



**MINUTES FOR THE MEETING OF THE BOARD OF THE  
BOSTON PUBLIC HEALTH COMMISSION  
Wednesday, January 14, 2016**

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Wednesday, January 14, 2016 in the Hayes Conference Room, 2nd floor, 1010 Massachusetts Avenue, Boston, MA 02118.

**Board Members Present:**

Paula Johnson, MD, MPH, Chair  
Huy Nguyen, MD, Interim Executive Director  
Harold Cox  
Manny Lopes

**Also Present Were:**

John Townsend, Tim Harrington, Chuck Gagnon, Kathy Hussey, Dan Dooley, Chief James Hooley, Rita Nieves, Jen Tracey, Beth Grand, Brad Cohen, Gerry Thomas, Lisa Conley, PJ McCann, Maia BrodyField, Debbie Allen, Snehal Shah, Neel Batra, Stephen Coussens, Stacey Kokaram, Debbie Lay, Ché Knight, Mimi Brown, Jeanne Cannata, Vivien Morris, Ann Henry, Shannon Gillie, Maxwell Oyer, and Thuydung Nguyen.

**Proceedings:**

***Chairwoman's Comments***

*Paula Johnson, MD, MPH*

- The meeting was called to order at 4:12pm by Dr. Johnson who thanked everyone for coming and turned the meeting over to Dr. Nguyen for his report.

***Report from the Executive Office***

*Huy Nguyen, MD, Medical Director and  
Interim Executive Director, Boston Public Health Commission*

- Dr. Nguyen wanted to update the Board on a few topics. First, the Board may recall that earlier this year, the Boston City Council passed an Ordinance creating a College Athlete Head Injury Gameday Safety Protocol. The Council named the Boston Public Health Commission as playing a role in compliance of this protocol. In your board packets, is a copy of a letter we sent out earlier this month to one of our regulated universities.

***Presentation: BPHC FY 2017 Budget Process and Overview***

*John Townsend, Esq., Director of Administration and Finance*

- Before getting to the actual budget process, Mr. Townsend wanted to review what we're currently doing. In light of the many calls to the Mayor regarding needles being found in numerous places across the city, Mobile Sharps was started. This is a citywide coordinated safe needle pickup and disposal program under the Addictions Prevention, Treatment and Recovery Support Services Bureau ("APTRSS").
- Mobile Sharps has collected approximately 7,000 syringes around Boston since the onset of the program in May 2015. With the addition of Mobile Sharps, the AHOPE program now has a 110% return rate on syringes. (required funding \$60,500)

