

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF FEBRUARY 10, 2010

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

**THE PUBLIC HEALTH COUNCIL OF
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston, MA**

Updated Docket: Wednesday, February 10, 2010, 9:00 AM

1. ROUTINE ITEMS: No Floor Discussion

- a. Compliance with Massachusetts General Laws, Chapter 30A, §11A ½ **(No Vote)**
- b. Record of the Public Health Council Meeting of January 13, 2010 **(Approved)**

2. PROPOSED REGULATIONS: No Floor Discussion/No Vote Information Only

- a. Informational Briefing on Proposed Amendments to 105 CMR 700.000 (Implementation of the Controlled Substances Act) Concerning Collaborative Drug Therapy Management
- b. Informational Briefing on Proposed Amendments to 105 CMR 590.000: State Sanitary Code Chapter X: Minimum Sanitation Standards for Food Establishments, to Comply with the Allergen Awareness Act

DETERMINATION OF NEED PROGRAM:

3. Category 1 Application:

Project Application No. 4-4935 of Boston Out-Patient Surgical Suites LLC – transfer of ownership of Boston Out-Patient Surgical Suites – LLC in Waltham, a single specialty (orthopedic) ambulatory surgery center **(Approved)**

4. PRESENTATION: No Vote/Information Only

“Massachusetts Strategic Plan for Care Transitions” by Alice Bonner, Ph.D, Massachusetts Department of Public Health, and Joel S. Weissman, Ph.D, Executive Office of Health and Human Services

The Commissioner and the Public Health Council are defined by law as constituting the Department of Public Health. The Council has one regular meeting per month. These meetings are open to public attendance except when the Council meets in Executive Session. The Council’s meetings are not hearings, nor do members of the public have a right to speak or address the Council. The docket will indicate whether or not floor discussions are anticipated. For purposes of fairness since the regular meeting is not a hearing and is not advertised as such, presentations from the floor may require delaying a decision until a subsequent meeting.

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on February 10, 2010, 9:10 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: John Auerbach, Commissioner, Department of Public Health, Dr. John Cunningham, Dr. Michèle David, Mr. Paul Lanzikos, Ms. Lucilia Prates Ramos, Mr. Albert Sherman (arrived at 9:55 a.m.), Dr. Michael Wong, Dr. Alan Woodward, and Dr. Barry Zuckerman. Absent members were: Ms. Helen Caulton-Harris, Dr. Muriel Gillick, Mr. Denis Leary, Mr. José Rafael Rivera, and Dr. Meredith B. Rosenthal. There is one vacancy. Also in attendance was Attorney Donna Levin, 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 noted the docket items to be heard.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF JANUARY 13, 2010:

Dr. Alan Woodward moved approval of the minutes of January 13, 2010. After consideration upon motion made and duly seconded it was voted: Chair Auerbach, Dr. Cunningham, Mr. Lanzikos, Ms. Prates Ramos, Dr. Wong, Dr. Woodward and Dr. Zuckerman in favor; Dr. David abstaining (Mr. Sherman not present to vote) to approve the **minutes of the Meeting of January 13, 2010** as presented.

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 700.000 (IMPLEMENTATION OF THE CONTROLLED SUBSTANCES ACT) CONCERNING COLLABORATIVE DRUG THERAPY MANAGEMENT:

Dr. Grant Carrow, Director, Drug Control Program, accompanied by Attorney Howard Saxner, Deputy General Counsel, Office of the General Counsel, presented the proposed amendments to 105 CMR 700.000 to the Council. The excerpts that follow are from his oral presentation to the Council as well as from the written memorandum presented to the Public Health Council by him and Dr. Alice Bonner, Director, Bureau of Health Care Safety and Quality, dated February 10, 2010. It was noted that Governor Deval Patrick signed An Act Establishing Collaborative Drug Therapy Management (Chapter 528, of the Acts of 2008) making Massachusetts the 44th state to allow pharmacists to participate in managing their patients' pharmaceutical care, within certain parameters. The Act amended M.G.L. c.94C, ss.7 and 9 and established M.G.L. c.112, s.24B ½. "The Law permits a pharmacist to enter into a written, collaborative practice agreement with a supervising physician, allowing the pharmacist to initiate, monitor, modify or discontinue a patient's drug therapy. The mutually developed agreement establishes individualized guidelines for the collaborative practice of the authorized pharmacist and supervision physician. The pharmacist would be required to have training and experience commensurate with the scope of the collaborative practice. The statute limits collaborative drug therapy management (CDTM) to the following settings: hospitals, long-term care facilities, inpatient/outpatient hospice settings, ambulatory care clinics, and community pharmacies (retail drug businesses) with physician supervision.

