

## **PUBLIC HEALTH COUNCIL**

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on October 21, 2009, 9:12 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, Dr. Michèle David, Mr. Paul J. Lanzikos, Mr. Denis Leary, Ms. Lucilia Prates Ramos, Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, Dr. Alan C. Woodward, and Dr. Barry S. Zuckerman. Members absent were: Ms. Helen Caulton-Harris, Dr. John Cunningham, Dr. Muriel Gillick and Dr. Michael Wong. Also in attendance was Attorney Donna Levin, DPH General Counsel. Note: Mr. Harold Cox resigned on September 17, 2009 so there is one vacancy.

Chair Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administrative and Finance. He went over the docket for the day. For the record, he noted that Drs. David and Zuckerman would be recusing themselves from voting on the Baystate Medical Center application.

### **RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF AUGUST 12, 2009 AND SEPTEMBER 9, 2009:**

Mr. Sherman moved approval of the minutes of August 12, 2009. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Record of the Public Health Council Meeting of August 12, 2009 as presented.

Mr. Sherman moved approval of the minutes of September 9, 2009. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Record of the Public Health Council Meeting of September 9, 2009 as presented.

**CATEGORY 1 APPLICATION: PROJECT APPLICATION NO. 4-3B74 OF BOSTON MEDICAL CENTER – ACQUISITION OF A POSITRON EMISSION MAMMOGRAPHY (PEM) UNIT TO BE LOCATED IN THE MOAKLEY BUILDING:**

Mr. Jere Page, Senior Program Analyst, Determination of Need Program presented the Boston Medical Center application to the Council. He noted in his presentation and/or his staff summary: "...Boston Medical Center Corporation (BMC) has filed a Determination of Need application to expand its existing Positron Emission Tomography (PET) service through acquisition of a Positron Emission Mammography (PEM) unit located in the Moakley Building on BMC's campus in Boston at 830 Harrison Avenue...PEM is an organ-specific high resolution PET scanner, which received Food and Drug Administration (FDA) approval in August 2003 for commercial use. PEM is further described as a high spatial resolution small field-of-view PET imaging system specifically developed for close-range spot imaging that provides high-resolution images of abnormal tissue in small body parts. More specifically, PEM utilizes glucose metabolism within a cancer to identify 'hot spots' on the scan, and the use of metabolism, versus breast morphology, means that PEM imaging is not limited by factors such as dense breast tissue or breast implants. As a result, PEM produces fewer false positives than a standard MRI follow-up exam for patients with breast cancer, and potentially those at high risk, and is therefore more effective in avoiding delays in treatment, unnecessary biopsies or chances for under-treatment. It is also reported that PEM has considerable promise as a tool to detect and manage other types of pathology in extremities and organs that can be easily isolated such as thyroid cancers, arthritis, and vasculitis, and it is currently being tested for use with these pathologies....There are two groups of patients who might qualify for a PEM scan. The first group includes patients diagnosed with breast cancer and undergoing a whole-body scan to check for distant metastases. This includes detecting multifocal disease in the breast with a known tumor, as well as in the contralateral breast. The PEM will take place immediately after the PET scan with the intention of supplementing the body scan images with information from the PEM scan...The second group of patients, for

whom a stand-alone PEM may be indicated, includes those whose mammograms are inconclusive as a result of breast density or hormone status...Patients at high risk of breast cancer also may be referred for PEM."

It was noted further in the staff summary that PEM is being used in nine other states across the country and this PEM unit will be the first in Massachusetts if the Council approves it. The PEM unit will be acquired with partial funding (\$325,000 or 74% of the total MCE of \$438,000) from the Department of Defense. The November 24, 1998 PET guidelines require that a single hospital must be affiliated with a tertiary teaching facility of which BMC is.

Staff has determined that this unique PEM unit will not have a negative impact on previously approved DoN PET/CT scanners, since demand for each PET or PET/CT unit is institution specific with no reliance on outside referrals. Mr. Page noted that staff has not held the PEM unit to the PET Guidelines minimum volume requirements used for whole body scanners but instead relied on BMCs actual and projected patient volume that determines the ability to provide sufficient number of scans for the PEM unit. Staff further noted that there is a precedent for approval of diagnostic units dedicated to extremities such as the breast as the Department has previously approved MRI unit for this purpose."