- The Overdose Prevention and Outreach Team, also under APTRSS, posted three (3) new positions to provide outreach and recovery coaching in the Newmarket and BMC area. Their key partners will be Boston Center for Youth and Families ("BCYF") and Boston Medical Center (required funding \$283,252).
- The Community Health Education Center ("CHEC") has been working to develop, pilot and evaluate a Community Health Worker ("CHW") skill-based assessment for CHEC's core competency training in order to qualify as a Certified CHW Training Center. They have identified best practices and models of competency-based approach recommended rather than written evaluation. They have identified potential partner. Partner will design CHW assessment method and tool with input from CHEC staff, trainers and CHWs (required funding \$58,251).
- The APTRSS and Homeless Services Bureaus have done a realignment of substance abuse counseling in emergency homeless shelters. The purpose of the realignment is to provide a differential response for sub-populations facing homelessness including people with disabilities, behavioral health disorders and substance abuse disorders. Mayor Walsh's Homelessness Task Force prioritized comprehensive assessments for new guests, including assessing for substance use disorders and provided a \$384,000 budget for 5 "front door triage" staff including a social worker (required funding \$0).
- Mr. Townsend noted we still have challenges that will shape FY2017. The Serving Ourselves Kitchen at 196 Quincy Street will be operational on January 25, 2016 and will serve over 2,000 meals a day. Equipment was brought over from Long Island. This new kitchen will provide improved food quality for our guests and result in cost savings over our current food service contract.
- The Emergency Shelter at 112 Southampton Street opened in February, 2015 and now provides 430 male beds. Phase III construction is underway on a new dining area, serving kitchen, medical clinic, ADA compliant elevator, office space and intake area and is scheduled to open in February, 2016. The facility will be open during the day and at night which will make operating costs significantly higher. Until the shelter has been operating for a while, system costs will still be estimates.
- We have attempted to give Long Island back to the City of Boston with no success. The FY2017 projected budget is \$1,629,000 for maintaining a staff presence on the Island, daily ferry service, and continued maintenance of the buildings and facilities. No BPHC programming is scheduled for the Island, however, Camp Harbor View will continue to operate there.
- Mr. Townsend commented that the process and general themes for FY2017 are to be in alignment of spending with Mayoral priorities for a thriving, healthy and innovative budget. We need to eliminate ineffective spending, propose innovated approaches to delivering services and freeing up capacity for high impact programming. This is a three part budget process: 1) the Maintenance Budget; 2) Reform proposals; and 3) Cuts, Investments and Revenue proposals.
- The goal of the Maintenance Budget is: to provide sufficient funding for core functions and mission critical activities in the most efficient manner and should include realignment of organization including staff transfers, position consolidation, streamlining business processes. The target number is \$73,950,274 which is the same as FY2016 before adjustments for fixed costs (OPEB, GO Debt, health insurance and pension costs).
- Any Reform Proposals should be to streamline or enhance Commission processes. Proposals may not always have an immediate cost impact. Proposals must have detailed description, an explanation of possible challenges and spending impacts.
- Cuts, Investments and Revenue need to addition budget reduction proposals to bring over-all Commission operations (non-fixed costs) appropriation to 97% from the FY2016 adopted budget; target reduction is \$1,445,824. New initiatives must be targeted toward achieving the Administration's vision of a thriving, healthy and innovative city. All proposed new spending should include analysis supporting how it will lead to measurable progress toward specific goals. We have an option to propose new revenue streams and opportunities to enhance revenue by updating fees and fines.

- Mr. Townsend gave a breakdown of the budget timeline: December 2015 - budget files are prepared; January 11-15, 2016 - Bureau meetings with Executive Office; January 14, 2016 - Board update; January 19, 2016 - Submission to C.O.B. Budget Office; February 23, 2016 - C.O.B. Budget meetings; February 25, 2016 - Board presentation and vote; March, 2016 - Budget submitted to Mayor; April, 2016 - Final Board Approval; and May, 2016 - City Council Hearing.
- The Maintenance Budget Framework for FY2017, as Mr. Townsend explained, is: to level funding in non-fixed costs (Fixed costs increased or decrease will change the current target number.); COLA for FY17 is 25 for Boston Police Patrolmen's Association/Boston EMS (Step increases included; most CBAs expire in July or September 2016; COLA will be part of the negotiations for the new contracts.); Grant applications: \$857,332 is pending for FY2017 (\$3,730,000 over 5 years).
- Mr. Townsend stated the targeted budget amount for FY2017 is \$163,690,000. 45% of that funding is from Boston City Appropriation; 29% is from Billed/Other revenue; 14% is from Federal Grants and the remaining 12% from State Grants. He then showed a chart depicting from where the funding for each bureau is coming.
- Lastly, Mr. Townsend spoke of the Capital Budget Proposals which include: critical facility repairs; EMS Station in Seaport District; EMS Training Academy at 215 River Street, Mattapan; interior improvements to Woods Mullen; Mattapan building improvements for Food Pantry and Entre Familia; Rehabilitation Study of Power Plant structure and space at 205 River Street, Mattapan; an Environmental Risk Assessment for Long Island's old power plant; Long Island pier/design completion and construction; a roll-on/roll-off facility at Long Island; 1 Megawatt Photovoltaic farm on Long Island; and solar powered electrical vehicle charging stations.

