

**MINUTES FOR THE MEETING OF THE BOARD OF THE  
BOSTON PUBLIC HEALTH COMMISSION  
Wednesday, December 21, 2016**

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Wednesday, December 21, 2016 in the Hayes Conference Room, 2nd floor, 1010 Massachusetts Avenue, Boston, MA 02118.

**Board Members Present:**

Francis J. Doyle, Esq., Chair  
Monica Valdes Lupi, JD, MPH, Executive Director  
Joseph Betancourt, MD, MPH  
Harold Cox  
Tyrek Lee  
Manny Lopes  
Myechia Minter-Jordan, MD, MPH

**Also Present Were:**

Elizabeth Skillen, Mary Jane Williams, Paul Horn, Mary Boyle, Bill Kessler, Ilyitch N. Tábora, Catherine D'Vileskis, Huy Nguyen, Angie Cradock, Gerry Thomas, Katie Donovan, Diana Chaves, Eugene Barros, Margaret Reid, Motolani Aina, Heather Gasper, Kathleen McKiernan, Selam Engida, Belkis Roman, Oyin Kolawole, Maia BrodyField, Mary Bovenzi, Ann McHugh, Leon Bethune, Neil Blackington, Dan Dooley, Nineequa Blanding, Amar Mehta, Angelica Recierdo, Brad Cohen, Roy Wada, Anita Barry, Helen Ayanian, Martha Farlow, Tim Harrington, PJ McCann, Chuck Gagnon, and Kathy Hussey.

**Proceedings:**

**Chairman's Comments**

*Francis J. Doyle, Esq.*

- Mr. Doyle called the Board of Health meeting to order at approximately 4:12pm. He thanked everyone for coming, wished everyone a happy holiday season and happy new year. Monica and her team have put together a significant response and presentation around the HI-5 CDC efforts, from whom we'll be hearing in a few minutes. Frank turned the meeting over to Monica for her to begin walking us through the agenda.

**Report from the Executive Office**

*Monica Valdes Lupi, JD, MPH*

*Executive Director, Boston Public Health Commission*

- Ms. Valdes Lupi said she'd walk through the Executive Office updates first.
- In terms of the Commission in the news, Monica wanted to thank our Board Members and the staff here at the Commission for a really robust conversation at last month's board meeting on the passage of Question 4 which was about measures focused on legalizing marijuana in this state.
- Our staff was also in the news recently as the Mayor hosted a press conference about the City's Winter Plan for the Homeless. We were there with colleagues Chief Dillon and Jim Green, Emergency Shelter Commission, Beth Grand and others here at the Commission to talk about the city-wide plans around the winter months and highlighted the attention we're paying to providing emergency shelter beds, overflow beds and all of this in partnership with the other shelters throughout the city.
- We were able to host Secretary Julián Castro from HUD on November 30, 2016 where he announced a new policy at the federal level to rollout smoke-free housing.

- On the government relations front, you'll find a memo that we've worked on with the programs staff here at the Commission and with our colleagues at City Hall. It highlights some of the key public health programs here at the Commission
- Frank had a question It seems like there's over \$50million we get from the federal government that is subject to review by the new administration at some level or another. Is that true? He just wanted to show the magnitude of it. Monica said yes, that was probably the amount and they would be at different stages of renewals too. We can certainly provide that breakout in terms of end dates and how those funds are distributed across our programs. It's not an insignificant amount. It is a diverse portfolio, so we rely on city, state and federal resources to support our core infrastructure here.
- We also wanted to highlight that the 21<sup>st</sup> Century Cures Act was signed by President Obama. You've probably been hearing a lot about this in the news. From the public health perspective, there was \$1billion announced in the Cures Act that would support state efforts. We're not sure whether we'll benefit from that infusion of funding. There's also about \$5billion over 10 years in additional funding to the National Institutes of Health and then funding and some changes in the FDA approval processes.
- On the state front, you've probably heard that the Governor was going to implement 9C reductions. We've worked with our colleagues at City Hall and, at this point and time, do not believe that any of the cuts announced are going to have a direct impact on BPHC.
- We are now working with the Mayor and City Hall around legislative priorities for the next session. The Mayor received and reviewed over 140 proposals. He agreed to be the supporter for 81 of those 140 proposals that were bills suggested all across his cabinets and departments. We submitted 14 proposals and 11 were actually selected to make that short list of the Mayor's.
- We'll be working with the Mayor the week after New Year's to find legislative sponsors.
- As a follow-up from the city-wide efforts around marijuana legalization and how to operationalize this ballot measure across our city departments, we were convened with Jerome Smith, who's the Chief for Mayor Walsh's Office of Neighborhood Services, along with other city departments to look around issues on zoning and licensing. We've been asked by the Office of Budget Management to look at potential cost implications for our programs internally at the health department. We're beginning to pull this together. You'll see in your packets an updated memo that PJ McCann, our Deputy General Counsel, has prepared around our scope of authority. Monica thinks that is the question that came up at the last Board meeting.
- Frank stated that Monica and the team have been very helpful in putting together very robust presentations for the Commission around important and front-line activities going on in public health. We're delighted to day to recognize and express our appreciation to Dr. Skillen who's here from the CDC. She is a Senior Advisor in the Policy, Research, Development and Analysis Office in the Office of the Associate Director for Policy at the CDC. Welcome to Boston. We very much appreciate you being here. Monica has other staff on the panel to be able to discuss the HI-5, School Safe Streets and other things as well. Thank you very much.