During his presentation, Mr. Page stated, "In response to community initiatives requirements, BMC has agreed to provide a total of \$46,900 over five years to fund initiatives for community health planning conducted by the Alliance for Community Health (CHNA 19) through the Neighborhood Level Community Health Planning Program. The funding may involve extensive staff assistance to coordinate at the neighborhood level, food and stipends for participants, and transportation."

Discussion followed by the Council. Mr. Sherman inquired about BMC's ability to afford the unit in light of their recent financial difficulties reported by the press. Ms. Gorga said that staff did check their financial statements which showed they had revenues over

expenditures of 69 million dollars in 2008 showing they can afford their contribution to the unit of \$113,000.

Dr. Alexander Norbash, Chairman, Radiology Department, Boston University addressed the Council. He said in part, "...PEM is the application of PET to a very concentrated area. The radio nuclide is injected, the cyclotron-generated radionuclide that is injected is the same that is done for a whole body PET, but what you are doing is, you are using a machine that is kind of like a magnifying glass, and you are concentrating on the breast specifically, giving you the opportunity to identify recurrent cancers at a much earlier stage and, even hypothetically, small cancers, our interest though, specifically, is in catching the recurrent cancers at an earlier stage in patients who are having a whole body PET CT anyway. They receive the whole body PET CT in the room, and they are moved over to a machine that is much smaller. It has a small focused area that looks at the breast specifically, and it allows us a much greater accuracy with identifying breast cancers. In the literature that has been written to date, the accuracy of PEM is as high as ninety plus percent for identifying breast cancers. Whole body PET CT, for identifying breast cancers, only has about a forty percent accuracy rate, and even mammography, at best, is sixty-five percent. We are very optimistic that using this technology will allow us to identify the recurrent cancers that kill the patients, much earlier than we otherwise were finding."

During discussion, Council Member José Rafael Rivera asked that a word/s be added to number nine of the interpreter condition, "culturally different". Mr. River noted his reason, "in order to respect differences even within race and ethnicity". Chair Auerbach said that he sees that suggestion as a friendly amendment to the Department that "culturally different" become part of the routine language in the interpreter condition.

Mr. Albert Sherman moved approval. After consideration upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-3B74 of Boston Medical Center** [Drs. David and Zuckerman recusing; Ms. Helen Caulton-

Harris, Dr. John Cunningham, Dr. Muriel Gillick and Dr. Michael Wong absent] to expand the existing Positron Emission Tomography (PET) service through acquisition of a Positron Mammography (PEM) unit to be located in the Moakley Building on the Boston Medical Center campus in Boston. This Determination is subject to conditions which are listed in the staff summary which is attached and made a part of this record as **Exhibit No. 14,938**. The estimated maximum capital expenditure (MCE) is \$438,000 (February 2009 dollars) and first year incremental operating costs of \$90,620 (February 2009 dollars). Boston Medical Center shall contribute 100% in equity of its share (\$113,000 in February 2009 dollars of the total \$438,000 MCE) toward the final approved MCE. The remainder of the MCE will be funded by a grant from the Department of Defense.

**INFORMATIONAL BULLETIN: REQUEST FOR APPROVAL OF INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS:**

Ms. Joan Gorga, Director, Determination of Need Program, presented the Informational Bulletin on Annual Adjustments to Determination of Need Expenditure Minimums to the Council. She said in part, "...The purpose of this memorandum is to request the Public Health Council's adoption of the attached informational Bulletin on Annual Adjustments to the Determination of Need Expenditure Minimums. These adjustments are being requested in compliance with M.G.L. c.111, §25B ½. Since the U.S. Department of Health and Human Services does not have an appropriate index, the inflation indices used by the DoN Program staff to adjust DoN threshold dollar amounts are: Marshall & Swift for capital costs inflation and the average of Global Insight (Health Care Cost Review) hospital and nursing home figures as the basis for the market basket of items defined by the Centers for Medicare and Medicaid (CMS) for operating costs. The precise mechanisms for these calculations are set forth in Exhibit A. The newly calculated expenditure minimums are set forth in Exhibit B. These figures are effective October 1, 2009."

Ms. Gorga noted further in her memorandum, "While the 2009 expenditure minimums have been prepared using the same methodology as previous years, the effect of the national economic downturn has been evident in both the Marshall & Swift data and the resulting expenditure minimums. Instead of an annual increase in the minimum expenditure thresholds in the range of 2% to 12% which has been experienced in recent years, the expenditure minimums for 2009 reflect a decrease of 4.4%."