During his presentation Dr. Carrow noted that three sets of regulations are involved in the implementation of the CDTM: The regulations of the Board of Registration in Pharmacy and Board of Registration in Medicine set the clinical practice standards for pharmacist and physician participation. The regulations of the Department's Drug Control Program provide for pharmacists to register and obtain a controlled substances registration in order to prescribe and dispense controlled substances....If the pharmacist will be prescribing federally controlled substances which are the narcotics and stimulants, then they would also have to register with the DEA. A pharmacist may issue, modify or discontinue a prescription or

medication order only in accordance with the agreement with the supervising physician.

Staff's memorandum notes, "The statute and proposed companion regulations establish special requirements for collaborative practice within the community (retail) pharmacy setting. A collaborating pharmacist is limited to (1) extending drug therapy initiated by the supervising physician for 30 days (2) administering vaccines; (3) modifying or discontinuing medication prescribed by the supervising physician for patients with specified disease states (e.g. asthma, diabetes, congestive heart failure, HIV or AIDS); (4) issuing initial prescriptions for schedule VI controlled substances only, for treatment of specified disease states, to the extent provided in the collaborative practice agreement. The patient must be referred, in writing, by the supervising physician to the collaborating pharmacist and the patient must provide written, informed consent to participation in the collaborative practice. The patient would have to be at least 18 years old."

Dr. Carrow noted in his presentation and in the memorandum to the Council that the proposed regulations (105 CMR 700.000) requires a pharmacist who engages in CDTM to register with the Department and meet the following requirements:

- As a licensee, the pharmacist meets all applicable requirements of the Board of Registration in Pharmacy;
- in addition to registering with the DCP, the pharmacist is registered with the U.S. Drug Enforcement Administration if the collaborative practice agreement allows for federally controlled substances to be prescribed;
- a prescription or medication order from a pharmacist may be issued, modified, or discontinued only in accordance with the collaborative practice agreement entered into with the supervising physician, and applicable regulations of the Boards of Registration in Pharmacy and Medicine;

- a pharmacist practicing in a retail setting is restricted to writing prescriptions for Schedule VI controlled substances only;
- a pharmacist may order and dispense a Schedule VI controlled substance for 'immediate treatment';
- a pharmacist may issue an oral prescription; and
- within a licensed health care facility (i.e., hospital, LTC facility, ambulatory care clinic, hospice), a pharmacist may prescribe a controlled substance for a patient as a written medication order documented in the patient's medical record; and
- a pharmacist practicing under a collaborative practice agreement is required to keep a record of all controlled substances maintained for the purpose of immediate treatment or administration; and
- a pharmacist who writes an initial prescription or modifies or discontinues a prescription is required to provide a copy to the supervising physician within 24 hours of issuance (unless more urgent notification is warranted).

Discussion followed by the Council, please see the verbatim transcript for the full discussion. Dr. John Cunningham asked staff to make sure there is no loophole involved in the pharmacist dispensing of oral prescriptions since it is stated very general in 105 CMR 700.003 (I) (7) of the proposed regulations. Attorney Howard Saxner noted that the ability to prescribe is limited by all three companion regulations but that he would double check for loopholes. Mr. Paul Lanzikos inquired about how this would impact homebound patients. Ms. Jean Pontikas, Director, Division of Health Professions Licensure participated in the Council discussion, clarifying that agreements would have to be in place between the patient and the physician and the pharmacist before any type of prescribing by a pharmacist could take place and that there is a possibility for the community pharmacist to be able to help the homebound patient with their prescriptions if there are agreements in place between the patient

