

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, February 11, 2009, 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 Caulton-Harris, Mr. Harold Cox, Dr. John Cunningham, Dr. Muriel Gillick, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, Dr. Alan C. Woodward and Dr. Barry Zuckerman. Absent Members were: Dr. Michèle David, Mr. Denis Leary, and Dr. Michael Wong. Also in attendance was Attorney Donna Levin, DPH General Counsel.

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. He further announced that the Minutes of December 10, 2008 were pulled until the next meeting of the Council.

PROPOSED REGULATIONS: (NO VOTE/INFORMATION ONLY)

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 445.000: MINIMUM STANDARDS FOR BATHING BEACHES (STATE SANITARY CODE, CHAPTER VII):

Ms. Suzanne Condon, Director, Bureau of Environmental Health, presented the proposed amendments to bathing beaches to the Council. She was accompanied by Mr. Michael Celona, Senior Environmental Analyst, Mr. Chris Huskey, Manager of the Beaches Program and Attorney Jim Ballin, Deputy General Counsel. Ms. Condon noted in part, "...In 1986, the U.S. EPA published a study evaluating water quality and health concerns in both marine and fresh waters, and they did identify statistically significant numbers of swimming associated gastrointestinal illnesses in polluted waters, in comparison to unpolluted waters. What followed was the Federal

Beaches Act (in the year 2000), which required consistent criteria in standards for coastal recreational waters across the country; and then, shortly thereafter, the Massachusetts Beaches Act was passed, and the Mass Beaches Act was aimed at providing minimum standards for public bathing beach waters.”

Ms. Condon continued, “It directed our department and local health officials to develop bathing water standards that would be protective of public health that would require regular bacteria testing at all public and semi-public beaches in the State, and a notification system for the public when violations were violated. It also directed our department to publish an annual report, analyzing statewide bacterial analyses and to help implement this new law, we sought and received funding from the U.S. Environmental Protection Agency, and those funds have partially supported the DPH staff, who enforced the regulations, and it provides technical assistance to local health officials. It provides for laboratory testing to coastal communities, to reduce cost for local health testing...During the period of 2001 to 2008, DPH has provided approximately half of a million dollars to support marine beach testing statewide so local health officials don’t have to carry the burden alone. The funds support and maintain a web site that provides real-time information to the public, where they can check to see if a marine beach is open or closed...”

It was noted that there are 194 communities with fresh water beaches in Massachusetts and 60 communities with marine beaches. Ms. Condon noted that the need for these amendments can be captured in four points: (1) to empower local health enforcement of these regulations; (2) improve the information for beach-goers (3) clarify some of the language that was included in the original regulations, specifically as it relates to the definition of a semi-public beach, and also clarifying language for sampling locations and protocols and (4) to strengthen the requirements for beach operators to report exceedances to the boards of health in a timely fashion.

The main proposed changes to the regulations are:

- Definition of Semi-Public Beach – The definition of a semi-public beach will be clarified by stating that bathing beaches that have common access or use by a group or organization, including bathing beaches used in connection with a neighborhood or residential association, are semi-public beaches. (105 CMR 445.010)
- Beach Season – Beach operators will be required to install a permanent sign indicating the dates of operation of the bathing beach and contact information for the beach operator (105 CMR 445.020)
- Sampling Protocols – The regulations will allow sampling locations to represent more than one beach if the beaches share the same water body and are near each other (105 CMR 445-032)
- Frequency of Sampling – The frequency of sampling section will be revised to require a first sample be taken within five days immediately preceding the opening of the bathing season. Also, beach operators will be required to sample or verify water quality prior to reopening a beach after a closure due to reasons other than an exceedance of a bacteriological standard (105 CMR 445.032 and 445.040)
- Reporting Levels Exceeding Established Standards – Beach operators will be required to report to the board of health within 12 hours of obtaining results indicating an exceedance of a bacteriological standard (105 CMR 445.033)
- Permits to Operate a Bathing Beach – The revised regulations will require beach operators to obtain a permit from the local board of health in order to operate a public or semi-public beach (105 CMR 445.400)

- Enforcement – The amendments will add a specific reference to the enforcement authority for these regulations.

In closing, Ms. Condon noted that they will conduct a public hearing, review the comments received, make any necessary changes and then return to the Public Health Council to seek approval of these proposed amendments.

Discussion followed by the Council (see verbatim transcript for full discussion). It was noted that the regulations don't apply to federally operated beaches like the Cape Cod National Seashore. They apply to state-operated beaches. Mr. Michael Celona, Senior Environmental Analyst responded to Ms. Caulton-Harris' question to define "short distance" in the sampling process. He said, it is loosely defined at about every 500 meters, however sewage overflow pipes nearby may cause it to be less than that. It was noted that these regulations cover physical hazards as well as bacterial. Physical hazards like jellyfish may cause a beach to be closed until they are cleaned up. Ms. Caulton-Harris asked staff to think about creating some uniformity in terms of setting of the permit fee. She didn't want her city to charge \$300.00 if another city would charge only \$100.00.

No Vote/Information Only

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) [CHAPTER 305 CHANGES]:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 140.000 (LICENSURE OF CLINICS) [CHAPTER 305 CHANGES]:

For the record, it was noted that Dr. Muriel Gillick recused herself from discussion on the clinic licensure piece.

Dr. Paul Dreyer, Director, Bureau of Health Care Safety and Quality, accompanied by Attorney Lisa Snellings, Deputy General Counsel, presented the proposed regulations to 105 CMR 130.000 and 105 CMR 140.000 to the Council.

It was noted that the proposed amendments to 105 CMR 130.000 to the Hospital Licensure Regulations does the following: (1) require hospitals licensed by the Department of Public Health to report serious reportable events (SREs) to the Department and prohibit hospitals from charging or seeking reimbursement for SRE-related services; (2) require hospitals to report healthcare associated infections (HAIs) to the Department; (3) require hospitals to establish a patient and family advisory council (PFAC); (4) require hospitals to develop a patient rapid response method (PRRM); and (5) amend the requirements for retention of hospital records to allow creation and maintenance of records in electronic format, shorten the retention period from 30 to 20 years, and require notification of DPH before records may be destroyed. In addition, the proposed amendments to 105 CMR 130.000 (6) update requirements for licensed cardiac catheterization services, and (7) make technical corrections to the newborn and maternal services section of the regulation.

