

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, May 13, 2009, 9:10 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 (arrived at 9:15 a.m.), Mr. Harold Cox, Dr. John Cunningham, Dr. Michèle David, Dr. Muriel Gillick, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman (arrived at 9:20 a.m.), Dr. Michael Wong, Dr. Alan C. Woodward, and Dr. Barry Zuckerman. Mr. Denis Leary was absent. 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.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF MARCH 11, 2009:

A record of the Public Health Council Meeting of March 11, 2009 was presented to the Public Health Council for approval. Council Member Dr. Alan Woodward moved approval after noting changes needed to the attendance section of the minutes: that he and Dr. Zuckerman were absent. After consideration, upon motion made and duly seconded, it was voted unanimously [Ms. Caulton-Harris and Mr. Sherman not present to vote] to approve the March 11, 2009 minutes of the Public Health Council meeting with attendance corrections.

For the record, Council Members Ms. Caulton-Harris and Mr. Sherman arrived at the meeting at the beginning of Ms. Golden's presentation on the Menu Labeling Regulations. They were not present to vote on the minutes above.

**FINAL REGULATIONS: REQUEST TO PROMULGATE
AMENDMENTS TO 105 CMR 590.000, STATE SANITARY CODE
CHAPTER X: MINIMUM SANITATION STANDARDS FOR FOOD
ESTABLISHMENTS, REQUIRING THE POSTING OF CALORIE
INFORMATION:**

Ms. Kristin Golden, Director of Policy and Planning, Commissioner's Office, accompanied by Attorney Lisa Noling Snellings, Deputy General Counsel, and Ms. Priscilla Neves, Director, Food Protection Program, presented the amendments to 105 CMR 590.000 to the Council. Ms. Golden presented on behalf of Ms. Suzanne Condon, Director, Bureau of Environmental Health who had to be at the CDC. Ms. Golden noted in part, "...The reason we have embarked on this initiative is due to the obesity crisis that is facing the nation and in Massachusetts in particular. Almost 60% of our adults are overweight or obese and a third of our students also have that problem, there is a disproportionate share among some of the minority residents..."

She continued, "Earlier this year, we launched 'Mass in Motion', a comprehensive approach to trying to address this problem...We have looked at policy changes, public information, individual behavior change and environmental change. The goals of 'Mass in Motion' are to both decrease the number of people who are overweight and then to decrease the percent of people who have chronic diseases'."

Ms. Golden said in part, "You voted earlier this year on BMI reporting for school age children, and then this regulation around calorie posting is another aspect of the 'Mass in Motion', to give consumers more information about calories. How do we know this kind of an intervention actually changes behavior? New York City did a telephone survey this year. This is recent data, from February of 2009, after they had implemented their Calorie Posting regulation. Eighty-two percent of those that they surveyed said that this had some kind of an effect on what they chose to eat. Of those, 70% said they actually got something with lower calories. Half of those people said they are never ordering certain items again, and three-quarters of the people said that this is a good thing for State and

Local government to do – that this is an appropriate role for government to help get consumers information.” Ms. Golden further noted that in NYC, some restaurants actually lowered calories in some items by changing the recipes or reducing the serving size.

Ms. Golden noted that 140 individuals or organizations provided testimony at the public hearings or submitted written comments regarding the proposed regulations. Ms. Golden went over the changes in the proposed regulations. She noted a change in the proposed regulations for the definition of a food establishment, which will be for restaurants with 20 or more establishments in Massachusetts instead of the originally proposed 15 or more establishments in the country. In response to Dr. Zuckerman’s question on “what was the rationale for even having a cut-off”, Ms. Golden replied in part, “...for a small, individually-owned restaurant, you have to go through a pretty sophisticated analysis to look at every single one of their menu items ...That could be pretty burdensome for them. The places that we are targeting actually already do this analysis...It usually is on web sites, not always, but the chains have it, and the idea was, this... is not adding a really big burden to the chains. Further discussion continued (see verbatim transcript for full discussion).