***Presentation: Local Perspective on Opioid Epidemic and Boston's Response***

*Dan Dooley, BA, Director, Analysis and Surveillance, Research and Evaluation Office*

*James Hooley, Chief, Boston Emergency Medical Services*

*Rita Nieves, RN, MPH, LICSW, Bureau Director, Addictions Prevention, Treatment and Recovery Support Services Bureau*

*Jen Tracey, MSW, Director, Office of Recovery Services*

- After introducing himself, Mr. Dooley explained the heroin/opioid data sources such as: ***unintentional overdose deaths*** from Boston Resident Death files, MA Department of Public Health ("MDPH") 2002-2013; ***hospital patient encounters*** ("HPEs"): hospital inpatient discharges, emergency room visits, and observational stays coded as heroin/opioid dependence, abuse, and unintentional overdose, Massachusetts Center for Health Information Analysis ("CHIA") FY2002-FY2013; ***substance abuse treatment admissions*** data from Massachusetts Department of Public Health, Bureau of Substance Abuse Services ("BSAS") 2002-2013; and ***heroin price*** data from Drug Enforcement Agency ("DEA") Domestic Monitoring Program ("DMP") 2002-2013.
- Mr. Dooley presented a chart depicting heroin/opioid abuse in Boston compared to the U.S. and MA overall. In 2013, ***drug overdose death rates (including suicides)*** were 13.8% in the U.S.; 16.0% in MA (17th highest among 50 states); and in Boston 18.4% (335 higher than U.S. and 15% higher than MA).
- In 2013, ***heroin/opioid death rates (including suicides)*** were 7.9% in the U.S.; (approximately 57% of drug overdose rate); and in Boston 14.7% (approximately 80% of drug overdose rate; 86% higher than U.S. rate). The ***unintentional heroin/opioid overdose mortality numbers*** for 2012 in Boston was 62 (9.3% of the MA total of 668); for 2013 in Boston was 81 (8.9% of the MA total of 911); for 2014\*\* in Boston was 87 (8.0% of the MA total of 1,089) [\*\*Please note Boston and MA 2014 total are considered preliminary as the death file has not been officially closed; use caution when interpreting as the counts may increase.]
- Mr. Dooley then presented a series of charts showing percentages for ***unintentional heroin/opioid overdose mortality*** in Boston residents during the 2002-2013 timeframe. The age-adjusted rates were per 100,000 population 12 years and over. There were 767 deaths during this period for an average of 64 per year. The mortality rates were grouped into three 3-year periods by overall Boston, gender and race/ethnicity.