The proposed amendments to 105 CMR 140.000, Licensure of Clinics does the following (1) require all Medicare-certified Ambulatory Surgery Centers (ASCs) to be licensed as clinics and allows the Department to “deem” a Medicare-certified ASC that is accredited by one of three nationally-recognized accrediting bodies to meet state licensing requirements; (2) require ASCs to report serious reportable events (SREs) to the Department and prohibits ASCs from charging or seeking reimbursement for SRE-related services; (3) require ASC's to report healthcare-associated infections (HAIs) to the Department; and (4) amend requirements for retention of clinic records to allow creation and maintenance of records in electronic format, shorten the retention period from 30 to 20 years, and require notification of the Department before records may be destroyed. In addition, the proposed amendments make technical changes to 105 CMR 140.000 to implement new Determination of Need requirements for ASCs and require notification of the Department of clinic closures and

temporary interruption of service.

Dr. Dreyer stated in part, "...The proposed amendments require hospitals to file a written report with the Department within seven days of the discovery of an SRE, and to provide a copy of this report to any responsible third party payer. The regulations require that the hospital inform the patient of the occurrence of the SRE within that seven day period and requires the hospitals to establish policies and procedures for how they are going to review the SRE to determine whether or not they may charge or seek payment for services as a result of the SRE, and also policies and procedures for notifying the patient, or patient's representative, about the SRE occurrence...The proposed regulations set forth the minimum content of the report, which includes a description of the policies and procedures followed by the hospital and its reimbursement analysis, a narrative description of the SRE, an analysis of identification of the root cause of the SRE, an analysis of the reimbursement criteria, and a description of any corrective measures taken by the hospital, following the discovery of the SRE. If the hospital does not seek reimbursement, which we expect may be the case in many instances, it must send notice of the decision not to bill to the Department, the patient, and any third party payers within thirty days of reporting the SRE to the Department."

Dr. Dreyer said further that if a patient is admitted to one hospital and then admitted to another hospital and the second hospital discovers that a SRE occurred at the first hospital, the second hospital must report it to the Department within seven days of discovery. The second hospital may charge for its services, however, if the SRE occurred at a hospital that shares a common ownership with the first hospital it may not charge for the services it provides. Staff added a provision to bring the regulation into conformance with federal laws. CMS has determined that Medicare patients are under their jurisdiction and are preempted from this state law. Dr. Dreyer clarified further that they are obligated to transmit the data reported to the Department to the Betsy Lehman Center and to the Health Care Quality and Cost Council for publication on its consumer health information web site; that staff is currently working on inter-agency

service agreements and protocols to accomplish the data sharing; that the statute provides a penalty of up to a thousand dollars per day under revocation or suspension of a hospital's license for failing to comply with the SRE reporting requirements and that the SRE non-payment policy does not apply to physicians because the statute's definition doesn't include them.

Discussion followed by the Council (see verbatim transcript of the proceedings for full discussion). Chair Auerbach said in part, "...This has been a very complicated amendment to work on, in part because, we at DPH are not accustomed to becoming involved in the reimbursement systems of institutions...We are now charged with playing an active role in determining what is billable and not billable. It is our belief that having a regulation like this in place as part of the hospital licenses will lead to better quality of care in health care facilities because it will create an added incentive to prioritize the avoidance of serious reportable events because of the financial consequences..."

Dr. Meredith Rosenthal asked, "What precisely is meant by not billing for SREs?" She asked further, "Can you explain exactly what you mean, how you quantify, or how the hospitals and health plans will quantify what ensued as a result of an SRE?" Dr. Dreyer responded, in part, "...It is between the hospitals and the payers and every payer may have a different means of coming up with a reimbursement rate for a particular condition and that methodology is going to determine how the hospital may do it...We realized that we had no way of coming up with a set of rules that would be general enough to apply to every payer..."

Dr. Barry Zuckerman said he wasn't sure that the insurers should be the ones deciding if they should pay or not "given their incentive to save the money..." Dr. Dreyer responded, "You are absolutely right. The hospital will do its preventability analysis, and send its decision to us and to the payer; presume that the hospital's analysis says that it is an event which was totally out of its control, preventable and therefore should be able to bill. It is absolutely true that a payer could take issue with that decision and not pay. The hospitals have in

their contracts with payers policies and procedures governing appeals in these cases....We are just not in a position to run a process to adjudicate potentially 400 payment decisions. We deliberately pushed that decision out to the payers because we don't have the wherewithal to do it."

Dr. Dreyer clarified further, "There are two parts to the non-payment equation. The first part is the occurrence of the event, and the second part is this preventability analysis that the hospital must conduct. The hospital will give its analysis. We have a due diligence to review all the reports we get and if, in doing that, we see an analysis that looks totally inappropriate, misguided, then we will intervene, but if it is prema facie reasonable, then we will accept it, and it will go to the insurer for a decision."

Mr. Paul Lanzikos made the suggestion that an "s" be put on the word payer, bottom of page 13, under section b of the regulations so the phrase would read "(b) Provide a written report to the Department, the patient and any responsible third-party payer(s) of the hospital's determination pursuant to 105 CMR 130.332(D) (1) (a) that it intends to charge or seek reimbursement for services provided as a result of the SRE. The recommended change is underlined. Dr. Dreyer said he would look at that suggestion.

Discussion continued around what information about SREs should be on the public web site and it was agreed that at the public hearing, staff will solicit information from the public about what they would like to see on the web site – should there be economic information about the SREs? Dr. Dreyer said, "...Our goal is to be able to provide the information about the SREs that have occurred, and the steps that hospitals have taken in response to those SREs." It was noted during discussion that Paul Dreyer will present a report to the Council at a future meeting of the Council on the SREs containing the number and type of SRE by hospital. Dr. Dreyer said they presently had about 400 reported SREs for the Calendar year report. Ms. Lucilia Prates Ramos questioned the number, stating that it seems very low. Chair Auerbach said further discussion on reportable events will occur at a future meeting of the Council. Ms. Prates

Ramos noted further that a public awareness campaign was needed that will encourage consumers to be fully engaged in their health care and that they should document everything that happens to them. Dr. Dreyer responded, "We will be delighted to work with you and Health Care for All, and other organizations around that campaign."