Staff’s memorandum to the Council summarized additional changes that include:

- Exemptions for grocery stores, markets, and convenience stores, except for separately-owned covered food establishments located on the premises of an otherwise exempt establishment.
- Exemptions for institutional food establishments such as schools, licensed health care facilities, assisted living and group residences, and prisons;
- Exemptions for private clubs, temporary food establishments, caterers, and vending machines.

Language referring to font size and format has been eliminated.

Covered food establishments with drive-through menu boards are required to display the calorie information directly on the drive-through menu boards rather than a separate stanchion as originally proposed.

- The amendments have also been revised to require covered food establishments to display calorie information for each menu item, regardless of the number of individuals intended to be served by the item.
- The implementation dates have been revised to extend the date to November 1, 2010, to allow for orderly implementation, including training of local boards of health with enforcement responsibility, and sufficient time for most covered food establishments to modify menus and menu boards.
- A procedure to request an extension of time for compliance has been added for franchised outlets of a parent business that can demonstrate extraordinary financial hardship. Such food establishments must provide documentary evidence to the Commissioner or his designee with a statement of the additional time needed to come into compliance.

Discussion followed by the Council.

Council member Dr. Alan Woodward said "I would be in favor of including chains that have twenty nationally... the positive impact could be that ...maybe they will, in the interest of transparency and public health, implement those in other states where there isn't a requirement.

Council Member Dr. Barry Zuckerman noted that he did not think that schools and vending machines should be exempted from the law. He said in part, "...These exemptions are very unnecessary gaps...providing information so people can make choices is critical..." Chair Auerbach instructed staff to revisit the school menu and vending machine calorie labeling issues outside of these regulations.

Council Member Paul Lanzikos added in part, "...I commend staff for their original presentation of the draft regulations and for the resulting recommendations. I am going to speak for endorsing the

regulations as presented. It is not ultimately where we would like to be, but I think it is very important not to get too far ahead of the public and have them push-back. I think by providing this level of information to consumers, as well as getting industry support, brings us to a significant plateau. We establish that and then we can move ahead...I like the fact that is caloric content value only because we are talking about fast food and people want to make decisions quickly and if we overload them with information, they are just going to shut down and not even consider any value....I wish it could be earlier than 2010 but I do especially in these economic times understand showing sensitivity..." Mr. Lanzikos further noted that "he hopes other restaurants not covered by the regulations voluntarily adopt calorie menu labeling because the public will embrace it and because that is how he plans on making his restaurant choices."

Dr. John Cunningham said he thinks they should compromise either extend the date but then cast a wider net or narrow the net and keep the original date of implementation of the regulations. Dr. Muriel Gillick suggested having a collaborative outcomes investigation with the State of California for outcomes analysis of the regulations. Ms. Helen Caulton-Harris noted, "I certainly understand the need for folks to want to bring that date up in terms of the implementation, but, as an enforcement entity, I really know that, for local boards of health, it is going to take time for us to be able to manage in terms of putting this into our enforcement process..." Dr. Alan Woodward added, "I think it is clearly appropriate that we push the compliance date back, and that gives people the appropriate window, but I do believe, between the media and our Mass in Motion initiative, we should encourage voluntary compliance in advance of that date...I hope we could encourage and maybe give some positive press to entities that comply in a timely fashion." Council Member José Rafael Rivera encouraged the Department to remember the information that "how we eat and when we eat can have just as much an impact on health as what we eat." Chair Auerbach responded that they "should have a follow-up presentation at a future meeting to talk specifically about the health education components – looking at how we are going to educate the public

about what an appropriate amount of calorie intake is as well as looking at the how, the when and the why pieces..." Dr. Meredith Rosenthal added, "I would like to join Mr. Lanzikos in commending the staff in making such a careful balance between burden and health promotion and encourage acceptance of these regulations in their current form as a work in progress. I do hope we will learn more about what their impact is, and have an opportunity perhaps to revisit them at some point as the Federal legislation shapes up as well." A brief discussion occurred on a motion to change the covered establishments to twenty nationwide instead of the staff proposed twenty or more in the state of Massachusetts. Mr. Lanzikos urged other members to vote against it stating in part, that we should not put at risk any ongoing business establishment that has only one or two locations in Massachusetts.