- **From 2002-2005**, the highest mortality rate was 19.3% of male residents, followed by 16.2% of White residents, 13.2% of Latino residents, 9.1% of Black residents, and 5.4% of female residents; the overall percentage for Boston was 12.2%. **From 2006-2009**, the highest mortality rate was 23.0% of male residents, followed by 20.1% of White residents, 16.6% of Latino residents, 12.6% of Black residents, and 8.3% of female residents; the overall percentage for Boston was 15.4%. **From 2010-2013**, the highest mortality rate was 19.0% of male residents, followed by 18.2% of White residents, 10.1% of Latino residents, 7.9% of Black residents, and 6.2% of female residents; the overall percentage for Boston was 12.4%. **During 2010-2013**, the neighborhoods of Charlestown, South End, South Boston, South Dorchester, and Roslindale showed the highest mortality rates; there were significant increases in Hyde Park, Mattapan and South Dorchester.
- **Hospital Patient Encounter Data Definitions** (based on ICD9-CM Codes) include: *heroin/opioid dependence* (code 304.00-304.02): there is a point at which drug use crosses from "dependence" to "abuse". Check documentation and or query provider for patient status. *Excludes: nondependent use of drugs. Heroin/opioid abuse* (code 305.50-305.52): ...has come under medical care because of the maladaptive effect of a drug on which he is not dependent and that he has taken on his own initiative (self-medicating) to the detriment of his health or social functioning. *Excludes: drug dependence, drug withdrawal syndrome, and poisoning by drugs. Unintentional heroin/opioid dependence* (codes E850.0, E850.1, E850.2, 965.0): includes poisonings with undetermined intent. *Excludes: intentional self-harm.*
- Next shown was a series of charts indicating the percentage rates for *heroin/opioid* and *unintentional opioid poisoning/overdose hospital patient encounters* of Boston residents based on encounter type, drug type, and gender during 2002-2013 as well as by age group, racial ethnic group and neighborhoods during 2010-2013.
- The average heroin treatment clients and admissions for Boston residents during 2002-2013 ranged from 188.2 admissions in 2002 to 175.8 admissions in 2013. The average number of heroin clients ranged from 80.2 in 2002 to 72.9 in 2013. Other opioid treatment clients and admissions (excluding heroin) ranged from 8.9 admissions in 2003 to 11.0 in 2013; other opioid clients ranged from 6.4 in 2003 to 8.6 in 2013. This set of information was then broken down by gender, race ethnicity and neighborhoods. A comparison between dependence/abuse hospital patient encounters and treatment clients for City of Boston residents by race/ethnicity was also made.
- The "street level" heroin price per pure milligram in Greater Boston during 2002-2013 ranged from \$0.73 cents in 2002 to \$0.80 cents in 2013. In 2006, the price spiked up to \$1.63 per milligram and reached \$2.22 in 2010 before tapering off to the \$0.80 price.
- In summary, the rates for heroin/opioid abuse among Boston residents between 2010-2013 increased as follows: unintentional overdose death increased 83%; heroin/opioid hospital patient encounters / dependence increased 21% and abuse increased 43%; unintentional poisoning/overdose rose 68% (heroin only rose 108%, other Opioids only, non-heroin no change, and unspecified Opioids and opioid combos rose 92%). Heroin/opioid substance abuse treatment admissions rates for heroin admissions increased 19% while other Opioids (excluding heroin) increased by 37%. The heroin price comparing 2010 to 2013 showed a 64% decrease.
- **BOSTON EMS:** Chief Hooley provided an EMS system overview. Boston EMS operates a minimum of 19 BLS units and 5 ALS units from 16 stations citywide during peak hours; 14 ambulances cover the city during lowest call volume hours of 2a.m. to 6a.m. Call volume for 2015: 122,162 incidents; 144,711 responses; 85,487 transports and 2,601 NRIs ("Narcotic Related Illness").
- Next, Chief Hooley gave a timeline of Narcan (Naloxone HCL) use in Boston. In 1978, Boston EMS Paramedics began administering Narcan. In 2006, Boston EMS was granted a Special Project Waiver: BLS Narcan. In 2007, BPHC began issuing Narcan to friends/family of addicts. In 2013, Boston EMS proves BLS Narcan Concept causing STP protocols to change. In 2013, the First Responder Narcan Program went into effect.