Council Member Sherman moved approval. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the **Informational Bulletin on Annual Adjustments to Determination of Need Expenditure Minimums** as listed in staff's memorandum dated October 21, 2009 as Exhibits A and B:

**Exhibit A**

Annual Adjustments to Determination of Need Expenditure Minimums: Determination of Need Regulations 105 CMR 100.020 require the Department of Public Health to adjust expenditure minimums (for inflation).

**Capital Cost Indices (Marshall & Swift):**

	October 2008	October 2009
Region – Eastern	2840.0	2689.6
Massachusetts	1.10	1.11

$$\frac{2689.6 \times 1.11}{2840.0 \times 1.10} = 0.9557$$

**Operating Costs (Global Insight):**

	4 <sup>th</sup> Quarter 2008	4 <sup>th</sup> Quarter 2009
Skilled Nursing Facility	1.169	1.195
Hospital	1.276	1.3

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$$\frac{(1.195 + 1.3)}{(1.169 + 1.276)} / 2 = 1.0205$$

**Exhibit B**

**ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS:**

**Capital Expenditures**

Project Type	October 1, 2008	Filing Year Beginning October 1, 2009
Equipment for non-acute care facilities and clinics	\$817,475	\$781,221
Total capital expenditure including equipment for non-acute care facilities and clinics	\$1,634,952	\$1,562,445
Capital expenditure, excluding major movable equipment, for acute care facilities and comprehensive cancer centers	\$15,327,687	\$14,647,931
Outpatient service expenditures and acquisitions other than new technology or innovative services	\$25,000,000	\$23,891,293

**Operating Costs**

Project Type	October 1, 2008	Filing Year Beginning October 1, 2009
Nursing, Rest Homes and Clinics	\$725,158	\$740,042

**NOTES FOR THE RECORD:** Chair Auerbach noted that (1) Dean Harold Cox has resigned from the Public Health Council to work as a

senior consultant for the Department of Public Health and (2) introduced Dr. Alice Bonner, the new Director, Bureau of Health Care Safety and Quality.

**PRESENTATION: NO VOTE/INFORMATION ONLY**

**"A PROFILE OF HEALTH AMONG MASSACHUSETTS ADULTS IN SELECTED CITIES, 2008", BY HELEN HAWK, PH.D., DIRECTOR, HEALTH SURVEY PROGRAM, BUREAU OF HEALTH INFORMATION, STATISTICS, RESEARCH, AND EVALUATION AND LIANE TINSLEY, MPH, SENIOR EPIDEMIOLOGIST, HEALTH SURVEY PROGRAM, BUREAU OF HEALTH INFORMATION, STATISTICS, RESEARCH, AND EVALUATION:**

Mr. Jerry O'Keefe, J.D., Director, Bureau of Health Information, Statistics, Research and Evaluation made introductory remarks. He noted that "this report was done in response to the Council's request for sub-state community level data. The report compares each of the selected cities to statewide information. It is not a comparison between cities since there is too much variability among the cities to do that." Dr. Helen Hawk, Director, Health Survey Program, accompanied by Liane Tinsley, Senior Epidemiologist, Health Survey Program presented a Powerpoint presentation to the Council, showcasing the newly released Report, "A Profile of Health Among Massachusetts Adults in Selected Cities, 2008". Dr. Hawk noted the seven selected cities: Boston, Fall River, Lawrence, Lowell, New Bedford, Springfield and Worcester. She noted that the cities were chosen because of their population size, geographical location, having a diverse population compared with the state overall, and BRFSS has historically chosen them in the past in order to collect information on minorities and lastly, to look at the Health Care Reform impact in these communities and organize a plan.

Dr. Hawk noted further, "that the population structure in these cities are different compared to the state. There are a greater percentage of younger people living in these cities than in the state overall and that the Hispanic population in Lawrence is reaching 70%.

Educational attainment is low and low household income is prevalent in these cities. Health Care reform was looked at before and after the date of implementation (July 2007) with positive results: All cities decreased the amount of their non-insured people and some of them even decreased that percentage more than the state like Fall River and Boston. However, statewide for 2008, the non-insured are at 3%. For oral health, 80% of people in the state had a dental visit and most of the cities are in-line with the state...About 15% of people in the state reported having a primary physician with the cities showing disparities in this regard. Twelve percent of people in the state considered themselves to have bad overall health and only Worcester is in-line with the state. The other city residents reported considering themselves to be in poor health. The trend in current smoking is decreasing in the state for 2008 at 16%. Boston and Lawrence are doing well and are in-line with the state figure. In the other cities the trend is decreasing, though the numbers are still higher than the state average. Overweight and obesity have increased nationally and in Massachusetts. Massachusetts is lower than the national average. It is 58% for the state and in two cities, Springfield and Fall River; they have more people than the state average that are overweight or obese. Massachusetts residents overall show a high rate of physical activity which should help with obesity."