A motion was moved by Mr. Sherman and duly seconded. The motion proposed changing the definition of covered food establishments to twenty restaurants owned nationwide by a single chain instead of staff's proposed twenty restaurants owned by a single chain in Massachusetts only. The motion failed.

A second motion was made by Dr. John Cunningham and duly seconded which would have changed the effective date of the regulations to January 1, 2010. The motion failed. Ms. Helen Caulton-Harris spoke against the motion, stating in part that the local boards of health need the extra time to be prepared to enforce the regulations.

A third motion was made by Mr. Albert Sherman and duly seconded to approve staff's recommendation. After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Leary absent] to approve **Promulgation of Amendments to 105 CMR 590.000, State Sanitary Code, Chapter X: Minimum Sanitation Standards for Food Establishments, Requiring the Posting of Calorie Information.**

REQUEST TO PROMULGATE AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) TO IMPLEMENT PROVISIONS OF CHAPTER 305 OF THE ACTS OF 2008 INCLUDING AMENDMENTS RELATING TO REPORTING AND REIMBURSEMENT FOR SERIOUS REPORTABLE EVENTS (SRES):

REQUEST TO PROMULGATE AMENDMENTS TO 105 CMR 140.000 (LICENSURE OF CLINICS) TO IMPLEMENT PROVISIONS OF CHAPTER 305 OF THE ACTS OF 2008 INCLUDING AMENDMENTS RELATING TO REPORTING AND REIMBURSEMENT FOR SERIOUS REPORTABLE EVENTS (SRES) AND LICENSURE OF MEDICARE-CERTIFIED AMBULATORY SURGERY CENTERS (ASCS):

Dr. Paul Dreyer, Director, Bureau of Health Care Safety and Quality, presented the proposed amendments to 105 CMR 130.000 and 140.000 to the Council, accompanied by Attorney Lisa Noling Snellings, Deputy General Counsel. He said in part, "...We are going to talk today about amendments to the Clinic Licensure Regulations that were mandated by the Legislature in Chapter 305 of the Acts of 2008, otherwise known as Health Care Reform II. These amendments imposed six new requirements on us with respect to the development of regulations...They include (1) Reporting and Reimbursement of Serious Reportable Events (SREs) (2) Reporting of Health Care Associated Infections (HAIs) (3) Retention of Patient Records, (4) Creation of Patient and Family Advisory Councils, (5) Development of Rapid Response Method and (6) Licensure of Ambulatory Surgery Centers. Not mandated by Chapter 305 are minor technical corrections to the Cardiac Catheterization Regulations and the Maternal and Newborn Service Regulations. The language with respect to SREs and HAIs and the Retention of Medical Records is identical in both regulations so we are only going to speak about them once. These four areas are only in the Hospital Regulations: the PFACs, Rapid Response Methods, Cardiac Catheterization Services and Maternal and Newborn Services. In the Clinic Regulations, there are new license requirements for Ambulatory Service Centers."

Dr. Dreyer noted that they presented these amendments to the Council in February 2009 and held public hearings in Boston and Springfield on March 23 and March 30, 2009. Testimony was received from 37 individuals and groups.

Dr. Dreyer said in regard to SREs, "...We have been collecting hospital reports of SREs according to NQF definitions since 1/1/2008. Hospitals have now been prohibited by statute from charging or seeking reimbursement for services provided as a result of an SRE....A major change to the proposed regulations is the requirement that a preventability determination be conducted on all reported SREs, regardless of whether or not the hospital does or does not intend to seek payment. SREs must be reported to the Department, patient and payer within seven days of discovery. Patients must be informed both verbally and in writing. The hospital must immediately suspend or rescind any claims to patients or payers pending the outcome of the preventability determination and no later than 30 days after the initial report is filed. The hospital must make a preventability determination, update the SRE report and provide copies of the updated report to the Department, patient and any responsible third-party payers." He noted that the non-payment policy on SREs does not apply to Medicare patients. "Those are basically the only changes we have made with respect to SREs. With respect to HAIs, we haven't made any except for housekeeping changes."