and their physician and the said patient's physician and the participating pharmacist. Dr. Wong noted his concerns about a pharmacist being able to write a patient a brand new prescription or switch a prescription that the patient is on especially in the instance of HIV care. Attorney Saxner responded that is why an agreement is required between the physician and the pharmacist detailing what is allowed or not allowed. Chair Auerbach clarified that "this is not a blanket granting of authority to pharmacists, this is allowing an individual doctor to make an agreement with an individual pharmacist, under limited conditions, allowing certain actions to take place within a 24 hour notice period [to the supervising physician]..." Mr. Lanzikos added in part, "...I know we are at the first stage of this, but I would hope, as it is being implemented, we can be looking at ways to get this as broadly implemented across home and community based settings because, as we are seeing more and more frail folks being cared for in home and community based settings, we have got to make sure the benefits of these types of innovations are applied to them. We don't want to inadvertently have to force more people back into institutions because that is where the best practices, you know, best medical care is being provided."

Discussion continued, Dr. Alan Woodward stated in part that "there are potential benefits to this in certain defined circumstances". He stated that he thought it would be beneficial for the PHC to look at the companion regulations being promulgated by the Board of Registration of Pharmacy, before the Council votes on the final regulations and suggested that the three agencies work together on a model agreement. Ms. Pontikas replied that the three boards plan on having a joint public hearing on the matter and so all the public comments will be available and brought back to the Council. She said further, that staff did plan on working on a model agreement and publishing it on the web as not a mandatory agreement but as an example agreement. Dr. Michael Wong raised the issue of liability and an indemnification clause. Attorney Saxner noted that the statute requires a million dollars in liability insurance for the dispensing pharmacist. Ms. Pontikas noted that the liability insurance requirement is in the statute and in the Pharmacy Board's proposed regulations. Attorney Donna Levin, DPH General Counsel stated "that

the issue is complex and those issues will have to be looked at carefully.”

Chair Auerbach noted that the regulations would after, the joint public hearing, return to the Council for a final vote in probably April or May. NO VOTE/ INFORMATION ONLY

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 590.000: STATE SANITARY CODE CHAPTER X: MININIM SANITATION STANDARDS FOR FOOD ESTABLISHMENTS, TO COMPLY WITH THE ALLERGEN AWARENESS ACT:

For the record: Council Member Sherman arrived at approximately 9:55 a.m. during Ms. Condon’s presentation on the proposed allergen regulations.

Ms. Suzanne Condon, Director, Bureau of Environmental Health, presented proposed amendments to the state sanitary code regarding allergens to the Council. She stated in part, “...In January of 2009, Governor Patrick signed the Food Allergy Awareness Act into law and it requires several things. It requires that certain food establishments permanently display a Food Allergy Awareness poster in the staff area of food establishments, that such establishments put a notice on menus for customers with food allergies, and that they provide for food allergy training for persons in charge, but also others who are certified food operators, food managers. It required the Department of Public Health to develop regulations. It required us to develop a training video in consultation with the Massachusetts Restaurant Association (MRA) and the Food Allergy and Anaphylaxis Network (FAAN) and further to develop a voluntary program for restaurants to be designated as Food Allergy Friendly, and to maintain a listing of restaurants receiving that designation on the Department’s web site.”

Ms. Condon continued, “...This Act covers food establishments that are licensed as Innholders or Common Victuallers under M.G.L. c.140 so they will be required to comply with this act when serving food.

The majority of restaurants in Massachusetts are licensed as Innholders and Common Victuallers...Common Victualler licenses are granted by Boards of Selectmen, not Boards of Health so our ability to take action at the local level, then requires that there be communication between the Local Board of Health and the Board of Selectmen, if an entity needs to take action against them [a restaurant]. Food establishments that are not licensed as Innholders or Common Victuallers are exempt. Food establishments should check with their local Board of Health and/or city or town if they have any questions about local licensure...Definitions are: The Common Victualler is a food establishment licensed under M.G.L. c.140, § 6, that cooks, prepares or serves food. An Innholder is likewise the same. A menu is defined as a printed list or pictorial display of a food item/s and their price(s), that are available for sale from a covered food establishment licensed under M.G.L. c.140, § 6 as a Common Victualler or Innholder...A Major Food Allergen means milk, eggs, fish (such as bass, flounder, or cod), crustaceans (such as crab, lobster, or shrimp), tree nuts (such as almonds, pecans or walnuts), wheat, peanuts, and soybeans; and (2) A FOOD ingredient that contains protein derived from a FOOD named in subsection (1). Major food allergen does not include: (a) Any highly refined oil derived from a FOOD specified in subsection (1) or any ingredient derived from such highly refined oil; or (b) Any ingredient that is exempt under the petition or notification process specified in the federal Food Allergen Labeling and Consumer Protection Act of 2004 (Public Law 108-282)."