***Panel and Discussion: CDC's Health Impact in 5 Years (HI-5) Initiative and Interagency***

***Efforts to address Social Determinants of Health in Boston***

***Elizabeth Skillen, PhD, Senior Advisor, Policy, Research, Analysis and Development Office,***

***Office of the Associate Director of Policy, Centers for Disease Control and Prevention (CDC)***

- Dr. Skillen stated she learned a lot about the great work from our team and was excited to be here to speak about their HI-5 initiative.
- HI-5 is the new CDC population health initiative to improve health in 5 years or less. The CDC's strategic directions are to: improve health security at home and around the world; better prevent the leading causes of illness, injury, disability, and death; and strengthen public health/health care collaboration.
- The health system is changing: 20 million Americans have insurance for the first time (fewer public health safety net services); shifting from "Volume-Based" Payment Model to "Value-Based" Payment Model (opportunities to improve population health and address health equity; increased focus on prevention and wellness); emerging clinical care models (need for more collaboration between clinical care and public health).

- Our office recently published a report: Public Health as Chief Health Strategist with several recommendations within that document and highlighting two here: Practice #2 – develop strategies for promoting health and well-being that work most effectively; Practice #5 – collaborate with a broad array of allies, including non-health sectors, to build healthier and more vital communities.
- The CDC has a three “Buckets” of prevention framework. Bucket #1: traditional clinical prevention to increase the use of evidence-based services. Bucket #2: innovative clinical prevention to provide services outside the clinical setting. Bucket #3: total population or community-wide prevention to implement interventions that reach whole populations.
- A complimentary initiative in our office that you may have heard about is the 6/18 Initiative. This is around buckets 1 and 2: increasing the adherence to traditional clinical or innovative clinical practices around 6 high profile conditions: tobacco use, blood pressure control, preventing healthcare associated infections, asthma control, prevent unwanted pregnancy and control and prevent diabetes. I’ll be focusing more on Bucket #3.
- Bucket #3 centers around community-wide prevention; implement interventions that reach whole populations. How do we improve population health in our states and communities? What is the best evidence of health *and* cost impact? What can we do that will begin to show results soon?
- A chart was shown with a Health Impact Pyramid that appeared in the *Frieden T. American Journal of Public Health* in April of 2010. The Pyramid had 5 sections from top to bottom: counseling and education; clinical interventions; long-lasting protection interventions; changing the context to make individuals’ default decisions healthy; and socioeconomic factors. In order to increase population impact, we start at the top of the pyramid and work downward. We reverse the process, from the bottom up, to increase the individual effort needed.
- There are a few caveats: the CDC’s roles: summarizing evidence and offering tools – no funding for implementation. There are many other worthwhile efforts, some take longer to work, are costly, and haven’t been evaluated. Some of the questions we’ve heard: “I work for a governor who only wants health initiatives that will lead to positive results before she runs for re-election? Got any of those?”; “How do I make the business case for my community-wide health strategies to a hospital board?”; “I lead a small health department. How do I address the social determinants of health?”
- HI-5 – Health Impact in 5 Years is comprised of 14 evidence-based, community-wide, population health interventions: improve health of community (not clinical/patient-oriented); demonstrate positive health impact in 5 years or less and cost effectiveness and/or savings over time. These interventions are linked to Section 4 Changing the Context and Section 5 Address the Social Determinants of Health in the Health Impact Pyramid.
- How was the HI-5 List developed? There were 4 steps in this process. **Step 1** were interventions that earned the highest evidence rating from “The Guide to Community Preventive Services” and the Robert Wood Johnson Foundation/U. of Wisconsin County Health Rankings/Roadmaps What Works for Health site; and CC experts. **Step 2** excluded Bucket 1&2 interventions and those with evidence of potential harm. **Step 3** excluded those without evidence reporting: measurable impact on health in five years; cost effectiveness and/or savings over the lifetime of the population or earlier; and those not implemented in more than 855 of states. **Step 4** excluded those not implemented at policy level. The result: 14 interventions that earned the highest evidence ratings, show positive health impact within 5 years, and report cost effectiveness/savings over the lifetime of the population or earlier.
- Eight of these 14 evidence-based interventions are centered in The Health Impact Pyramid’s Section 4 Changing the Context: Making the Healthy Choice the Easy Choice: school-based programs to increase physical activity; school-based violence prevention; safe routes to school; motorcycle injury prevention; tobacco control interventions; access to clean syringes; pricing strategies for alcohol products; and multi-component worksite obesity prevention.
- The other 6 evidence-based interventions are prevalent in the Pyramid’s Section 5 Social Determinants of Health: early childhood education; clean diesel bus fleets; public transportation system; home improvement loans and grants; earned income tax credits; and water fluoridation.
- Public transportation system introduction or expansion. By way of description, this intervention include a variety of transit options such as buses, light rail, and subways and increases both access and use of public transit and to reduce traffic. Its health impact would cause reductions in health risk factors such as motor vehicle crashes, air pollution, and physical inactivity and increases in walking per day. The economic impact is the typical American public transit service improved to high quality urban rail or bus rapid transit service would result in per capita annual health benefits of \$354.86.