With regard to Retention of Patient Records, Dr. Dreyer noted the major change is the legislature reduced the record retention period from 30 to 20 years. It clarifies that the retention period runs from the date of discharge of the final treatment related to the episode for care contained in the record and it requires hospitals to notify the Department before destroying the record...It permits the retention of records to be created in an electronic digital format. Hospitals are required to notify patients in writing of their record retention and destruction policies.

With regard to Patient and Family Councils, Dr. Dreyer noted the statute requires that the Department require hospitals to establish Patient and Family Advisory Councils to facilitate patient and family participation in the hospital care and decision making. The timelines have been revised as requested by both the hospitals and the consumer advocacy organizations. The time lines are revised as follows: By September 30, 2009, hospitals must prepare a written plan with the establishment of a PFAC by October 1, 2010. By that date, hospitals must prepare an annual report documenting compliance with the PFAC requirement and prescribing the PFAC's accomplishments during the preceding year. The initial proposed amendments required that hospitals file an annual report with the Department; the amendments have been revised to make the September 30, 2009 and October 1 annual reports publicly available through electronic or other means and to the Department upon request. The proposed amendment requires that at least 50% of a PFAC's members be current or former patients or family members. At the suggestion of the Schwartz Center and Health Care for All, the proposed amendment was revised at 105 CMR 130.1801(B) (4) to require that the PFAC family and patient members should be "representative of the community served by the hospital." Regarding chair or co-chairs of the PFACs the language is revised to read, "the department recommends that the chair or co-chairs be current or former patient(s) or family members (s), or a staff person and a patient or family member. The phrase "the extent allowed by state and federal law" was added to 130.1800(A).

Regarding Rapid Response Method, Dr Dreyer indicated, "...This is a technique in hospitals whereby patients who are experiencing a change in condition can be rapidly assessed by a staff member so as to prevent a deterioration that might result in a code. This is sort of a pre-code process for identifying patients who are undergoing a change in condition. The legislation requires hospitals to develop such a method and it includes a way for families and staff to access that method. It has to operate 24/7." Dr. Zuckerman questioned whether there is evidence that these RRM's work, noting a paper that Council Member Gillick sent to members stating that they do not. Dr. Dreyer responded, "...The legislature required the development and

implementation of written policies and procedures describing the Rapid Response Method and including criteria for activation, education of staff, and patients and family members who might activate it. What is interesting is the Joint Commission (JCAHO) has weighed in on this concept and has required, as of January 1, 2009, that hospitals have in place a Early Recognition and Response Method most suitable for the hospital's needs and resources, which may be activated by staff, patients, and/or family methods. So, whatever concerns about the evidence base for this approach, JCAHO has decided that it is necessary; and we have just added language to make sure that what we are doing is consistent with the JCAHO standard. It is also a National Patient Safety goal. So we are consistent with that. The one change we have made is we have required written documentation for each instance of activation for the Rapid Response Method, including assessment of patient family member satisfaction with the method which is consistent with the National Patient Safety Goal."

Dr. Dreyer went over the housekeeping amendments on Cardiac Catherization Services and Maternal and Newborn Services sections of the hospital regulations: "We have proposed some changes to the Cardiac Catheterization regulations. We have received testimony from community hospitals opposed to the Two Hundred Interventional Procedure Requirement. We have proposed eliminating physician operator minimums for diagnostic procedures because there was no evidence base for that...We added a quality improvement process for all procedures, and we required physicians performing angioplasty to be Board certified in Interventional Cardiology. Much of the commentary on the Cardiac Cath changes related to the operation of fluoroscopy equipment. It is in the Radiation Control Regulations and so we took the language out of these hospital regulations....We changed the language so that Board Certification in Interventional Cardiology isn't required for the Director so long as there is someone else who can serve that function in the Catherization lab. With respect to Maternal and Newborn Services, we made some technical corrections to put back in some items that had been omitted by error. The language has to do with the ability of hospitals to perform a rapid emergency C-section within

30 minutes and we put that back in the regulations in three sections with the addition of the word 'emergency' before the words Cesarean surgical birth."