Regarding Family Advisory Councils, Dr. Dreyer noted, "This section of the regulations requires hospitals licensed by the Department to establish Patient and Family Advisory Councils, to facilitate patient/family participation in hospital care, in decision-making, information sharing and in policy and program development. The PFAC concept is based on the work of the Institute for Family Centered Care, which is credited for developing the core principles that are at the foundation of the Patient and Family Centered Care Movement. The regulations require the PFAC to advise the hospitals on matters including, but not limited to, patient and provider relationships, institutional review board, quality improvement initiatives, patient education on safety and quality matters. At least fifty percent of the PFAC members must be current or former patients and/or family members. The proposed time line is hospitals must have established the PFAC by 9/1/2009 and by 10/1/2009, report their compliance with the PFAC requirements to the Department. By 12/1/2009, the PFAC must be chaired, or co-chaired, by a patient or family member and we are asking hospitals to file an annual report with the Department, detailing the work of the PFAC.

The next section has to do with the Development of a patient rapid response method. This section requires acute care hospitals licensed by the Department to adopt an early recognition and response method for staff members, patients and families to request additional assistance directly from an especially trained individual if the patient's condition appears to be deteriorating. The logic here is, by early recognition, you can prevent codes (the patient is in cardiac arrest) from occurring and reduce mortality....The method established by the hospital must be available 24/7; the development and implementation of written policies and procedures describing the

patient rapid response method established by the hospital, which must address the criteria for activation, education of staff, patients and family members who might activate it. As required by the Joint Commission, as of January 1, 2009, hospitals are required to have in place an early response and recognition session method. These regulations mirror that requirement."

In regards to electronic medical records, the department now permits hospitals to convert existing paper records to electronic digital format before the expiration of the retention period, and permits hospitals to create original records in electronic digital format. The regulations require hospitals to notify patients in writing of the hospital's Record Retention and Destruction Policy. Dr. Woodward asked for clarification on notifying patients about destruction of their records. Dr. Dreyer said that means going forward, to let patients know their records will be retained for 20 years.

Discussion continued, Mr. José Rafael Rivera asked about guidelines for the PFACs to ensure that there is going to be racial, ethnic, linguistic and socioeconomic diversity in the PFACs. Ms. Prates Ramos added that each PFAC should be reflective of the community they serve. Dr. Dreyer said he would ask for comments at the public hearing on this to figure out the best way to accomplish their suggestions. Mr. Lanzikos made two suggestions (1) that there be a mechanism so the public can reach the PFACs without going through administration (perhaps a poster) and (2) annual report to the public through a publication or local newspaper or hospital community newsletter so that patients and their families can benefit from the PFAC. Dr. Dreyer said DPH will think of a way to best accomplish that. Dr. Woodward noted that he thinks there should be a report send to the Legislature that informs them that their legislative directives are beneficial and also if they are duplicative or unnecessary provisions. For example, the Rapid Response Teams is now a requirement of JCAHO so why does DPH need the same requirement in its regulations? Chair Auerbach noted that the Department attempts to do that, especially with Chapter 305, offer the Department's feedback to the legislature. Ms. Caulton-Harris suggested a public hearing in the Western part of the state and

maybe in the Cape area due to the importance of the regulations. Chair Auerbach said DPH will take that advice on the public hearing.

Dr. Dreyer noted, "...We have proposed to change the Clinic Licensure Regulations to mirror the Hospital Licensure Regulations with respect to SRE reporting, HAI reporting and patient record retention. We have made minor amendments to implement the new DoN requirements for ASCs and we are proposing amendments requiring notification of the Department for clinic closure and temporary interruption of services, which should have been in the Clinic regulations all along but were not. And to clean-up the regulations with respect to Cardiac Catheterization Services, which we currently license, to eliminate a physician operator minimum requirement for diagnostic procedures and instead require a quality improvement process for cath labs. We also proposing that physicians who are performing angioplasty be board certified, as required by the American College of Cardiology and have included a few technical amendments to the maternal and newborn services regulations."

In closing, Dr. Dreyer said they plan to hold a public hearing on March 23, 2009 in Boston and expect to come back in May or June with final promulgation. And further, that he heard the Council request for further hearings in strategic locations. Chair Auerbach thanked Dr. Dreyer and Attorney Snelling for their work on these complicated regulations and said, "Dr. Dreyer is doing this in the context of seeing his budget shrink and, as I think everyone knows, and the Department's budget is declining by 70 million dollars as of July 1st. I know you are doing this with fewer resources so I just want to publicly say that taking on additional responsibilities with fewer resources is a very difficult challenge, and I think we realize that, and we appreciate even more your leadership in this regard."

No Vote/Informational Only

**DETERMINATION OF NEED – CATEGORY 1 APPLICATION:
PROJECT APPLICATION NO. 3-3B62 OF LOWELL GENERAL
HOSPITAL:**

Ms. Joan Gorga, Director, Determination of Need Program, introduced Jere Page. Mr. Jere Page, Senior Program Analyst, Determination of Need Program presented the Lowell General Hospital application to the Council. He said, "...The applicant, Lowell General Hospital is seeking approval for new construction and renovation on the Hospital's campus in Lowell. The project involves new construction of a six story, seven level stand-alone bed tower on Lowell General's main campus to increase the hospital's adult medical/surgical capacity from 121 beds to a 148 beds, relocate 33 existing medical/surgical beds, expand OR surgical capacity from ten ORs to 13 operating rooms and relocate the Emergency and Trauma Center from the other existing building. Some renovation of existing and adjacent building space will also be required to enlarge the Emergency Department's waiting and triage area, as well as connect the new tower to existing buildings. In support of the new bed tower, the hospital reports that it is currently experiencing various challenges related to the limitations of its physical plant capacity and that there is inadequate infrastructure flexibility in much of the existing facility, which limits its ability to upgrade and expand to accommodate substantial increased inpatient surgical and medical/surgical volume. Inpatient discharges at the hospital have increased by 16% from FY 2007 to FY2008, and the number of inpatient days increased by twelve percent in the same period. By the hospital's calculations, they are the fastest growing acute care hospital in the Commonwealth, at least in 2008. The entire project is expected to be completed in 2013. We have included for the first time, outpatient cost, as well as inpatient in compliance with Chapter 308 of the Acts of 2008 signed by the Governor on August 10, 2008."

Mr. Page indicated that the revised maximum capital expenditure is \$126,561,245 (July 2008 dollars) and estimated revised first year incremental operating costs are \$24,172,795 (July 2008 dollars) and will provide funding for community initiatives of more than 6.3 million dollars over 14 years to fund service initiatives involved with obesity

reduction, tobacco prevention, cultural competency, maternal/child health care, chronic disease management, community support programs and training and program support evaluation.

