MINUTES FOR THE MEETING OF THE BOARD OF THE BOSTON PUBLIC HEALTH COMMISSION
Thursday, September 17, 2015

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Thursday, September 17, 2015 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
Joseph Betancourt, MD, MPH
Manny Lopes
Myechia Minter-Jordan, MD, MBA
Kate Walsh
Celia Wcislo

Also Present Were:
John Townsend, Chuck Gagnon, Kathy Hussey, Tim Harrington, PJ McCann, Mimi Brown, Lisa Conley, Maia BrodyField, Debbie Allen, Nineequa Blanding, Debra Paul, Devon McCarley, David Susich, Chief Jimmy Hooley, Stacey Kokaram, Snehal Shah, Ann Henry, Osagie Ebekozien, Anne Heerdegen, Vivien Morris, Maria Rios, Brad Cohen, Roselaine Koech, Natasha Louis Jean, Catilda Turner, Steven Watson, Monique Denaud, Rosette Galimango, Brandee White, Cassandra Millet, and Richard Hedstrom.

Proceedings:

Chairwoman's Comments
Paula Johnson, MD, MPH

- The meeting was called to order at 4:04p.m. Dr. Johnson noted it was good to see Ms. Wcislo and we were glad to have her back. Dr. Johnson stated that she had spoken with our Senior Leadership Team to bring them up to speed with the fact that the search process is in full swing. We will be communicating with you, as we have, regularly as things are moving forward. Hopefully, we will have good news in the near future. We have a great pool of candidates to move forward. Dr. Johnson turned the meeting over to Dr. Nguyen for his update.

Report from the Executive Office
Huy Nguyen, MD, Medical Director and
Interim Executive Director, Boston Public Health Commission

- Dr. Nguyen had a few brief announcements as we have a packed agenda. This is Recovery Month and we are participating in a number of events that recognize the challenge, but also great success, of our community members who are dealing with substance abuse disorders and are in recovery. One worth pointing out is we are partnering with Boston Medical Center on a drug take back. Also, next Friday, September 25, we'll be having an informal event recognizing our new peer-to-peer recovery center. It's a wonderful program that's going to give us the opportunity to, in a programmatic way, recognize the important role of families in recovery and the individual recovery.

- The Board has heard about some of our activities around the Partners in Community Health Grant that the CDC is funding. This Saturday, September 26, we will be hosting an event at 10:00am at the Roxbury YMCA to recognize and celebrate the first year of work of our Community Health Champions. There are 75 residents who are working with us in a very new and exciting way in driving the policies, systems and environmental change that will allow us to make real progress in preventing chronic disease.
- The Board may have noticed on your way in that we are embarking on a Workforce Development program as part of our professional development. It includes a number of really great new courses that we'll be offering to staff, particularly around presentations and communicating the work that we do, particularly more effectively around community meeting settings.
- Finally, as you'll see in your packets, this green book which is the second part of the study that the Commission completed in partnership with Children's Hospital. This is the CHAMP, Child Health Assessment Mapping Project. As the Board will recall, Dr. Shah and her office presented some of the data from the first installment, which was the blue covered book. This is the second piece of that which maps a lot of the data to the specific neighborhoods. Dr. Johnson congratulated Dr. Nguyen on the fine work done by Dr. Shah and her staff.

Presentation: One Key Question Initiative
Deborah Allen, ScD, Director, Bureau of Child, Adolescent and Family Health