A discussion followed by the Council. It was noted that if a patient is transferred to another health care facility after experiencing a SRE, the second facility can bill for their services unless it shares common ownership or governance as the facility that the SRE occurred in and it was noted further that there are protections in the hospital licensure regulations that does not allow hospitals to dump patients because they did not want to incur the cost. And in addition, there are patient protections in the Federal Medicare Regulations in the hospital discharge planning section. Council Member Prates Ramos voiced her concerns about patients being able to navigate the system when it comes to SREs. Chair Auerbach suggested that maybe hospitals could offer written materials in different languages for patients who encounter SREs so they can understand their rights and also perhaps they could telephone the Department's Office of Patient Protection for assistance. Dr. Dreyer acknowledged that there may be unintended consequences of the regulations that they will need to monitor.

Dr. Woodward raised concerns about retention of patient records beyond the 20 years, recommending that the twenty years should be defined as "inactivity of patient care at that institution not just a specific episode of care." Attorney Snellings noted that "we are actually preparing circular letters and other sub-regulatory direction to hospitals in terms of how to implement this" and Dr. Dreyer added "We will clarify it in sub-regulatory language."

Mr. Lanzikos made some suggestions that will be implemented through sub-regulatory means: (1) that if there is to be a chair of the Patient Family Council that it be a current or former patient or family member and if the PFC will have co-chairs, one should be a staff person and one should be a current or former patient or family member (2) that the annual reports of the PFCs be submitted to the local media and a written copy be posted in a public location; and (3) the public be invited to apply for membership in the PFC, perhaps it

can be noted in the annual reports. Dr. Wong noted that the date requiring an annual report listed in the regulations may be confusing to hospitals so Chair Auerbach asked staff to communicate to the hospitals that for the first year, the Department just wants to know that they have created the PFC and what they have done so far at this point.

Council Member Muriel Gillick made a motion to approve staff recommendation along with the additional sub-regulatory action steps noted above. After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Leary absent] to approve **Promulgation of Amendments to 105 CMR 130.000 (Hospital Licensure) to Implement Provisions of Chapter 305 of the Acts of 2008** Including Amendments Relating to Reporting and Reimbursement for Serious Reportable Events (SREs).

Staff continued discussion on the proposed amendments to the clinic licensure 105 CMR 140.000 on the Ambulatory Surgical Centers (ASCs). Dr. Dreyer said, "...Chapter 305 requires that Ambulatory Surgical Centers that are Medicare certified, obtain a Clinic License and undergo Determination of Need Review...Prior to this amendment, Ambulatory Surgery Centers that were organized as Physician Group Practices were exempt from licensure and therefore exempt from Determination of Need. The purpose of this amendment I think was to primarily bring ASCs under the DoN requirement. So by requiring licensure, it brings the ASCs into the DoN world. There is a grandfathering provision which states that an ASC in operation or under construction as of August 10, 2008 is exempt from DoN review, but must apply for Clinic License no later than six months after the effective date of these proposed licensing regulations, and which we think will probably be around the first of the year. We made some minor changes that were needed to implement the new DoN requirements, and we are also requiring notification to the Department when they close or their service is temporarily interrupted."

For the record, Council Member Mr. Paul Lanzikos left the meeting here at the start of discussion on the clinic licensure regulations. He left at 11:15 a.m.

Council Member Albert Sherman moved for approval of staff recommendation. After consideration, upon motion made and duly seconded, it was voted unanimously (Dr. Gillick recusing and Mr. Lanzikos not present to vote) [Mr. Leary absent] to approve **Promulgation of Amendments to 105 CMR 140.000 (Licensure of Clinics) to Implement Provisions of Chapter 305 of the Acts of 2008** Including Amendments Relating to Reporting and Reimbursement for Serious Reportable Events (SREs) and Licensure of Medicare-Certified Ambulatory Surgery Centers (ASCs).