He pointed out a few corrections in the staff summary: page 5, Table 3, under FY 2006 and FY 2007, the number of surgical beds in those two years is one hundred, not one hundred eighteen and the overall occupancy rate from 2006 to 2008 was 3% not 19%.

Mr. Normand E. Deschene, President and CEO addressed the Council next, accompanied by Ms. Amy Hoey, RN, BSN, Vice President of Patient Care Services/Chief Nursing Officer and Ms. Lisa Breen, Director of Planning and Research, for Lowell General Hospital. Mr. Deschene said in part, "...As part of our strategic plan, we did a comprehensive review of all of our facilities and, based upon that, as well as the fact, that in Fiscal Year 2008, we recorded almost 15,000 inpatient admissions, a 16% increase of admissions over the prior year. We are requesting this project to move forward."

Mr. Deschene said further, "Lowell General Hospital is the dominant health care provider for approximately three hundred thousand residents of the Greater Lowell area. We continue to focus on our mission to provide first class health care that meets the needs of our very diverse population. The hospital needs to invest in its infrastructure of buildings, technology and to better support our historical growth and the projected demand for services. More than half of our buildings are over sixty years old, and we have not build a new bed facility for over thirty years, and that creates some significant challenges for our staff, as well as for our ability to deal with technology and changing needs...Contemporary hospital design really calls for much more efficiency, much more flexibility, use of space, as well as our ability to deal with emerging technologies, new equipment and computerization."

"In addition", he said, "patient expectations have changed significantly. Where once multi-bed wards and later semi-private rooms, were the norm, private patient rooms are now the standard requested by most patients. We also believe it is very important to

have private rooms for increased privacy and for infection control. We have outgrown our facilities. Our Emergency Department was built to accommodate 36,000 visits and this year, we will treat nearly 50,000 visits and the projected growth rate is positive. Since 2001, our outpatient counters have increased 11% and our inpatient surgeries have increased 33%..."

In summary, Mr. Deschene said, "This expansion will modernize our campus, provide us with the ability to improve and expand our clinical offerings, allow us to provide leading edge and lower cost health care required to meet the needs of our community for now and into the future."

A brief discussion followed by the Council. Dr. Woodward asked for clarification on (1) the percentage of private rooms available post project (2) if their fund-raising goal of 15 million dollars is realistic in this economic environment and (3) do they anticipate that the cost of the project may decrease because of the economic environment since many construction and architect firms rates are down five to fifteen percent?

Mr. Deschene replied that (1) Private rooms will increase to 76% from 17% currently; (2) Yes, their fund-raising goals are realistic, they have raised three and a half million dollars already in a short period of time and have community support and involvement in the project and (3) they hope to take advantage of the better pricing available. Mr. Deschene further informed Mr. Woodward that he would be taking down one old building for the project and replacing about half their campus, the new building will be approximately 200,000 gsf.

Mr. Paul Lanzikos moved approval of the project. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-3B62 of Lowell General Hospital**, based on staff findings, with a revised maximum capital expenditure of \$126,561,245 (July 2008 dollars) and revised first year incremental operating costs of \$24,172,795 (July 2008 dollars). A staff summary is attached and made a part of this record as

Exhibit No. 14, 921. As approved, this application provides for new construction of a six-story (seven level) stand-alone bed tower on Lowell General's main campus to increase the hospital's adult medical/surgical capacity from 121 beds to 148 (an addition of 27 beds), relocate 33 existing medical/surgical beds, expand surgical capacity from 10 operating rooms (ORs) to 13 ORs, and relocate the emergency and trauma center from another existing building. The project also includes renovation of existing adjacent building space to enlarge the emergency department's waiting and triage area, as well as connect the new tower to existing buildings. The total gross square feet (GSF) for this project shall be 207,112, which includes 200,019 GSF for new construction of a six-story (seven level) bed tower on the Hospital's main campus to increase its adult medical/surgical and OR capacity, relocate existing medical/surgical beds, and relocate the emergency and trauma center from another existing building. Also, 7,093 GSF of existing adjacent building space will be renovated to enlarge the emergency department's waiting and triage area, as well as connect the new tower to existing buildings. This Determination is subject to the following conditions:

1. The Hospital shall accept the maximum capital expenditure of \$126,561,245 (July 2008 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.
2. The total gross square feet (GSF) for this project shall be 207,112 GSF, which includes 200,019 GSF for new construction to expand medical/surgical bed and OR capacity, relocate the emergency and trauma center from another existing building, and add shell space for future growth. The total GSF also includes 7,093 GSF for renovation of existing adjacent space to enlarge the emergency department and waiting and triage area, as well as connect the new tower to an adjacent building.
3. Lowell General shall contribute 19.95% in equity (\$25,250,000 in July 2008 dollars) to the final approved MCE.

4. Lowell General may build 32,018 GSF of shell space on the basement and ground levels, as well as the fourth floor of the new bed tower. Under 105 CMR 100.753 (D), build out of this shell space is a significant change that must be submitted to the Department.
5. With regard to its interpreter service, Lowell General shall:
 - Assure that policies and procedures language is direct and consistent throughout and affirms the use of only trained interpreters to provide medical interpretation and/or logistical support, prohibits the use of minors as interpreters, and discourages the use of family and friends as medical interpreters.
 - Continue to post signage at all points of entry and contact informing patients of the availability of interpreter services at no charge.
 - Continue to provide timely, accurate, competent, and culturally appropriate patient educational materials.
 - Continue to assure the quality and competence of interpreters provided through contracted vendors.
 - Continue ongoing training for all hospital clinical staff on the appropriate use of interpreter services, inclusive of telephonic services.
 - Include the Hospital's Director of Interpreter Services in all decision-making processes that affect communities that are racially, ethnically, and linguistically diverse.
 - Continue to identify how the patient data on race and ethnicity will be used to improve patient care and eliminate health disparities.

- Submit a plan for improvement addressing the above to the Office of Health Equity (OHE) within 45 days of DoN approval.
- Submit an Annual Progress Report to OHE within 45 days of the end of each federal fiscal year.

In addition, Lowell General shall notify OHE of any substantial changes to its Interpreter Services Program and follow recommended National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.