Ms. Condon and staff's memorandum to the Council, dated February 10, 2010 explains the proposed amendments as follows:

(4) Amend 590.009: Special Requirements to add new subsection (H):

(H) Food Allergy Awareness Requirements for Common Victualler or Innholder. No later than July 1, 2010, a food establishment licensed as a common Victualler or Innholder under M.G.L.c.140, section 6 that cooks, prepares, or serves food shall comply with the following requirements.

- (1) Poster. Prominently display in the employee work area a poster developed and approved by the Department relating to major food allergens. The poster shall include the following information:
 - (a) Major food allergens;
 - (b) Health risks of food allergies;
 - (c) Procedure to follow when a customer states that they have a food allergy; and
 - (d) Emergency procedure to follow if a customer has an allergic reaction to a food.
- (2) Notice on menus. Include on any printed menu a clear and conspicuous notice requesting a customer to inform the server before placing an order, about the customer's allergy to a major food allergen. The notice shall state: Before placing your order, please inform your server if a person in your party has a food allergy.
- (3) Training.
 - (a) Each certified food protection manager shall view a training video approved by the Department, concerning major food allergies and celiac disease-related food intolerance, once every five years. Such manager shall prominently post at the food establishment where he or she works, the certificate indicating that he or she has viewed the video.
 - i. Beginning July 1, 2010, a person shall view the training video in order to become certified or recertified as a food protection manager.
 - ii. Persons who are certified as food protection managers on July 1, 2010 and who are not due to become recertified within the following 6 months shall view the training video no later than January 1, 2011.
 - (b) Each person in charge, certified food protection manager, and alternate person in charge shall:
 - i. Demonstrate knowledge of MAJOR FOOD ALLERGENS during inspections and upon request of the REGULATORY AUTHORITY, by describing the

symptoms that MAJOR FOOD ALLERGENS could cause in an individual who has an allergic reaction, or by displaying the certificate indicating that he or she has viewed the training video described in 105 CMR 590.009 (H) (3)(a); and

- ii. Ensure that employees are properly trained in food allergy awareness as it relates to their assigned duties.

In closing, Ms. Condon stated, "We will publish a notice for the hearing, then schedule and convene the hearing (tentatively scheduled for March 12, 2010 at DPH, 250 Washington Street, Boston). We will review any and all comments and incorporate those comments as warranted. Then we will return before you for final approval of the regulations, as amended as necessary and then the regulations are submitted to the Secretary of State for promulgation."

Discussion followed by the Council, please see the verbatim transcript for full discussion. Dr. Alan Woodward suggested that a simple statement be required on menu boards as required on menus. Ms. Condon agreed to ask for feedback on this suggestion at the public hearing. Dr. Barry Zuckerman suggested that the training video show explicit pictures of a child in an Intensive Care Unit on a ventilator so people understand the impact. Dr. Woodward, suggested that the training video include statistics on the number of significant allergic reactions and the number of deaths and further include discussion of the symptoms because the patient may not recognize them or even know they have an allergy (i.e., turning red, swelling of the lips, shortness of breath, horse voice etc.). He said a poster with the symptoms may also be a good idea. Dr. Zuckerman noted, "Food allergy, in general, is a disease of younger people, adolescents and children. It hasn't become common among adults as it is for children." In response to questions by Mr. Lanzikos, Ms. Condon noted that a restaurant wouldn't be required to print their menu, it could use a sticker; that web-based menus are included, and that enforcement is up the local authorities. Mr. Sherman asked about requiring a restaurant to have an Epi pen for emergency use.

Ms. Condon said she would mention the suggestions to the working committee.

