threatened or injured with a weapon at school in the past year. Fewer kids report suicidal ideation, that they have considered suicide in the past year, or that they have made a suicide plan in the last year; fewer kids report riding with a driver who had been drinking. Also, we are finding that there are more kids who are using seat belts. There are fewer kids who are reporting drinking after driving.”

Dr. Goodenow continued, “Again, here are things that we hope to see trends on the next time around. From a risk behavior point of view, these are often overlooked but major causes of school absenteeism, which of course is a big issue for us, having to do not with risky behavior, but with chronic conditions. The report found that over a third of high school students and slightly under a third of middle school students have had a cavity in the last year. A fifth to a quarter of students have been diagnosed with asthma. Four percent of high school students and three percent of middle school students have been diagnosed with diabetes....We are seeing some very positive trends in protective factors. There has been an increase in high school students who said that they could talk to a teacher or other school staff member if they had a problem...We found an increase in high school kids who said they could talk to parents or other family adults about things that are important to them. Kids who do have a relationship with their parent and family adults engage in fewer risk behaviors. Currently, about eighty-six percent of high school and eighty-seven percent of middle school students, were getting at least decent grades, A’s, B’s, or C’s, and eighty-eight percent of students have seen a dentist in the past year and over eighty percent of kids have a primary care physician that they see for a regular checkup or medical needs....In one issue after another, what we are seeing is a lot of incremental improvement. There are a few areas that really have not budged much. One of them, which is really a concern, is the epidemic of obesity. We have not seen any improvement in dietary behavior or physical activity. No change has occurred in fruit and vegetables consumption.”

Dr. Goodenow concluded, “...The general picture is very good. Significant reductions in many areas of risk behavior. What we want to do in the future is really zero in and pay more attention

to those programs, both school programs and community programs, and work with parents and doctors to try and address prevention and find ways to foster healthy development.”

Several Council Members (Ms. Helen Caulton-Harris, Chair John Auerbach, and Mr. Harold Cox) asked if the data could be applied to individual communities or cities especially in regard to racial disparities. It was noted that the data could only be applied statewide. Chair Auerbach noted, “I would relay a serious concern about the applicability of the data to many of the communities that we are most concerned about some health problems that we have identified through looking at racial and ethnic disparities; it’s an odd message for us to look at a report and then feel like it is not relevant to those communities...On behalf of the Council, a very strong encouragement that the data that gives us the insight into the sub-population be released as soon as possible, or else we really can’t use this to the fullest degree, in terms of it being helpful in addressing community issues.” Discussion continued; please see the verbatim transcript for full discussion.

Ms. Donna Johnson, Director, MDPH, Division of Primary Care and Health Access, said in part, “...We have developed a continuum of Substance Abuse programs for youth and young adults...A very innovative program we currently have in our Massachusetts Tobacco Prevention effort is an interactive web site, developed by our Tobacco Control Program, that focuses on the 84 percent of the youth in Massachusetts who are not using tobacco, and it shares activities and their efforts at mobilizing youth to engage other youth in being smoke-free young adults. Another of our innovative areas is Youth Violence Prevention grants, recently released and funded here at DPH, that use a very comprehensive approach to addressing violence prevention. In our Nutrition and Physical Activity unit, we have a program called the Health Choices Effort, that utilized a comprehensive curriculum called Planet Health-Eat Well and Keep Moving, in addition to the 5-2-1 School Curriculum focusing on five vegetables a day, two hours or less of television watching and one hour of physical activity...”

Ms. Johnson continued, “In our Essential School Health Area...for two years the school health staff collaborated with UMass Medical School on a significant control study looking at an innovative tobacco cessation effort...What is exciting right now is that the study has expanded to other schools, looking at longitudinal impact of the Smoking Cessation program and now we are looking at adapting that curriculum and seeing if it can be used by school nurses, again in partnership with UMass Medical School, to focus on overweight and obesity, utilizing school nurses with a very structured curriculum. That is very exciting and there are focus groups going on now with students, parents, teachers, and health educators around the feasibility of doing that, and the willingness to participate in the program.”

Ms. Johnson said, “Also in School Health, we had a recent forum where our School Health staff met with the AAP, the Mass. Association of School Nurses, and the School Physicians Committee around how can they better collaborate and coordinate, particularly around the

obesity crisis. Blue Cross/Blue Shield has been an active partner in those discussions, and recently has funded mini grants to support primary care providers and school nurses in local communities to get together and have conversations about how they could better collaborate, share information, and address some of the high risk obesity issues and overweight issues with the schools. We have about forty-seven School-Based Health Center Programs across the state. They primarily provide primary care services in the middle schools and high schools and some elementary schools. They target the schools that have the highest need, kids who are most at risk of not being able to access primary care services, kids who have the greatest health disparities... We have additional mental health/substance abuse expansion grants or enhancement grants for school-based health centers in the state, and within those programs, they are doing a very intensive analysis of the barriers to getting mental health and substance abuse treatment referrals, and they are using the risk assessment. They are linking with the community. The School-Based Health Center Programs are providing education to the parents and teachers around the mental health and substance abuse issues.”

Ms. Johnson said, “Another area I think it is important for you to hear about is our Healthy Development program which funds Teen Pregnancy Prevention Programs across the state. These are pregnancy programs that are using science-based curriculum to approach the teen pregnancy issues in the highest need, or highest pregnancy rate communities in the state. Some are based in schools. Some are based in housing projects... They frequently augment services with extracurricular activities that are focused on giving HIV/AIDS education, assisting young people to work in the community doing community service, engaging the parents in some of these programs...”

Ms. Johnson concluded, “The last thing I want to say is that, with the support of the administration, Staff at DPH have come together for an interdepartmental working group from our AIDS Bureau, from our STD Bureau, from Family Planning, from our School Health programs, from our Violence area, trying to figure out together, as a first step, how we can incorporate the issues of how to have healthy relationships in its broader sense and really see if we can incorporate some stronger messages across our programs.”

Chair Auerbach said, “I would just say thank you very much. Clearly, so much work has gone into the process and the planning, and the gathering of the information and the data... Thanks for the terrific work on this... We look forward to hearing more about the progress that is being made in both analyzing the data and thinking about ways to respond.”

#### **Informational Only/No Vote**

The meeting adjourned at 12:00 p.m.

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John Auerbach  
Chairman, PHC