6. Lowell General shall provide a total of \$6,328,056 (July 2008 dollars) over 14 years at \$452,004 per year to fund community health service initiatives involved with obesity reduction, tobacco prevention and cessation, cultural competency, maternal/child health, chronic disease management, community support programs, training, and program support/evaluation described below, with payments to begin on the date of project implementation (anticipated in 2013). Specific activities are included, but not limited to only the ones listed under the above topics. The funding allocation of the payment distribution is outlined in the chart detailed below. Based on continued dialogue with the Department of Health Care Safety and Quality and the Office of Healthy Communities (OHC), the programs and funding distribution timelines may be modified with the provision that Lowell General maintains funding at the present value dollar amount of \$3,837,135. In the event the total project's MCE is reduced, the Hospital's initiatives funding would be proportionally reduced based on the new lower MCE of the project unless all initiatives funds were previously paid and distributed to recipients. In the event the project's MCE increases, the Hospital will provide additional proportional initiative funding contributions. Also, because of potential changes in community needs and corresponding program modifications, the Hospital will notify the Greater Lowell Health Alliance ("GLHA") and the OHC of impending payments six months prior to implementation of the project. The funding for these initiatives will be allocated to the GLHA of CHNA 10 as

well as other key local agencies in the Greater Lowell community that are research informed and relate to best or promising practice in the area. Lowell General states that in order to ensure that all appropriate agencies receive the opportunity to be part of initiatives and funding, announcements will be made at the networking task force luncheons in the Greater Lowell area, as well as at the coordinating task force meetings. Lowell General agrees that all invited agencies willing to participate in an initiative will be invited to send a letter of interest to the appropriate coordinating taskforce, which will be created to align with the initiatives described below:

I. Obesity reduction (Healthy weight and nutrition)

The first area of focus for the GLHA has been on obesity and creation of a Healthy Weight Taskforce, which is comprised of diverse community agencies working together to raise awareness about obesity, as well as developing and implementing a long-term, evidence-based campaign focused on fighting obesity through the following initiatives:

- Peer Education Program designed to be taught to all 5th grade students in the region.
- Prevention education with after school programs and other youth organizations.
- Cessation classes, support groups and web-based resources for cessation information.

II. Tobacco

The GLHA has developed a Tobacco Taskforce to address tobacco use. The Taskforce's work to date has focused on preventing tobacco use by educating youth as well as providing the tobacco cessation programs indicated below:

- Peer Education Program designed to be taught to all 5th grade students in the region Prevention education with after school programs and other youth organizations
- Cessation classes, support groups and web-based resources for cessation information

III. Cultural Competency

The Cultural Competency sub-committee of the GLHA will continue to focus on increasing awareness and education of the diverse Greater Lowell community through the following initiatives:

- Support to continue offering the “Bridging the Gap” interpreter training program at least four times per year.
- Provide funding to the Lowell Community Health Center to help restore programs that have been suspended due to lack of funding of the Cambodian Community Health 2010 project.

IV. Maternal Child Health

The GLHA will assign a task force to focus on the following in Maternal Child Health:

- Collaborate with community-based organizations to educate women about the importance of prenatal care.
- Partner with local school departments and teen agencies in an effort to reduce the rates of teen pregnancy and provide prenatal and postnatal education to pregnant teens.
- Partner with teen agencies and school departments on an adolescent gynecology program, to include education about HPV and other sexually transmitted diseases.
- Collaborate with youth organizations and local schools to educate parents and children about asthma and the importance of management of those with asthma.

V. Chronic Disease

GLHA will assign a task force to focus on the following areas:

- Chronic Disease Management programs: Funding for the Stanford Model, Chronic Disease Self-Management programs in multiple locations and multiple languages throughout the Greater Lowell area.
- Community-based education programs focused on increasing education and awareness of risk factors, lifestyle changes and management of chronic disease.

Additional Community Health Initiatives

- Focus on prevention of diabetes and heart disease with programs to serve all residents in the community with special assistance to the poor and at-risk segments of the population
- Obtaining a mobile screening van that can travel across the Greater Lowell region providing accessible cardiovascular, oncology and pediatric risk screenings
- Navigator program to assist diabetes and cardiac patients from diagnosis through treatment by aiding in dispelling fears, providing supporting resources for quality of life, and being a comfort and friend to patients and their families specifically focusing on those hard to reach patients identified by local agencies
- Provide the Greater Lowell Community with the first pediatric urgent care clinic to be able to respond to emergent needs of children

VI. Community support programs

Through the GLHA support will be given to the following community programs:

- Grants to community-based agencies to develop programs for:
 1. The City of Lowell's plan to end homelessness

2. The prevention of domestic violence
3. Access to transportation for residents to health appointments
4. Annual scholarships for high school graduates from the Pawtucketville neighborhood in which Lowell General is located to help promote the advancement of health professions.

VII. Training

Each taskforce detailed above would receive funding for training relative to its specific area.

VIII. Program support/Evaluation:

In order to ensure the effectiveness of all of the initiatives detailed above, a full-time coordinator will be hired to provide administrative support to the GLHA/CHNA 10 Executive Board, as well as the specific taskforce in order to constantly monitor, report and benchmark each initiative's impact. Program support will also include staff support from the Northeast Center for Healthy Communities, underwriting administrative costs and development costs for future task forces including the Networking Task Force member lunches of the CLHA. The support provided by the Northeast Center for Healthy Communities would include but not be limited to community health assessments, community engagement, evaluation design, and grant writing. Additionally the Executive Board would be involved in the selection and approval of the Northeast Center for Healthy Communities support staff.

In an effort to share and promote the results of each initiative, and to be consistent with 105 CMR 100.551(J), GLHA/CHNA 10 will file written reports to the Department's Office of Healthy Communities annually through the duration of each approved project, including a) reporting period; b) funds expended; c) recipients(s) of funds; d) purposes(s) of

expenditures; e) project outcomes to date; f) proposed changes, if any, to the approved initiative; g) balance of funds to be expended over the duration of the project; and h) name of applicant's representative, including complete contact information. Reports may but are not required to include copies of printed materials, media coverage, and DVDs.

The projected initiative payment distribution is outlined in the staff summary which is attached to this record.