NO VOTE/INFORMATION ONLY

DETERMINATION OF NEED PROGRAM: CATEGORY 1
APPLICATION NO. 4-4935 OF BOSTON OUT-PATIENT
SURGICAL SUITES LLC: Transfer of ownership of a multi-specialty ambulatory surgery center

Ms. Joan Gorga made introductory remarks to the Council, noting a correction to the staff summary. The applicant is a multi-specialty (orthopedic and pain management) not a single-specialty ambulatory surgery center as noted in the original staff summary. An updated staff summary was distributed to the Council with the correction. The applicant provided staff with a copy of their official certification letter from Medicare showing their certification as multi-specialty ambulatory surgery center since 2004.

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the Boston Out-Patient Surgical Suites Project to the Council. He noted in part, "...It is a relatively complex transfer, it has several components. Boston Out-Patient Surgical Suites, LLC (BOSS) in Waltham (BOSS) will first merge into a Tennessee limited company, also called Boston Out-Patient Surgical Suites L.L.C. (LLC). Waltham Administrative Management L.L.C. (WAM), an entity which is owned primarily by BOSS physicians and which currently manages BOSS, will also merge into LLC. Following these mergers, AmSurg Holdings, Inc., a Tennessee corporation, will purchase sixty-five (65%) of the ownership interests of LLC, and the remaining thirty-five percent (35%) of LLC's ownership interests will then be contributed to a to-be-formed entity called BOSS Holdings, LLC (which, as a result, will be owned mostly by current BOSS owners). When the transfer is completed, AmSurg will own sixty-five percent (65%) of LLC and BOSS Holdings, LLC will own thirty-five (35%); and LLC will be the new owner/operator of the BOSS ambulatory surgery center."

Mr. Page said that based on staff's review of the BOSS's ambulatory surgery practice, staff has determined that it satisfies the standards set forth in the DoN regulations for a Transfer of Ownership 105 CMR 100.600 and 100.602 and recommends approval of Project Application No. 4-4935.

Discussion followed by the Council, please see the verbatim transcript for the full discussion. Dr. Barry Zuckerman suggested and Mr. Paul Lanzikos concurred that the Department should come up with a mechanism allowing for applicants of transfer of ownerships (Ambulatory Surgery Centers) to contribute to patient care initiatives (i.e. for needed diversity or interpreter services etc.). Chair Auerbach suggested that staff from the DoN Office, Office of Health Equity, Office of Community Health Services and Legal get together and discuss the possibilities and return to the Council within 60 days with a recommendation.

Notes for the record: At this point in the discussion, Council Member Dr. Barry Zuckerman asked for clarification about conflict of interest with regard to this application. Legal staff were asked to clarify whether there is a conflict of interest issue for Boston Medical Center employees (Dr. Barry Zuckerman and Dr. Michèle David) or for Beth Israel Deaconess employee (Dr. Wong) on the BOSS application. At this time, discussion temporarily ended on the BOSS application. The Council heard the next docket item entitled, "Massachusetts Strategic Plan for Care Transitions" until staff returned to the table with the BOSS application later in the meeting. However, the presentation is summarized at the end of this document for ease of reading and comprehension of the information presented. Dr. Barry Zuckerman left the meeting at 10:45 a.m.

Donna Levin, General Counsel informed Chair Auerbach that Dr. Michèle David and Dr. Barry Zuckerman have no conflict of interest, therefore, Dr. David can vote on the BOSS application, securing a quorum of eight members present to vote. Chair Auerbach asked DoN Staff to return to the table, Ms. Gorga and Mr. Page of the Determination of Need Program.

Ms. Gorga explained the outcome of the conflict of interest discussion for the record. She stated, "The issue is whether or not any of the physicians in the BOSS practice would do their inpatient surgery at either of the two hospitals represented by the Council Members, BI or University Hospital because those hospitals would be the ones affected by an ambulatory surgery center that would take business away from those hospitals, and we have spoken with Dr. Ross, who knows the members of his practice, and has said that, to the best of his knowledge, none of the surgeons in his practice do their inpatient surgery at either one of those two hospitals. So, those two hospitals are not impacted by the transfer of the ownership of this multi-specialty ambulatory surgery center. On that basis, Dr. David does not need to recuse herself because her hospital, as well as Dr. Wong's, will not lose business from this transfer of ownership." Attorney Donna Levin, General Counsel for the Department of Public Health said that was an accurate statement. No questions were asked by the Council.