- Dr. Johnson commented that Ms. Allen had introduced her to this concept over a year ago. Although, she thinks it's a small concept, but thinks it's a revolutionary one. We're looking forward to hearing more. Ms. Allen thanked Dr. Johnson. Ms. Allen stated she asked to be on the agenda because it was Infant Mortality Awareness month. We rushed very hard to get out a campaign. Some of you may have seen the bus ads. We wanted the Board to be aware of what we're doing, so that some of your agencies can be involved, some already are.
- Ms. Allen explained that this campaign was originally launched in Oregon. She continued with an overview of the rationale for One Key Question® ("OKQ"), how it is implemented, and our activities around OKQ.
- The rationale for a focus on preconceptional health is based on the fact that about 505 of US and MA births are unplanned; among Health Start clients in Boston, the rate is 75%; the "Healthy People 2020" goal is 82.4% intended and 17.6% unintended. Unplanned pregnancy is associated with adverse outcomes: Boston Perinatal Periods of Risk ("PPOR") findings indicate that the largest source of Black-White disparity in Boston birth outcomes arises from women's health entering pregnancy; US data indicate that unplanned pregnancy is not equally distributed across demographic groups. Current practice does a poor job addressing this due to a lack of systematic attention to pregnancy intent and a bifurcated system.
- Prevention rates are low. Only 14% of women report talking to their PCP about reproductive health needs. 70% of women who have had unintended pregnancies report prior lack of comprehensive contraception advice from clinicians. Only 33% of women who deliver babies report having taken folic acid. Among smokers, 13 % have discussed the effect of smoking on reproductive health and pregnancy. Percentages among women who experience the following conditions: cervical cancer 0.7%; alcohol misuse 10%; breast cancer 12%; depression 27%; hypertension 27.5%; diabetes 38.5%; unintended pregnancy 48%.
- Most approaches to preconceptional health emphasize "reproductive life planning" **(http://www.cdc.gov/preconception/reproductiveplan.html)**. This may be unrealistic for many women, especially low income, young women. The feasibility of life span planning. The cultural meaning of planning in relation to pregnancy: for women who are poor; for women with certain religious or cultural norms.
- One Key Questions entails screening for pregnancy intention among all women 18-50*; with no exceptions based on provider biases, assumptions, or discomforts. Makes screening a routine part of care. Implies that ALL women have the right to want to have a baby. Poses the nonjudgmental question: "Would you like to become pregnant in the next year?" (*with possibility of younger women who are sexually active as well)
- If a woman's answer is Yes, preconception care would include: screen for conditions that can affect pregnancy; medication review; counsel on nutrition, exercise, substance use; recommend folic acid daily; recommend early prenatal care; and address any social concerns. If her answer is No, then contraceptive service can be provided: ask whether she is using a contraceptive method; check satisfaction with current method; offer contraception option, emphasizing LARC; and offer emergency contraception.

- If a woman is ok either way regarding pregnancy, follow up with her to ensure she is prepared for a pregnancy and recommend preconception counseling and early prenatal care. If a woman is unsure about whether she wants to become pregnant, follow up with her and offer a combination of contraception and preconception care, depending on her needs and circumstances; discuss ambivalence and relevant issues.
- Boston Healthy Start ("BHSI") strategies sees OKQ as a culture change. Bilingual ad campaign will run throughout September; prior outreach to BHSI sites and other providers alerting them to campaign; ads direct viewer to PCP and website; Mayor's Health Line equipped to make referrals; client brochures available in English and Spanish; press release planned with reference to National Infant Mortality Awareness Month. Engagement of multi-sector Healthy Start Community Action Network with participant groups signed on to support OKQ prior to funding. We are now asking each member organization: how can you help: either nonclinical sites and/or clinical sites.
- Boston Healthy Start looks at OKQ as a clinical intervention. Contract provision for all BHSI sites: all BHSI site staff trained in January; sites moving towards implementation; Codman Square Community Health Center is early adopter and producing tool kit for other sites. For other clinicians, BHSI conducted Grand Rounds as BMC in January; two clinicians are available for further training of staff at non-BHSI sites. There is an ongoing discussion of appropriate implementation in school health via CAN: Boston Public Health Commission-run school-based health centers and Boston Public School Health services.

Presentation: Boston Health Equity Goals Mid-Point Report

Vivien Morris, MS, RD, MPH, LDN, Director, Office of Racial Equity and Health
Deborah Allen, ScD, Director, Bureau of Child, Adolescent and Family Health
Nineequa Blanding, MPH, Associate Director, Chronic Disease Prevention and Control Division, Community Initiative Bureau