PRESENTATIONS: NO VOTE/INFORMATION ONLY:

"HIGHLIGHTS FROM MASSACHUSETTS BIRTHS 2007", BY MALENA HOOD, SENIOR EPIDEMIOLOGIST, DIVISION OF RESEARCH AND EPIDEMIOLOGY, BUREAU OF HEALTH INFORMATION, STATISTICS, RESEARCH, AND EVALUATION

"DEPARTMENT OF PUBLIC HEALTH'S RESPONSE TO BIRTH DATA", BY DR. LAUREN SMITH, MEDICAL DIRECTOR:

Some of the statistics from the report follow:

- In 2007, there were 77,934 births to Massachusetts resident mothers compared with 77,670 in 2006. From 1990, the number of births to Massachusetts residents has declined by 16%. The birth rate (defined as the number of births per 1,000 women ages 15-44) among women of reproductive age declined by 8% between 1990 and 2007.
- The percentage of births to white mothers decreased by 1%, from 68.2% in 2006 to 67.5% in 2007. There has been an overall decrease of 14% in the percentage of births to white since 1990, when it was 78.4%. In 2007, the percentage of births to Asian, Hispanic, and black mothers remained stable from the 2006 figures; however, these percentages have increased since 1990 by 106%, 53%, and 8%, respectively.

- The percentage of births to non-U.S. born mothers remained stable between 2006 and 2007 at about 27%, but there was a 4% increase in the percentage of non-U.S. born black mothers and a slight, but significant, decrease in the percentage of non-U.S. born Asian and Hispanic mothers.
- The percentage of mothers who breastfeed or intended to breastfeed in 2007 was 79.2%, which was significantly lower than the 79.9% rate in 2006. The rate of breastfeeding has increased by 52% since 1989 when it was 52.2%. Among race and ethnicity groups, Asians had the highest percentage of breastfeeding, 86.1%. The percentage of mothers who were breastfeeding decreased for whites from 78.2% in 2006 to 77.3% in 2007 and, for Hispanics, from 82.6% in 2006 to 81.1% in 2007. Only blacks had an increase in the percentage of breastfeeding, from 80.7% in 2006 to 82.8% in 2007.
- In 2007, there were 4,944 births among residents' ages 15-19 years, which represents 222 additional births from 2006. The Massachusetts teen birth rate has decreased from 35.4 births per 1,000 women ages 15-19 years in 1990 to the current figure of 22.0 in 2007.
- In 2007, the cesarean delivery rate did not increase significantly from the previous year for the first time since 1998. The 2007 cesarean delivery rate was similar to that in 2006 (33.4% in 2006 vs. 33.7% in 2007). The cesarean rate in Massachusetts in 2007 was 8% higher than the 2006 nationwide rate of 31.1%.
- In 2007, there were 380 infant deaths (deaths of infants less than one year of age), 11 more infant deaths than in 2006. The infant mortality rate was 4.9 deaths per 1,000 live births in 2007, compared with 4.8 deaths per 1,000 live births in 2006. This change was not significant.
- In 2007, blacks continued to have the highest IMR among all race and ethnicity groups at 10.2 deaths per 1,000 live births compared to 11.1 deaths per 1,000 live births in 2006. The white IMR was

4.2 in 2006 and 3.9 in 2007. The IMR for Asians was 1.8 in 2006 and 3.1 2007. The Hispanic IMR was 5.8 in 2006 and 7.4 in 2007. None of these changes were statistically significant.

In closing, Ms. Malena Hood said, "Massachusetts over time has seen many improvements in the birth indicators, and we continue to compare very favorably with the United States in indicators such as teen birth rates, smoking during pregnancy and low birth weight ...but we have seen continued increases in indicators such as gestational diabetes, low birth weight and late preterm, and smoking during pregnancy, after declining for many years, is leveling off. We also must continue to address the persistent disparities in birth indicators. ..."

Dr. Lauren Smith, Medical Director for the Department, made a slide presentation, with data that has come from the Department's Birth Data Working Group, on how the Department is gathering the most accurate statistical information possible especially for cesarean deliveries and gestational diabetes. She said in part, "...Our initial goals were to understand the factors that were associated with the increasing rates of Cesarean deliveries as well as gestational diabetes in Massachusetts...Our goal is to provide data that would facilitate improvements, both in programs and in clinical interventions." She noted that the Department's current data was based on birth certificate data only and they are going to link this data with hospital discharge data. Dr. Smith explained further, "We are going to be looking at additional hospital factors that could influence cesarean delivery rates and survey hospital labor and delivery staff, to understand more about their processes, and their infrastructure that are available in the hospital, that could contribute to this; for example, who was on call, what kind of backup anesthesia is available, how many ORs do we have available for cesarean deliveries, the kind of things that we would need to understand at the hospital level."

Dr. Smith continued, "The second topic that we decided to dive into was gestational diabetes which, as many of you know, is the onset of glucose intolerance during pregnancy...The reason this is so

important for us to focus on is that we know that gestational diabetes increases the likelihood of poor outcomes, both for the mother and the child, and the increase in particular of Type 2 diabetes among mothers later in life, and among their children. We have had a 44% increase since 1998 in gestational diabetes.”

Dr. Smith noted, in working with the Diabetes Control Division at DPH, staff realized they had an incomplete understanding of the relationship between the risk factors that were identified and the development of gestational diabetes; identified that there were no standardized State guidelines for the screening, diagnosis and treatment of women with gestational diabetes; and noted the disparities among racial and ethnic groups; and the opportunities for improved surveillance. To combat these issues, a task force of internal/external experts was convened; and the Department will be doing a follow-up PRAM (Pregnancy Risk Assessment Monitoring Survey) survey and a provider practices survey this summer on how care is delivered to women. Dr. Smith noted that the Diabetes Prevention Control Program developed guidelines with a task force, that cover many areas such as screening and diagnosis at the beginning of the trajectory and follow-up of the mother and infant after delivery so the mother can detect the onset of early diabetes. This will probably be released this spring.

In closing, Dr. Smith said, “In terms of future directions for DPH, we want to continue the surveillance and data collections, as well as efforts to improve data quality, and I mentioned this previously, the idea around improving the data collection in birth certificate data. This is going to be an important task that some national sort of efforts has been retrenched around some of those things. We are going to continue our in depth collaborative data analysis process with our partners, and one of the best things that has happened since I have come to the Department, has been this opportunity to partner with our Department, has been this opportunity to partner with our external colleagues, who really engage in giving of their time and their expertise in helping us with this process; and finally, we are going to continue to focus on translating the data analysis

specifically in strategies for both programmatic and clinical interventions...”