- Tobacco Control Interventions by description: tobacco price increases; high-impact anti-tobacco mass media campaigns and comprehensive smoke-free policies. The health impact would be reduced hospitalizations for asthma and heart attacks; reduced numbers of young people who start smoking; and increased quitting in young and adults. The economic impact would include smoke-free indoor policies that would reduce hospital admissions by 5-20%; mass-media campaigns that would have a benefit-to-cost ration up to 74:1; and raising prices by 20% would have a healthcare savings of up to \$90 per person per year.
- Tobacco cessation can be included in all three buckets. Bucket 1 traditional clinical prevention: expand access to evidence-based tobacco cessation treatments; remove barriers that impede access to covered cessation treatments. Bucket 2 innovative clinical prevention: promote increased utilization of covered treatment benefits by tobacco users. Bucket 3 community-wide prevention: tobacco price increases; high-impact anti-tobacco mass media campaigns; comprehensive smoke-free policies.
- What's next? We will present webinars to highlight specific HI-5 interventions; webinar series to continue in 2017. We'll continue to learn from cities, counties, communities, states and you, the Commission; email us at [Healthpolicynews@cdc.gov](mailto:Healthpolicynews@cdc.gov). We'll continue to evaluate our efforts to spread the word about HI-5.

*Anne McHugh, MS, Director, and Mary Bovenzi, MPH, Associate Director,  
Chronic Disease Prevention and Control Division, Community Initiatives Bureau, BPHC*

- Ms. McHugh stated she would present the first few slides before turning the presentation over to Ms. Bovenzi. Mary Jane is here to participate in this discussion and answer Safe Routes to School (SRTS) questions. She also wanted to acknowledge 2 other colleagues, Selam Engida from our Injury Prevention office here at the Commission and helped develop a lot of the materials. She also acknowledged Dr. Angie Cradock from Harvard Prevention Research Center at Harvard University School of Public Health. Angie is the Deputy Director of the PRC and is the lead evaluator on this component. Harvard PRC is our overall evaluator on our Healthy Boston initiative.
- Anne gave an overview of the initiative Boston Partnerships to Improve Community Health (PICH). This is a \$5.22 million, 3-year grant funded by the Centers for Disease Control and Prevention. It supports voluntary policy and systems (PSE) changes to encourage healthy choices in physical activity, nutrition and tobacco control. The Partnership model includes: BPHC's Division of Chronic Disease Prevention and Control; Boston Alliance for Community Health (BACH), Community-based organizations, City agencies, Harvard Prevention Research Center (evaluator), and Consultants (Toole Design for SRTS).
- What is SRTS? It's goal is to increase daily physical activity among children; decrease obesity and overweight; create *safe, convenient, and fun* opportunities for children to *walk and bicycle* to and from school. Congress approved SRTS funding in all state transportation departments in 2005.
- We did a comparison between walking and biking to school versus being driven to school. In 1969, 48% of children walked or biked to school while 12% were driven. By 2009, those numbers had reversed with 44% of children being driven and 13% walking or biking to school
- The program benefits for students are: more physical activity; improved academic performance; improved on-time attendance rates; better social, emotional and physical health; and greater independence. Benefits for everyone are: improved air quality; safer walking and bicycling environment; less traffic congestion; and cost savings.
- SRTS: Why now in Boston? Because of Boston Public Schools (BPS) and City of Boston policy changes: home-based student assignment policy and middle school MBTA passes in 2014; and the launch of Vision Zero Boston in 2015. Also because of the Boston neighborhood infrastructure: dense and mixed land uses; robust sidewalk network; and access to public transit. Fewer students will be bused over the next decade: what decisions will families make about how students will travel to school? How can we use this opportunity to achieve a triple win: more physically active students; who arrive at school ready to learn and less traffic, fewer carbon emissions.
- Ms. Bovenzi provided data on how BPS students say they get to school. A district-wide report of grades K-8 in the Spring of 2016 showed that 35% of students reported getting to school by bus or family vehicle, 20 % walked, 7% took public transportation (MBTA), 3% carpooled and 1% biked. The reported numbers for students getting home are very similar: 37% by bus, 29% by family vehicle, 22% walked, 8% took public transportation (MVTA), 3% carpooled, and 1% biked. A chart was also shown that had the percentages broke down by grade level.