- Ms. Morris gave a background overview of the Health Equity Goals which represent a cross-organizational effort to align our practice with our mission: to protect, promote and preserve the health and well being of all Boston's residents, particularly the most vulnerable. The goals speak directly to our intent to be held accountable in our efforts to address racism and the social determinants of health. In choosing the Health Equity Goals, three criteria were used: (1) Each is a long-standing problem; (2) Inequity exists in the health outcome where certain groups are affected disproportionately due to unjust causes; and (3) There are promising practices to help us address each goal.
- The Boston Health Equity Goals are focused on: Obesity - to reduce the obesity/overweight rates among all Boston residents, and reduce the gap between White and Black/Latino obesity/overweight rates by 20% for adults and 30%for school-age children; Chlamydia - to reduce Chlamydia rates among all Boston residents age 15-24, and reduce the gap between White and Black/Latino Chlamydia rates for residents age 15-24 by 25%; and Low Birth Weight - to reduce the low birth weight rates among all Boston infants, and reduce the gap between White and Black low birth weight rates by 25%.
- The Mid-Point Review represents a first look at possible trending of these indicators and potential progress and offers consideration of 3-4 years of available data. The final report will review data between the years 2010 and 2016, and with additional data years, should provide a more complete picture of trends.
- With respect to Obesity, Ms. Blanding explained BPHC is working to: implement policies and practices that promote physical activity, healthy eating, and breastfeeding in childcare settings; implement policies that support healthy eating and physical activity in school and out-of-school-time settings; support opportunities for physical activity and improve environmental infrastructures in the community; enact organizational policies throughout the city to increase the availability of healthier foods/beverages; support policies and programs for healthy eating, physical activity, and weight management among BPHC clients (note: not in active implementation); and support implementation of a "Health in All Policies" framework in city agencies.
- Campaigns and Initiatives include: ReThink Your Drink (Healthy Beverage) Initiatives; Healthy Childcare Initiative; Out of School Nutrition and Physical Activity (OSNAP) Initiative; Community physical activity initiatives (e.g.: Get Active partnership with YMCA, PlayWays, FitKits, Summer Fitness in the Parks); and Boston Bounty Bucks farmers' market collaboration.

- Data indicates no statistically significant changes in obesity rates for Boston White, Black, and Latino adults or public high school students from 2010-2013; obesity rates for Black and Latino residents remained higher than the rates for White residents; the gap between the White and Black/Latino rates did not change significantly. (Stable rates during this three-year period are promising, as the historical national obesity trend has increased in past three decades.) Data also indicates there were no statistically significant changes in obesity rates for Boston White, Black and Latino public high school students from 2010 to 2013; during that timeframe, the percentage of Black public high school students consuming one or more sodas per day decreased from 28.9% to 16.2%.
- As to Chlamydia, Dr. Barry stated BPHC is working to: improve surveillance data through implementation of the updated BPHC reporting regulation; develop and implement a plan to normalize testing for sexually active 15-24 year old residents; increase Chlamydia awareness and the number of testing resources in communities and schools, including the Health Resource Centers; and increase STI testing in risk groups citywide.
- Campaigns and Initiatives include: Infectious Disease Bureau (IDB) nurses provide directly-observed treatment and Expedited Partner Therapy (EPT) for selected cases in the target group; Chlamydia Advisory Group (convened by the IDB) meets to discuss best practices and new ideas; the IDB funds community-based agencies to provide sexual health education for teens/young adults in the target group; media campaign using "camo" and tagline "It Can Easily Go Undetected" developed with input from youth carried out in high-risk neighborhoods.
- Data indicates that from 2011 to 2013, the Chlamydia rate for Black residents decreased by 20%, while the rates for Latino and White residents remained stable; the goal to reduce the Black/White gap for Chlamydia rates in 15-24 year olds by 25% has been achieved (27% decrease from 2011 to 2013); Black residents still had the highest Chlamydia rate at 1,095 cases per 100,000; Latino residents had the second highest rate at 696 cases per 100,000; and Chlamydia rate for Black and Latino residents was 5.5 and 3.5 times as high as that in White residents, respectively.
- Where Low Birth Weight ("LBW") is concerned, BPHC is working to: create a cultural shift, promoting preconceptional health as one key to a healthy outcome; promote optimal support for women during pregnancy, including case management commensurate with need; assure consistently high quality of prenatal and post partum care, especially for women at high risk; and build partnerships to address the social determinants of adverse health outcomes. Campaigns and Initiatives include: One Key Question®; Boston Healthy Start Initiative and Centering Pregnancy; Healthy Baby / Healthy Child and Father Friendly Initiative; and Healthy Start in Housing.
- Data indicates that overall, Boston LBW decreased significantly between 2010 and 2012 from 9.4% to 8.4%; Black LBW decreased between 2010 and 2012 from 12.4% to 10.5% (This change was borderline significant); and the change in the Black-White gap in LBW 2010 to 20120 was not significant. Data on Infant Mortality Rate ("IMR") indicated that the Black IMR was more than twice the White IMR (6.6 per 1,000 vs. 3.0 per 1,000 live births) in 2012; while meaningful, the one-year gap was not statistically significant. The reduction in the Black-White gap from 2010 to 2012 was not statistically significant; analysis of IMR data over four-year intervals from 2010 to 2012 demonstrates significant declines in Black IMR and the narrowing of the Black-White gap.
- Our conclusions are that the data trends highlighted here support the continued need for policy, systems, and environmental changes. Lasting and significant downward trends in obesity, Chlamydia, and low birth weight rates depend on systemic policy and programmatic approaches that address the root causes, such as racism and its effect on the social determinants of health.