Discussion followed by the Council (see verbatim transcript for full discussion of the presentations by Ms. Hood and Dr. Smith). Council Member Rivera requested data on Puerto Rico born citizens broken down in U.S. Mainland versus Non-U.S. Mainland born. Council Member Zuckerman requested data on drug use and pregnancy outcome. Dr. Bruce Cohen replied to both requests (from the floor) stating that the Puerto Rico data was available and that the drug use data isn't available from the birth certificate data but that there are other sources available.

Ms. Caulton-Harris spoke about being heart sick to see the City of Springfield high on the list again despite all their hard work over the years on the infant mortality issues. She said she agreed with Dr. Zuckerman that other factors need to be looked at besides adequacy of prenatal care. Tobacco use, and alcohol and drugs among other things need to be explored as well. Ms. Caulton-Harris asked if there was other data that they could look at, that may shed a broader light on some of these issues – community specific data. Ms. Caulton-Harris said the City of Springfield has completed an analysis by neighborhood and zip codes, linked to the poverty rate. She noted in part, “We can overlay everything, every other health status indices and understand those neighborhoods are impacted disproportionately in every category, but I am just wondering, is there something we haven't looked at...that may give us additional information so that we can respond in a way that will get the positive outcome that we are looking for...”

Chair Auerbach responded, “We hear the frustration that, in spite of considerable efforts, at the local level and at the state level, we are not making the kind of progress that we would like to be making and that really speaks to our need to continue to go deeper into the issue and to understand what can be effective in terms of having an impact on that...”

In response to Dean Harold Cox asking about the programmatic impact of the 70 million dollar cut to DPH's budget, Chair Auerbach said in part, "...We are in the process of fully understanding what the impact of those significant budget cuts will mean in terms of particular kinds of programs, particular kinds of interventions and access. As we have a better understanding of that, we are going to try to do everything we can over the coming months to minimize the negative consequences by thinking about- are there alternative approaches to addressing these issues, that we can call upon, or we can utilize, to try to minimize some of the harmful impact of budget cuts and those may mean, for example, working to increase the emphasis on the importance of smoking cessation counseling during pregnancy, as part of routine prenatal care, of utilizing the fact that we have more populations now that are insured; and maybe we can increase the amount of prescribing practices related to nicotine replacement. We are going to try very hard to be creative in order to absorb these cuts, and minimize the potential for very serious health outcomes that may result from them."

Dr. Woodward added in part, "...It is clear from your data in gestational diabetes that obesity is a huge risk factor to the mother and their ongoing health and particularly to their infants and it might be something we can incorporate into the Mass in Motion." He also noted a Boston Globe Newspaper article in the morning paper with a report on meta-analysis of 18 studies that show that obese women are twice as likely to have infants with neural tube defects and multiple other birth defects.

NO VOTE/INFORMATION ONLY

PRESENTATION: "DETERMINATION OF NEED COMMUNITY HEALTH INITIATIVES UPDATE", BY GEOFF WILKINSON, SENIOR POLICY ADVISOR AND MS. CATHY O'CONNOR, DIRECTOR, OFFICE OF HEALTHY COMMUNITIES:

Chair Auerbach stated in part, "...This presentation is a response to a request by the Council that we attempt to reflect on how those funds have been used, and if there are ways of improving the oversight of

those funds, and that came out of a DoN application review where we were asking questions about that and wanting to know, could we see the evidence that those funds were making a difference in terms of health within the State...”

Mr. Wilkinson, Senior Policy Advisor, DPH began his presentation, “...I think the previous discussion and presentation gives urgency to the discussion that we are about to have because this is a discussion about resources that are coming into the stream, even despite public budget cuts, and about the process of community input, and collaborations between institutions and community partners in deciding how these resources are spent...I want to put this in the additional context, that the work that we are talking about is to support the top priorities for the Department that were identified in the summer of 2007, after data analysis and a series of regional meetings that the Commissioner held all around the State.

Staff memorandum to the Council, dated February 11, 2009 stated in part, “One of the five priorities included building public health capacity at the local and state levels. As part of our work to implement this priority, we undertook a comprehensive review of the community health initiatives program (CHI). We found that no annual reporting about CHIs had been collected by the Department since the 2003 report, and the Department had no systems in place to document CHI allocations or to assess impacts of funded initiatives. We also learned that institutions holding approved DoNs and community health partners alike had questions about how the CHI process worked. Because the CHI program provides such a valuable resource for addressing the needs of vulnerable populations and strengthening community capacity to improve public health, we took several steps to strengthen the program. Specifically, we: (1) contracted to develop a data base (in Access), using approved DoN letters to document financial and programmatic details about all CHIs approved DoN letters since October 1, 2000; (2) sent a survey to hospitals and other DoN holders in order to gather information about actual CHI expenditures for projects approved since October 1, 2000; and (3) developed standard policies and procedures...We believe that the new CHI policies and procedures will provide a valuable tool for

promoting improved community health planning.”

Staff’s memorandum to the Council noted further, “The interim CHI policies and procedures set parameters for allowable and non-allowable expenditures. This represents a significant change from traditional practice and is intended to target CHI resources to health priorities identified by MDPH while preserving flexibility at the community level to address local and regional needs. The policies and procedures state that CHI expenditures should be directed to evidence-based or promising, innovative practices to improve primary care and preventive health services for vulnerable populations, with a focus on at least one of the following MDPH issue priorities: (1) eliminating racial and ethnic health disparities and their social determinants; (2) promoting wellness in the home, workplace, school, and community; and (3) preventing and managing chronic disease.”

Mr. Wilkinson noted further, “We were surprised to discover that the 86 DoNs approved since October 1, 2000 included total funding of \$62.8 million to support nearly 300 CHI projects. When one imagines the impact such resources might have had if targeted at a particular set of issues or vulnerable populations, one cannot help but appreciate the merits of considering some strategic guidance for future CHI investments. The entire combined budget for teen pregnancy prevention programs supported by MDPH in roughly the same period, for instance, was about \$25 million. For breast cancer prevention, total expenditures were about \$42 million; for oral health programs, about \$17 million...”

Mr. Wilkinson continued, “The new policies and procedures seek to clarify the “rules” and balance stakeholder power in the CHI planning process by offering a consistent written description of roles and procedures. We heard from some DoN applicants that the lack of publicly available policies and procedures provided excessive flexibility for MDPH in interpreting how the process should work. Similarly, we encountered frustration and confusion among community partners who did not understand their roles and prerogatives in CHI planning. Because it was common for MDPH to

sanction a division of CHI funds into separate “pots” of money to be allocated at the discretion of the applicants (hospitals) and community partners (CHNAs), we found inadequate engagement by the respective partners about how to gain maximum impact from the overall CHI investments. By encouraging partners to develop comprehensive proposals for CHI allocations, and by bringing additional partners to the planning “table” when appropriate, we expect CHI allocations will reflect improved community planning and, hopefully, improved services and health outcomes for vulnerable populations.”