A copy of the approved regulations and supporting documentation of 105 CMR 130.000 (Hospital Licensure) and 105 CMR 140.000 (Clinic Licensure) are attached and made a part of this record as **Exhibit No. 14, 926.**

PRESENTATION: "UPDATE ON H1N1 INFLUENZA":

Alfred DeMaria Jr. M.D., Medical Director, Bureau of Infectious Disease presented an update on the H1N1 influenza virus. He said in part, "...We are here to review the first three weeks of swine influenza because it was three weeks ago yesterday that the CDC brought to the attention of the country the human-to-human transmission of swine-origin influenza A H1N1 in North America, both in the United States and Canada, and subsequently introduced in the rest of the world."

He continued, "This was a significant event because it was a novel human influenza virus, a transition from swine flu to human flu means a novel virus, but it is also very significant, I think, because it is a particular swine influenza. There are a number of influenza A viruses that can infect pigs, but this one has special historical significance and probably significance in terms of over observing in the epidemiology of H1N1 swine influenza in that it is a progeny of

the 1918 H1N1 Flu Virus in the 1920s that emerged in pigs. At that same time, H1N1 went on to infect human beings, as well. There was a divergence in the swine strains and the human strains of H1N1. The human strains circulated until 1957 when they were replaced by H2N2, and the swine influenza viruses basically infected swine, and what we are seeing now is a recombinant of the Eurasian swine influenza virus H1N1, and the North American virus, and one of them also has human and avian genetic components, as well. H1N1 in human beings that followed in 1918, emerged in 1977, and has been transmitted every year since then, in some years, it has been the dominant circulating influenza strain. This is a particular H1N1 in terms of swine influenza, but I think it raised a concern because it was an animal adapted influenza virus that was now adapted to human transmission, but also because of that connection to 1918.

He said further in part, "...We had two cases initially in Massachusetts related to travel in Mexico and many of the cases now are occurring in small clusters – often school-based clusters and we are seeing more swine positives than ordinary flu but still 80% of what we are testing at the State Laboratory is negative for any influenza virus and about 10 to 12% is positive for H1N1 or swine-origin flu..."

Dr. Lauren Smith, Medical Director, Dept. of Public Health addressed the Council to speak about the Department's intervention with schools and child care facilities regarding the H1N1 flu. Dr. Smith stated in part, "We developed treatment guidelines that went out to clinicians via numerous mechanisms that I am sure Mary Clark will talk about. We developed guidance around school closure and what would be the appropriate situation for school and day care closure. As the outbreak continued and modified in terms of how we were responding to it, we needed to then do guidance around how schools were going to address staying open with increased numbers of cases and children with influenza-like illness. As we and the CDC backed away from saying you have to close, we then needed to give guidance about, what you do when you have increasing numbers of cases in your school, and then information for the concerned parents because that was a major sort of source of consternation for the local school officials. We had to do this rapidly, in the space of days,

hours, sometimes minutes...Through our connection with Early Education and Care and Elementary and Secondary Education, we were able to get guidance out real time to school superintendents ... school nurses and school-based health centers. They were a key part of our response. They really were the front line of making sure that their local school leadership understood what was going on, and it was essentially to have Anne Sheetz and her School-Based Health Center Group do their piece..."

Ms. Mary Clark, JD, MPH, Director, Emergency Preparedness Bureau for DPH, addressed the Council. She spoke about how the Department organized its response in terms of Incident Command, about situational awareness and the parties they communicated with regularly, the deployment of SNS (Strategic National Stockpile) assets, this being the first time the assets were deployed to Massachusetts and the first time the assets were deployed beyond the Receipt, Storage and Staging facility.

She said in part, "...On April 26, we started a modified Incident Command structure which gave us the ability to create daily situational reports, to collect all of the information that was going on in the various bureaus and elsewhere and to put that into a single report which was distributed inside and outside the Department."

Ms. Clark further indicated that (1) the United Way Mass 211 emergency telephone line was activated so folks could call in with their questions about the flu; (2) set-up operations center at 250 Washington with computers, phones and cable access for situational awareness and planning; (3) had conference calls with clinicians and local boards of health, fire and EMS Services, and school nurses to get out the right information (4) had daily contact with the Mass Emergency Management Agency (MEMA); (5) used the Health and Homeland Alert Network (HHAN) to send out alerts and links to guidance on the web for clinicians, local boards of health, and EMS agencies; (6) met with the Executive Office of Public Safety and Security; (7) maintained daily contact with distributors of antivirals and personal protective equipment as they learned of shortages.