Presentation: Boston School Immunization and Exemption Rates
M. Anita Barry, MD, MPH, Director, Infectious Disease Bureau

- Dr. Barry explained the topics she would be covering: Massachusetts requirements for immunization; how rates are measured; what exemptions are allowed; and the rates in Boston schools.
- Massachusetts immunization requirements legal basis is MGL Chapter 76, Section 15 which states: "No child shall....be admitted to school except upon presentation of a physician's certificate...."; MDPH regulations (105 CMR 220.000) outline specific requirements including vaccines required for entry from daycare through college; and policies around *enforcement of exclusion* of unimmunized children are developed by individual school districts.

- Kindergarten requires the following immunizations for each child: Hepatitis B - 3 doses; DTap/DPT - 5 doses; Polio - 2 doses; MMR - 2 doses; and Varicella - 2 doses (verified history of disease is acceptable). The requirements for 7th Grade are: Hepatitis B - 3 doses; DTap/DPT - 4 doses OR >= 3 doses Td (plus 1 dose of Tdap); Polio >= 3 doses; MMR - 2 doses; and Varicella - 2 doses (verified history of disease is acceptable); and Meningococcal - 1 dose, residential only.
- MDPH requests immunization information from schools, with a focus on particular grad levels: Kindergarten and Grade 7. Individual student immunization records are reviewed by school personnel, abstracted onto MDPH forms and submitted directly to MDPH (these forms are not shared with local health departments).
- BPS collects immunization records collected at student registration sites. The challenges there are: no school assignment at this point, so it's not clear where to send an individual student's records; no data input staff; and registration pre-dates school entry by months, so subsequent vaccinations may not be captured. BPS nurses at each school complete the MDPH forms.
- There are only two types of exemptions allowed in Massachusetts: (1) Medical exemptions where a physician submits documentation that an immunization is medically contraindicated; and (2) Religious exemptions where a parent or guardian submits a written statement that immunizations conflict with their sincere religious beliefs. Documentation for either type must be kept on file. **Philosophical exemptions are NOT allowed under Massachusetts law.**
- Not all schools have provided data. A chart for years 2012 to 2015 showed the total number of schools in Boston for both Kindergarten and Grade 7 and the percentage of those schools who did not respond to MDPH. Also included on the chart was the number of schools with fewer than 30 students. Charts comparing the immunization/exemption rates from 2012 to 2015 for Boston and the State in Kindergarten and Grade 7 were also shown.
- There was chart showing the range of exemption rates, both medical and religious, by county in MA for 2014-2015. In addition, there were charts depicting immunization/exemption rates for Kindergarten and Grade 7 with class sizes < 30 students.
- To summarize, the evaluation of school immunization and exemption rates is limited by incomplete data, inaccessible data, and information that may be out of date. Available information suggests that exemption rates overall in Boston schools are low, but there is a wide range. A significant proportion of children appear to be missing immunizations, but additional information is needed to confirm this.

Acceptance and Approval of July 2015 Board Meeting Minutes

- Dr. Johnson asked for a motion to approve the minutes from the July 16, 2015 meeting. Ms. Wcislo and Mr. Lopes seconded the motion with no objections. The minutes were unanimously approved by the Board members in attendance.

Adjournment

With no further business before the Board, Dr. Johnson thanked everyone for coming and adjourned the meeting at 6:00p.m.

Submitted by:

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Kathy Hussey, Board Secretary