- A typical incident flow begins with a call to the EMS, BFD or BPD, followed by patient assessment/treatment with the patient either being transported to hospital, refusing treatment, referred to Medical Examiner or other. Data mining is done via CAD or ePCR ("Patient Care Report"). Boston EMS NRI methodology starts with documentation. All patient encounters are documented in the electronic Patient Care Report. An automated data query is run searching clinical impression, cause and free text fields. All records with one or more of the identified key words/text strings is manually reviewed by a department paramedic/analyst to determine if they meet the case definition for NRI. The analyst categorizes NRI calls as either: Heroin Observed (HO), Heroin Mentioned (HM), or Other Abuse (OA), as well as type of opioid/opiate. Of the 2,601 NRI calls in 2015, the vast majority (85%) were coded as HO. EMS personnel who cared for the patient may be contacted for additional information.
- Chief Hooley explained the EMS NRI data terminology: **Narcotic Related Illness** - a Boston EMS clinical incident identified as suspected to be related to narcotic use (including opiates and opioids) after review. Potential NRI cases are identified based on information entered in patient care reports by on scene EMTs or Paramedics, with confirmation of pinpoint pupils and altered mental status. It does NOT include: cocaine, meth, benzos, or marijuana. **Cardiac ("CARD")** - a patient identified NRI (based on presence of narcotic paraphernalia or verification by a first-person witness) determined to be in cardiac arrest, without vital signs, by Boston EMS. **Heroin Observed (HO)** - Heroin drug use identified based on presence of altered mental status, myosis, patient's admission of heroin use, evidence of recent/chronic venipuncture, possession of narcotic injecting/insufflating paraphernalia, and/or eye witness report of heroin use. **Other Abuse (OA)** - when patient admits to an opioid source other than heroin. **Heroin Mentioned (HM)** - a case where the patient admits to narcotic use as part of their medical history, but is unrelated to presentation. **Narcan Given** - Narcotic-related incident in which patient's condition required administration of Narcan. **Referred to Medical Examiner ("RME")** - patient with identified NRI (based on presence of narcotic paraphernalia or verification by a first-person witness) determined to be non-viable on scene and referred to the Medical Examiner by Boston EMS.
- Boston EMS NRI database fields for confirmed cases includes: neighborhood of response and residence; gender and age; type of drug: heroin or other opioid (methadone, suboxone, oxycodone); level of impairment: cardiac arrest, respiratory failure, stuporous, or sick (withdrawing from opioids); treatments: narcan, oxygen, etc.; disposition: hospital, referred to Medical Examiner. In 2015, NRI accounted for 2.1% of EMS incidents.
- A chart depicting Boston EMS NRI incidents from a historical perspective from 2010 through 2015. It showed the number of NRI cases, number times Narcan was administered, number of those in cardiac arrest and number of cases referred to Medical Examiner. There have been steady increases in these areas during this timeframe.
- Demographic data from 2014 indicates that of the recorded NRI patients, 22% reported their residence as outside of Boston; 26% had an unknown residence; and 8% were listed as homeless. Cumulatively, 56% of NRI patients for 2014 were either *homeless*, living *outside* Boston, or had an *unknown* domicile. 71 people were transported 3 or more times in 2014. Of the 3 or more NRI transports, 69% were males with an average age of 38; 31% were females with an average age of 34. Fatal overdoses were 22% females with an average age of 35; 78% were males with an average age of 39.
- Another chart displayed the time and date of overdoses in 2014. The highest numbers of suspected opiate overdoses were recorded on Friday, followed by Saturday. There was only a 123 person difference between the highest (Friday) and lowest (Sunday) numbers for days of the week, suggesting a fairly even spread. NRI transports occurred primarily during the daytime, as evidenced by the following: the most common times for NRI transports began around 11a.m., peaking between 1:00p.m. and 4:00p.m. and tapering down by 10:00p.m. Most NRI related deaths were recorded between 12:00p.m. and 8:00p.m., with Tuesday, Friday, and Saturday as the heaviest days.