Ms. Clark noted that the Strategic National Stockpile consisted of 240 courses of antivirals, a hundred thousand or more of N95 masks, surgical masks, gowns, gloves and other things. Ms. Clark noted that pharmacies didn't have significant supplies of Tamiflu on hand because the flu season was waning and they usually don't have the need at this time of the year. In order to help with this situation, the antivirals the Department had from the SNS were distributed to health facilities such as hospitals, community health centers, ambulatory care centers, EMS services, college and university health centers and others. The Commissioner of Public Health issued an emergency order declaring an emergency and authorizing dispensing from these facilities.

Discussion followed about their not being enough swabs for cultures. The Commissioner suggested that the Department should perhaps expand the list of supplies that the state purchases to complement the federal supplies in order to be ready for a future outbreak.

Ms. Clark noted that in terms of public communication they (1) reached out to various media outlets, including ethnic media, providing daily press releases, media opportunities with senior staff members who provided one-on-one interviews with the press; and (2) the DPH web site was updated regularly along with the DPH blog; informational videos were distributed and they sent emails to Listservs.

Chair Auerbach commended Dr. Mary Gilchrist and her State Laboratory staff for their outstanding work. They were responsible for doing the testing initially and screening for H1N1. They were involved in sending the specimens to the CDC for confirmation and then they became one of six states in the country that was allowed to confirm tests in Massachusetts, which reduced confirmatory testing time from about four days to 24 hours. She is being recognized this week by the American Society for Microbiology with the Public Health Award.

Discussion followed by the Council. Dr. Alan Woodward commented in part, "...I think it is really important as a Public Health Department,

to help the public put things in perspective with consistent messages about where we are, and what does this really mean, and what is the magnitude of the threat. On the other hand, we need to be prepared and we need to have appropriate stockpiles and get the appropriate state funding for this and support the Preparedness bill..."

Dr. Michele David stated, "...As a physician, I must say, we need to take this opportunity to establish how important public health is in the health of the population. We always think, like when we do Health Care Reform, that health insurance is a key to the health of the population. It is really in concert with public health that we ensure the health of the population. We need to find a way to advocate for good public health funding to ensure that, both we partner with Medicine and Public Health to ensure the health of our population."

Dr. Michael Wong spoke about the hysteria from the media as did Dr. Woodward; and also about staff's conference calls being very helpful to them in getting the correct information and being able to pass it on to their hospital and community health centers. Dr. Zuckerman raised the issue, as did Dr. Woodward earlier about the overuse of Tamiflu. Dr. Zuckerman noted the importance of getting the message out to the public that overuse could cause resistance problems in the future.

No Vote/Information Only

Postponed Docket Items:

Due to time constraints, items 4a and 4b on the revised docket, the staff briefings on (1) Amendments to 105 CMR 128.000, Health Insurance Consumer Protection and (2) Informational Briefing on Proposed Rescission of 105 CMR 950.000 et seq. (Criminal Offender Records Checks) were postponed until the next meeting of the Council.

Follow-up Action Steps:

- Look at food in schools and vending machines – is there a way to address this? (Zuckerman, Auerbach)
- Have a follow-up presentation on health education components of obesity, how, when and why of eating habits (Rivera, Auerbach)
- Hospital Patient Family Council's - have chair be a current or former patient or family member, or if having co-chairs then they should consist of a staff person and a patient or family member (Lanzikos to Dreyer and Snellings) [sub-regulatory suggestion]
- Hospital Patient Family Council's annual report be made public through local media and that the public be invited to meetings (Lanzikos) [sub-regulatory suggestions]
- Patient records need to be kept longer than 20 years in some instances (i.e., liability issue pending or on-going patient care) (Woodward, Sherman)
- State needs to supplement federal emergency supplies with items like swabs (Zuckerman, Auerbach)

The meeting adjourned at 12:12 p.m.

John Auerbach, Chair

LMH