Mr. Albert Sherman made the motion to approve the BOSS Application. After consideration upon motion made and duly seconded, it was voted unanimously (Chair Auerbach, Dr. Cunningham, Dr. David, Mr. Lanzikos, Ms. Prates Ramos, Mr. Sherman, Dr. Wong and Dr. Woodward in favor) to approve **Project Application No. 4-4935 of Boston Out-Patient Surgical Suites LLC, Waltham (BOSS) for Transfer of Ownership** based on staff findings that the application satisfies the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. of the Determination of Need Regulations and also found that the applicant satisfies the standards applied under 100.602 of the Determination of Need Regulations. When the transfer is completed, AmSurg will own 65% of LLC and BOSS Holdings, LLC will own 35% and LLC will be the new owner/operator of the BOSS ambulatory surgery center. The revised staff summary is attached and made a part of this record as **Exhibit No. 14, 943.**

“MASSACHUSETTS STRATEGIC PLAN FOR CARE TRANSITIONS”, BY ALICE BONNER, PhD, RN, Director, Bureau of Health Care Safety and Quality, and Joel Weissman, PhD, Senior Health Advisor, Executive Office of Health and Human Services

Dr. Alice Bonner made introductory remarks stating that the 80-page strategic plan is the culmination of over two years of work by many different organizations in Massachusetts. The draft is available on the Health Care Quality Cost Council web site.

Dr. Joel Weissman noted some of the organizations that provided input into the document: Institute for Health Improvement, Massachusetts Hospital Association, State Auditor’s Office, Health Care for All and consumer and providers. During his presentation, he said he would address barriers in effective transitions, the State Quality Improvement Institute and speak to these questions, What are the effective transitions?, What is Known? What is the policy landscape? And what their vision is for maximally effective care transitions. Dr. Bonner will speak about the principles, recommendations and action steps and how they are going to measure success.

Some excerpts from his presentation follow please see verbatim transcript for the entire Massachusetts Strategic Plan for Care Transitions presentation. “In putting together this document, we identified a number of barriers to effective care transitions...Even though a lot of people probably everybody in this room has a personal story about somebody who has left the hospital, left the nursing home, even walked out of the doctors office and had a problem with care transitions. There are a lot of barriers to actually making those transitions smoother. We have divided those into three general areas; structural, procedural, performance measurement and alignment. For example, under structural issues, there is a lack of integrated care systems. Medical care tends to be provided in silos and they are not integrated. There is a lack of longitudinal responsibility. Once somebody leaves a doctor’s office or medical facility, it is unclear who has responsibility for that patient over time

or even over life course. The lack of standardized forms and processes is an interesting one....There are other problems with incompatible information systems. There is a lack of training in care coordination and team based training and a lack of community links....When it comes to procedural issues, there is ineffective communication, failure to recognize cultural, educational, or language differences and as I mentioned before, processes are not patient centered and longitudinal. There is an under use of measures to indicate optimal transitions. We tend to know when they fail, when there is a bad outcome such as a rehospitalization or readmission..."

Dr. Weissman continued, "... Coordination and performance incentives are not aligned with care coordination and transitions. A lot of times you ask a physician or a nurse, why aren't you following this patient? Why can't you provide this information after the patient leaves the hospital, and they kind of look sheepishly and say, 'we are not compensated to do that', and we need to align those incentives, of course, payment tends to be for volume of services rather than outcomes."

He said, "The major focus of this work is transitions across settings – from hospitals to the community, hospital to the nursing home, to an L-TAC, to the physician's office, from a physician's office to a specialist - any time you change settings that are not integrated with a single medical record or involve some sort of a handoff. Other settings that a patient/family may need to deal with are: emergency departments, home health agencies, skilled nursing facilities, pharmacies, emergency medical services, long term care services, senior councils on aging, Hospice, outpatient rehabilitation services, and health plans or insurers...There are Aging and Disability Resource Centers and Aging Service Access Points, which provide a lot of coordination of care for Medicaid patients and for actors who need to come together to really provide the optimum transitions....The purpose of this strategic plan is to create what we are calling a living document. This is not intended to be a white paper, which will be a static thing...The landscape is changing and the policies are changing so we expect that this document could be updated without that much effort on at least an annual basis. The idea is to create a vision for