- Lastly, Chief Hooley noted there are information gaps and limitations. He commented that all NRI deaths should be qualified as *suspected* NRI deaths, as only the Medical Examiner can definitively confirm the cause of death. Boston EMS does not receive final status on patients transported. Because MDPH captures hospital data, their numbers will be consistently greater, although they take a year to generate. Some NRI data is subjective and can be subject to biases, both during the initial response and in the follow-up analysis.
- **APTRSS:** Dr. Johnson requested that Ms. Nieves shorten her presentation to allow enough time for Ms. Tracey to speak. Ms. Nieves began with a timeline of our efforts. Between 2000-2003, a growing OxyContin epidemic and an increase in youth substance abuse mortality creates movement for prevention efforts in several Boston communities. In 2003, Mayor Thomas Menino provided the funding for the NoDrugs Coalitions as a city-wide approach to grassroots substance abuse prevention and advocacy efforts. In 2004, the NoDrug Coalitions were expanded to 14 neighborhoods.
- 2006 saw expanded overdose prevention efforts with the implementation of the Narcan Pilot. In response to increasing rates of opioid overdose, the City's Board of Health passes a regulation authorizing an overdose prevention program including distribution of intranasal naloxone to potential bystanders as well as family members of active users. In 2008, through a grant from MDPH, the Commission implemented 4 neighborhood-based projects to address fatal and non-fatal overdose at the neighborhood level (MassCall2); the neighborhoods included Charlestown, Roxbury, Jamaica Plain, South Boston and the South End. This was the first time in the nation local communities were funded to do this work. In 2013, a number of state-funded initiatives were implemented, including: prevention training in local communities to reduce non-medical prescription drug use among 13-17 year olds and strengthening partnerships and systems to prevent and address opioid use, abuse, and overdose.
- Some key achievements included increased education and training activities by hiring two overdose education and prevention specialists; expanded narcan access and overdose prevention training to multiple groups such as jails, shelters, detox centers, substance abuse treatment programs and sober homes; installed drug return kiosks in 11 police stations throughout the city for safe disposal of prescription drugs; developed PAATHS (Providing Access to Addictions Treatment Hope and Support) program; developed strategic partnerships with hospitals, health centers, Boston Health Care for the Homeless, BEST Team and DMH to facilitate screening and placement of individuals into the substance abuse and dual diagnosis systems of care.
- We continue working with survivors and key partners to establish consistent protocols in emergency settings to respond to clients after a non-fatal OD. We are developing a model Rapid Response Team using recovery coaches to connect with OD victims in the EDs. We are targeting populations at high risk of OD and providing OD prevention training and Narcan. We continue to build capacity within organizations to provide OD education. We need to expand the train the trainers approach (i.e. Victory Programs train their own staff in OD prevention) and continue to expand work with corrections.
- We continue working closely with EMS to monitor and respond to trends in OD. We've promoted narcan training of all Fire and Police in the city. BFD began to carry narcan in 2015, BPD in 2016. We continue to provide referral and resources through the newly created BPD Overdose Prevention Squad in the Drug Unit. We will continue to improve collaboration between agencies with access to data (EMS, ME, hospitals, BPHC, MDPH).
- We implemented PAATHS to assist people to get into treatment and navigate the system of care. We've increased advocacy efforts to facilitate integration of substance abuse services into community health settings. We are working to increase medication-assisted treatment programs and have partnered with BMC in seeking DPH funding to implement an Opioid Urgent Care Center at BMC's ED to facilitate treatment placement, medical clearance and faster access to medication assisted treatment.
- **Office of Recovery Services is headed by Jennifer Tracey.** Ms. Tracey gave an overview of her office stating that in May 2015 the Mayor released the report: "Addiction and Recovery Services in Boston - A Blueprint for Building a Better System of Care."

- In August 2015, the Office of Recovery Services was launched. The Office's work is structured around three (3) priority areas: 1) Increase access to a continuum of high quality addiction treatment and recovery services across the City of Boston; 2) Forge partnerships across departments, providers, and community; and 3) Increase public awareness and advocacy. In addition, the Office will work on special projects as needed.
- Tasks involved with the First Priority include: advocate for expanded capacity of triage, care coordination and recovery support services for residents of Boston; ensure fair and equal access to all levels of treatment and recovery services; and advocate for increased use of evidence-based practices.
- Tasks involved with the Second Priority include: driving joint efforts to improve inter-agency coordination and drug use outcomes; consistently collect, analyze and track data on addiction, treatment and recovery support services to inform timely and appropriate inter-agency responses; and maintain a comprehensive on-line inventory of available TA and Training Providers and evidence-based practices for treatment and recovery.
- Tasks involved with the Third Priority include: serving as the City's voice in increasing understanding and awareness of substance use disorder prevention, early intervention and recovery services; explore initiatives to encourage more people who need services to seek services; and raise the profile of the face of recovery through development of a recovery "corps", recovery month activities and stigma reduction efforts.
- Ms. Tracey concluded by stating that the ongoing work and initiatives are a joint effort between City Hall, BPHC, The Office of Recovery Services, the APTRSS Bureau and the Addiction Recovery Advisory Group.

*Acceptance and Approval of December 17, 2015, December 23, 2015 and January 14, 2016 Board Meeting Minutes*

- As we did not have a quorum present at today's meeting, the Board was unable to vote on the approval of the minutes from the two December Board meetings.

*Adjournment*

Dr. Johnson thanked everyone for attending and adjourned the meeting at 6:00pm

Submitted by:

  
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 Kathy Hussey, Board Secretary