Dr. Hawk continued, "Diabetes rates are high in the state at 7%. Lawrence, Springfield and Fall River have significantly higher percentages of people diagnosed with diabetes. The trend over time shows that the rates in these cities have remained flat and are not increasing. For Asthma, the state average is 10% and the cities are in-line with the state figure. The state average for HIV testing is 40%, higher than the national average and the cities like Boston, Lawrence, and Springfield are doing even better than the state in this regard. Colorectal cancer screening is high in Massachusetts. The trend consistently is going up and increasing for all cities. Second-hand smoking/environmental smoking at home and in the working place has decreased across the state and in every one of the selected cities..."

In summary, Dr. Hawk noted that discrepancies exist in the cities versus the state; many health indicators in the cities are encouraging; and that the results are affected by the following: the diverse populations in the cities, the different age/race compositions, the populations being less wealthy and having a lower educational attainment."

In conclusion, Mr. O'Keefe said in part, "This is just part of a wider program to get information out to the community, make the data available ... we also expect to meet with the cities to discuss the findings and what they have learned from it, what they can advise us about the findings with their cities, but also to identify some best practices in areas where some of the cities are having some successes..." Mr. O'Keefe noted the potential uses of the information for communities, help cities to quantify the burden and make a case for public health needs in their communities, inform efforts about cultural competency, to dialogue with hospitals on collaboration with community and primary care efforts, and for grant applications.

Discussion followed the presentation by the Council. Mr. Dan Dooley of the Boston Public Health Commission introduced himself from the audience as requested by Chair Auerbach. Council Member Albert Sherman inquired about why the disparities between adjoining towns such as New Bedford/Fall River and Lawrence/Lowell? Dr. Hawk said an answer to that would require further analysis. Mr. Sherman asked "Can we find out how many towns are providing public exercise programs or have playgrounds available?" Dr. Hawk replied yes and said that they plan to combine Youth Survey data with their data to get a bigger picture on adolescents. Mr. O'Keefe added that the Commissioner has asked them to look at community assets and what is available locally in communities to provide physical activity. Council Member Lanzikos asked, "Does it have application now within the DoN analysis and if it doesn't are there ways we can start incorporating some of these findings into the analysis that the DoN program conducts?"

Chair Auerbach responded, "...You raise a relevant issue one that is actually being considered now. Twenty, thirty years ago, a

component of the DoN process, the health planning activities of the Department, utilized that kind of health data that was presented today, as well as a more detailed analysis of the service provision in community basis as part of presenting a profile of a region or community. Over the years, what has happened, as the regulatory pendulum swung, there was less regulation and there was a defunding for the health planning activities of the Department. At one point there had been about 30 people in the Determination of Need Program. There has been considerable discussion over the last few months about whether or not there should be a reinvigoration of the health planning activities within state government in order for us to pay more attention to both quality and cost, and the appropriateness of certain applications as they come before us, and we have put forward what we think is the minimum staffing requirement in order to accomplish that...that analysis and the recommendations regarding that are included in a report that is under consideration today by the Quality and Cost Council and there is a road map for health, that is under consideration, and it talks about reinvigorating those efforts. Currently, it doesn't happen. Could it happen in the future? The answer is definitely. It would just require additional expertise and personnel to be able to take that data, add some additional components to it, and then include it within the Determination of Need process."

Mr. Lanzikos suggested further "that analysis to track the impact of decisions that both providers and the Public Health Council make be explored. For instance, today the Council approved a PEM – to be able see over time if decisions around those types of technology are going to be affecting various health indices." Chair Auerbach replied, "...that would be a wise thing for the Department to do and that Dr. Hawk's Division looked at the question of Health Care Reform impact and that may serve as a model for how we can see policy decisions and analyze them with regard to what the outcome is."

Dr. Woodward also suggested to the BHISRE staff that they include the national average as well in their reports from the positive message perspective. He noted in part further that "...some of these cities are doing a really good job on some of the health indicators.