optimal transitions in care for Massachusetts residents....We are going to set broad goals and actionable steps that will lead to implementation, and the other purpose of this was to ensure that this work is aligned with related state and federal health care and payment reforms. The vision for this is to use interdisciplinary and multi-disciplinary teams to deliver safe, effective and timely care that is culturally and linguistically appropriate within and across settings and to do so, we think that you really need to have the three legged stool aligned: clinical care of individuals, thinking about public health and populations, and involve health policy, which we define as payment and organization of services."

Dr. Weissman noted some of the elements of care common to most of the transition models are the following: medication management, medication reconciliation, assessing the patient's understanding and ability to follow the care plan, discharge support, coaching for primary care physician visits, use of home visits, screening for cognitive ability, use of centralized health record, involving family and caregivers, and arranging community-based support services.

Dr. Weissman said further, "...We know that this is really a patient safety issue, that when you are discharged from the hospital in particular, if you are rehospitalized, it means a failure in some way often, not all the time, but often, of community care, especially if that happens within seven, fifteen, or thirty days, and that reducing those events can actually save money.

Dr. Bonner added, "One of the topics that comes up very often is, who is saving? If there's cost savings, to whom is that accruing and, of course, this is typically to Medicare. We do get into those discussions about how can the state leverage these savings so we are gaining at the state level?"

Note for the record: Dr. John Cunningham left the meeting at this point, during this presentation at approximately 11:00 a.m. and Mr. Albert Sherman followed at 11:05 a.m.

Dr. Bonner noted the seven principles and key recommendations of the strategic plan: (1) Timely feedback and feed forward of information which includes standardized, minimum datasets, cross-continuum teams, and enhanced early post-acute care follow-up. (2) Communication infrastructure which includes contact information provided, a Living database and medication tracking. (3) Patient and family engagement which includes patient and/or advocacy group representation. (4) Accountability for care remains with the sending set of providers which includes handoff responsibility and an identifiable provider. (5) Provider and Practice Engagement which includes education/best practices and mentors. (7) Payment reform which includes incentive alignment and Data transparency.

Regarding principle (4) above Dr. Bonner stated, "It is not going to be easy to implement that, and we are not saying that is going to be slam dunk at all, but we have the Mass Hospital Association saying, we understand, we think this is important, and other groups, as well, same thing with the nursing home community, the notion that, if you are leaving a skilled nursing facility and going back to the community, there is a physician or, in my case, a nurse practitioner in the SNF who is taking care of that patient, that accountability continues until you have had that call with the primary care person, saying, yes, I understand. I've got it."

Dr. Bonner noted further that "...when people first look at the initiatives, a physician or hospital may first think, how much more work, are they asking me to do? What's important to look at are the models where they have reengineered the team and figured out who can do what, maybe an office assistant, a nurse or a peer manager can do a task, it doesn't necessarily have to be the physician. It's not only about hospitals sending people out into the community and having them bounce back and people saying it's the hospital's problem. It's looking at the community's responsibility, what is the skilled nursing facility's responsibility and looking at it. That is why it seems like it is a Public Health issue. It's really about populations and it is about organizations working in communities.

Council Member Paul Lanzikos asked about where to find the standardized forms. Dr. Bonner said forms are available on the Mass Health Data Consortium web site as well as on other states' web sites in Akron, Ohio and Indianapolis.

In closing, Dr. Bonner noted in part, "In terms of measuring success, the Health Care Quality Cost Council next week is going to endorse the strategy as well as other Massachusetts organizations so we can move into implementation" She noted that they have a model, "the Model for Better Outcomes Across the Continuum of Care" which involves implementing the strategic plan with regional collaboratives. And further Dr. Bonner noted that "We already have regulations in place that we could enhance to improve health status and patient experience, such as fewer complications, improved function, reduced adverse events, improved satisfaction and understanding which leads to appropriate utilization, fewer ER visits, fewer readmissions and fewer preventable admissions and unnecessary tests and procedures...We think this framework makes sense and is aligned with a lot of other work going on in the state, and certainly in public health."