- Parents were also asked they weren't allowing their children to walk to school. The most common answer was distance. The new assignment policy going into effect will make walking to school less of a problem. City agencies are in the highest tier.
- Mary described the multi-tiered approach they have for this initiative. We have partnered and are working with City Agencies, such as the DPW and BPD, School Districts and schools on the many components of this program from the infrastructure to enforcement to education and evaluation. We were very specific in creating this brand that it's "Boston Safe Routes to School" not BPS Safe Routes to School because we want this to be an initiative that is really owned by the City. Educational materials are available to all schools as well. 32% of K-8 schools have participated in one or more program elements.
- Some of the challenges involve complex multi-sector coordination; infrastructure improvement costs; safety concerns – traffic, bullying, crime; and culture shift – how to change behavior norms.
- What comes next? LGHB funding ends in September 2017. There is a sustainability plan under development to determine: what city department should be lead(s); how to continue momentum; and find sustainable funding.

***Presentation: Fiscal Year 18 Budget Process Overview***


***Grace Connolly, Director of Administration and Finance, BPHC***

- Ms. Connolly provided some background information: the city is experiencing an all-time high in revenues from property tax and local receipt categories; we have a AAA credit rating, which is the best you can have; we're seeing lower state aid; growth in fixed costs is anticipated at 9% for FY17; and the collective bargaining agreements are expiring.
- Just a reminder that this is a two-step process: maintenance request; and new budget proposals which include operational reforms, budget savings, new initiatives/investments, and revenue proposals.
- The Maintenance Request will reflect FY17 operations in terms of FY18 costs. It will also review possible realignments during this period: staff transfers and consolidations; streamlining business processes; shared service models; reduce fragmentation and duplication of effort; and enhancing managerial controls.
- New Budget Proposal will include operational reforms: operational audit recommendations (BPHC's operational audit will begin in January, 2017); use experience guiding reforms to make operations more efficient, effective and responsive; one-time investments must show ROI (return on investment) and implementation steps; and savings proposals of at least a 2% reduction (\$990,808) must be proposed.
- We must also propose new initiatives/investments and provide analysis to show measurable progress toward specific goals. We must have priority for projects that: data show investment will have a significant positive impact relative to the investment; targeted at the vision of a thriving, healthy and innovative city; and leverage other spending and resources. Revenue options must have estimates consistent with service levels in maintenance budget; alternatives include reviewing outdated fees and fines that haven't risen to keep pace with inflation; new opportunities to provide services and bring in revenue, e.g. SUDS treatment, mental health counseling (new revenue will support the entire budget, not just single appropriations).
- The Capital Budget addresses urgent needs while planning strategically for the city's future; Facilities projects, submitted November, 2016 (Public Facilities Department feasibility site visits and data collection ongoing); IT and Equipment proposals are due 12/31/16; Departmental meetings will be held in January and February.
- Lastly, Grace presented the budget timeline: 11/2/16 – Capital instruction released; 11/23/16 – Capital facility requests submitted; 12/14/16 – COB maintenance budget instructions released; 12/19/16 – BPHC budget instructions released; 12/21/16 – Board meeting, review FY18 budget; 12/22/16 – Program Directors, review FY18 process; 12/31/16 – IT and equipment capital requests due to COB; 01/04/17 – Program files due to BPHC Budget Office; 01/08/17 – Budget office completes files review; 01/13/17 – Executive office completes budget review; 01/17/17 – Files finalized and submitted to COB; 01/18/17 – Board meeting to review FY18 as submitted; March 2017 – COB OBM budget meetings; Board presentation and vote; submit to Mayor; April 2017 – Changes resulting from Mayoral review; May 2017 – Final Board approval, City Council hearings; June 2017 – All staff meetings to review FY18 budget.

**Adjournment**

- Mr. Doyle adjourned this meeting of the Board of Health promptly at 6:00p.m.

Respectfully submitted by:



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Kathy Hussey, Board Secretary