In conclusion, Staff, memorandum indicated, “The DoN Community Health Initiative program is an important resource for improving the health of vulnerable populations and for building community capacity to protect and promote public health. Over the past eight years alone, hospitals and other DoN applicants have agreed to allocate over \$62 million for some 300 projects across the state, working in partnership with community-based service providers and health coalitions to identify and address local priorities. The program reflects the Department of Public Health’s long standing commitment to a comprehensive, systems approach to protecting and improving population health, relying on the joint capacities of health providers and community representatives.

The interim draft policies and procedures for DoN Community Health Initiatives that accompany this report are based on over 15 years of experience in negotiating CHIs with hospitals and community input. The policies and procedures are designed to make the process for developing CHI proposals transparent and accessible to all stakeholders and to strengthen collaborative planning and decision-making at the community level. The policies and procedures are also intended to chart a new direction in Departmental support for community health planning by aligning the CHI process more closely with the Attorney General’s community benefit program, by laying the foundation for regional support of Community Health Networks , and by providing for broader participation in the CHI proposal development process.”

Discussion followed by the Council. Chair Auerbach noted this report was a follow-up to Council Member Lanzikos request for background on the CHI program and that it turned out to be an enormous amount of challenging work. Council Member Paul Lanzikos stated, "Bravo, both for the work and the analysis. I think this portends for the future of effective Public Health planning and policy at the local level. One of pieces of the data that struck me in your original material was the amount of funding that has been available this period. Close to Sixty-three million, and how you contrast that to other important and effective initiatives, and how they were funded in a fraction of that. It shows what the potential of this is, and a lot of good has occurred and the ability to even magnify that, I think is going to be very significant as a result of the analysis and the resulting changes in policy and practice here....I look forward to the annual reports and to seeing the impact in our communities."

Council Member Harold Cox noted asked "...Do we know that the money has been spent and what is the process that will actually help us to know that the dollars actually will be spent?" Mr. Wilkerson and Ms. Cathy O'Connor expressed that they know the money has been spent from receiving the information from the hospitals and that the Office of Healthy Communities is in regular contact with the community health networks. Mr. Wilkerson noted that they are thinly staffed due to the budget crisis but hopes to have graduate interns to help with the project. Dr. Muriel Gillick asked about other states having similar projects and Dr. Paul Dreyer noted that other states don't have this CHI program. Dr. Alan Woodward noted said in part, "...I think we need to think about how we can assess impact down at the community level, the recipients' level." Mr. Lanzikos asked whether, a small amount of the CHI money could be used for a staff person to administer the program. Dr. Dreyer noted his concern about potential conflict of interest if the Department does that. Chair Auerbach wondered if a community-based agency assumed the statewide responsibility would that work....Mr. Wilkerson said it was a helpful idea and would take the suggestion under advisement. Mr. Wilkerson responded to Dr. Woodward's question and said in part, "...I don't expect that we are going to be able to document discreet health outcomes as a result of individual expenses, but by

strategically targeting the money, we can expect that it is going to help; and, in some cases, we may be able to have some discreet measurements.” Dr. Woodward replied in part, “...it is important to get that data in that city where the money was spent, even if it was part of a much broader program, and say, at least we are showing positive impact, whether we can attribute it all to this specific expenditure or not because if we are not seeing any impact, then you have to wonder, are these the right priorities if we are seeing negative trends.” Ms. Caulton-Harris clarified that these new guidelines apply to future DoNs and will not effect DoNs already approved like the Baystate Hospital project which is far along in the planning process. Mr. José Rafael Rivera noted he appreciated that this was done in true partnership with the communities.

No Vote/Information Only. Supporting material is attached and made a part of this Record as **Exhibit No. 14,922**. For the record, Council Members Rosenthal, Sherman and Zuckerman left the meeting at approximately 11:35 a.m. at the beginning of Mr. Wilkerson’s presentation. General Counsel Donna Levin left also during Mr. Wilkerson’s presentation. Mr. Lanzikos left meeting at 12:05 p.m.

Action Steps/Follow Up:

- Uniformity in terms of the setting of beach permit fees across the state (Caulton-Harris to Condon)
- Add and “s” to the word payer, page 13, in 105 CMR 130.332(D) (1)(a) of the Hospital Licensure Regulations (Lanzikos to Dreyer)
- Ask at the public hearing what economic information regarding SREs should be included on the public web site (Lanzikos to Dreyer)
- Paul Dreyer present a future report to the Council on SREs containing the number and type of SRE by hospital (Auerbach

to Dreyer)

- Public Awareness Campaign needed to encourage consumers to be fully engaged in their health care and to document it (Prates Ramos to Dreyer)
- Ask at public hearing for suggestions about how to obtain racial, ethnic, linguistic and socioeconomic diversity in PFACs and that they reflect the community they serve (Rivera and Prates Ramos to Dreyer)
- Mechanism so public can reach hospital PFACs without going through administration (poster perhaps) (Lanzikos to Dreyer)
- Annual Report to the public through local newspaper or hospital community newsletter so patients/families can benefit from PFAC (Lanzikos to Dreyer)
- Provide Legislature with feedback on their directives to let them know if they are beneficial or duplicative (Woodward to Dreyer)
- Hold a public hearing in the Western part of the state and perhaps down on the Cape on these proposed hospital and clinic licensure regulations (Caulton-Harris to Dreyer)
- Request for birth data on Puerto Rico born citizens broken down by U.S. Mainland versus Non-U.S. Mainland born (Rivera to Cohen)
- Request for birth data that includes drug use and pregnancy outcome (Zuckerman to Cohen)
- Request for community specific data for infant mortality issues that looks at all the issues besides adequacy of prenatal care, such as tobacco use and alcohol and drug use etc. (Caulton-Harris to staff)

- Request that CHI monies be monitored on the community level to see if the money is making an impact (Woodward to Wilkerson)
- Figure out if a small percentage of CHI money can be used to pay a staff person to administer the program (Lanzikos to Wilkerson/Auerbach)

The meeting adjourned at 12:10 p.m.

John Auerbach, Chair

LMH