For the next steps, Dr. Bonner said they will meet with Secretary Bigby to talk about implementation of the plan. She stated in part, "...We ought to get moving with this, since we have been working on it for a couple of years."

Dr. Weissman stated in part, "...Unless we can transform primary care into patients that are in medical homes, unless we can put into place the mechanisms to improve transitions across care, no matter how you change the incentives, you are not going to get the desirable outcome...no matter what we do with Health Care Reform and accountable care organizations, moving the health care system in this direction we think is important, not only in the near future, but in the distant future, as well."

Dr. Bonner noted further that one of the functions of the Bureau of Health Care Safety and Quality is to survey and inspect nursing homes, home health agencies and hospitals. One of things the

Bureau will do its work with the surveyors so they can look for safe care transitions and work with the institutions to make sure they understand about safe care transitions and can work toward improvement.

Discussion followed by the Council, please see the verbatim transcript for the full discussion. Council Member Dr. Alan Woodward noted that he thinks there should be one common form for everybody to use "because if a physician has to deal with twenty different formats for the same information, you don't have consistency. And further that it would be a good idea to identify the sender and receiver of the patient at the top of the form – identify the responsible recipient." Dr. Weissman said in part, "...When a patient leaves the hospital, why isn't that patient contacted in the next day or two to make sure that their medications are working and that they have a follow-up appointment? When you ask clinicians, why isn't this done, it's partly a compensation issue, and partly it is a training issue, they haven't been trained to do this, it's an accountability issue. I think people are starting to realize that this is something that needs to be done....The reason I think that hospitals are so interested in this is that CMS is starting to talk about some big changes. They are already collecting information on readmissions and there is strong talk about non-payment for readmissions and so then it becomes in their business interest to do something about this, even without broad national health reform."

In closing, Chair Auerbach noted, "I think that one of the hallmarks of the Public Health Council is that we are an action-oriented group and what you are hearing is great enthusiasm for this, great interest in supporting the work that you have done and a real desire on the part of the PHC members to do something about this. I would suggest that what we should do at DPH is draw up our own list of what the actions steps are within the Department's control, either from a regulatory perspective or a policy perspective, that we can just start moving ahead because I think the danger is that there are so many things that need to change, that this could be something where everybody buys into the vision but then the pieces don't start to get aligned...The range of things include the establishment of a

common form, we may be able to mandate that as a condition for licensure for hospitals and other health facilities, discharge summaries, writing the regulation on electronic medical records and insert in those regulations elements to reinforce this. So thinking those kinds of things through and coming back to the Council or by giving us a memorandum with some action steps that you can actually move ahead on. We would appreciate that..." The Council suggested further that the hospitals' Patient and Family Advisory Councils could be engaged in this and perhaps also consider this when approving a Determination of Need (DoN) application - ask perhaps on a checklist, "What steps is your institution taking to effectively transition patients?"

Chair Auerbach noted that he would work with Dr. Bonner on these suggestions and come back to the Council and say, "We heard your endorsement of the vision. Here's what the Council's role is in terms of making that a reality."

NO VOTE/INFORMATION ONLY

ACTIONS STEPS/FOLLOW-UP:

- Make sure there are no loopholes in 105 CMR 700.003 (I) (7) regarding dispensing of oral prescriptions by pharmacists (Cunningham, Saxner)
- Look at ways the CDTM pharmacists can be applied in home and community settings (Lanzikos, Pontikas)
- Regarding CDTM, issues of liability and insurance reviewed (Wong, Saxner, Levin)
- At public hearing, BEH should ask about putting stickers on menu boards as required on the menus (Woodward, Condon)

- Staff should check on the possibility of a mechanism allowing for applicants of transfer of ownerships (ASCs) to contribute to patient care initiatives and return to the Council within 60 days with a recommendation. (Zuckerman, Lanzikos, Gorga, OHE, OCHS, Legal)
- Identify actions steps DPH can take from a regulatory/policy perspective such as creating a standardized common form, writing regulations for electronic records, etc. (Auerbach, Bonner).

The meeting adjourned at 11:45 a.m.

John Auerbach, Chair

LMH