What is different about what they are doing and how do we disseminate that best practice information across the state? Note: for full discussion, please see the verbatim transcript of the proceedings.

Council Member Denis Leary inquired about the wording of the Survey question on veteran's status. Dr. Hawk asked him if he would like to review it and he agreed to that. Chair Auerbach noted that "Mr. Leary is the Council expert on Veteran's Health and said further that it is an area the Department wants to pay additional attention to because veterans are at risk in certain areas such as for smoking and suicide." Council Member Ms. Lucilia Prates Ramos asked out of the 20,000 people surveyed how many are immigrants or for whom English is not their first language. Dr. Hawk replied that the Department can only guess that those who replied to the survey in Spanish are immigrants because they cannot ask the sensitive question directly. The survey is available in Hispanic and Portuguese. Mr. O'Keefe stated that they include a question on ethnicity. Ms. Prates Ramos added further, "The number of uninsured may be reflective of immigrants' ineligibility for health care coverage." Ms. Lucilia Prates Ramos noted for the record that if the survey sample from Lowell included the Asian population – such as the Cambodian population – the numbers would have been totally different, especially in regards to smoking.

## **NO VOTE/INFORMATION ONLY**

### **PRESENTATION: NO VOTE/INFORMATION ONLY: "H1N1 VIRUS UPDATE":**

Ms. Donna Lazorik, Adult Immunization Coordinator, Bureau of Infectious Disease, DPH, accompanied by Dr. Lauren Smith, Medical Director, addressed the Council to update them on the availability of flu and H1N1 vaccines. Some excerpts from her presentation follow:

"One of the points, I did want to emphasize, though, is that there is still plenty of time to vaccinate with seasonal flu vaccine. We don't expect seasonal flu viruses to start circulating until December. It

usually doesn't peak in Massachusetts until January or February and continues into the Spring....There is two major challenges with H1N1 vaccine that are different from seasonal flu vaccine and one is that the H1N1 virus is already here. Unlike seasonal flu vaccine, where we are vaccinating the fall, before the season starts there's time, looking back now, it seems luxurious, although it never does in the fall, that we have plenty of time to vaccinate, and then the season starts at the beginning of the winter, and moving forward. With H1N1 vaccine, the virus is already here. So, in sense, we are in a race with the virus, and our goal is really to try to vaccinate as many people as quickly as possible..."

"For the most part, the target groups are the same for both seasonal and H1N1 with some minor differences. Pregnant women are a target group for both seasonal and H1N1 vaccine because pregnant women really disproportionately suffer complications if they become infected with influenza. Household contacts and caregivers of infants younger than six months of age because infants this age are too young to be vaccinated; and so, we try to vaccinate their household contacts and form a cocoon of immunity around them. Healthcare workers and emergency medical services personnel because of their increased exposure to influenza, as well as their increased chances of, if they do become infected, transmitting it to their patients. For H1N1 vaccine, persons younger than 24 years of age are the target group. People younger than 65 years of age, who have high risk medical conditions, basically the same ones that put them at risk for complications from seasonal flu, chronic diseases, heart, lung diseases, immunosuppressant, diabetes, and asthma...If folks with these diseases become infected with either H1N1 or seasonal flu, they are at increased risk for developing complications...People 65 years of age and older seem to have some immunity to this strain of H1N1 virus...Folks 65 years and older are still a target to receive the flu and pneumococcal vaccines."

Discussion followed whereby Ms. Lazorik and Dr. Smith replied to questions by the Council. Please see verbatim transcript for full discussion. NO VOTE INFORMATION ONLY.

## **FOLLOW-UP ACTIONS STEPS:**

- Mr. Paul Lanzikos inquired about reinvigorating health planning efforts within the DoN analysis using the BHISRE data. Chair Auerbach said it may be possible, that the issue is before the Quality and Cost Council but it would require additional expertise and personnel. [Auerbach, BHISRE, DoN]
- Mr. Paul Lanzikos asked if it would be possible to track the impact of decisions that both providers and the Public Health Council make over time. [The model used to track Health Care Reform may be a possible way to do this via BHISRE.]
- Dr. Alan Woodward suggests that BHISRE staff include the national average in their report as a way of showing the positive message. [BHISRE]
- Mr. Denis Leary agreed to review the wording for the BHISRE survey question on veteran status. [HAWK]

The meeting adjourned at 11:06 a.m.

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John Auerbach  
Chair

LMH