MINUTES FOR THE MEETING OF THE BOARD OF THE BOSTON PUBLIC HEALTH COMMISSION
Thursday, June 18, 2015

A meeting of the Board of the Boston Public Health Commission ("Commission") was held on Thursday, June 18, 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
Harold Cox
Manny Lopes
Myechia Minter-Jordan, MD, MBA
Kate Walsh

Also Present Were:

John Townsend, Tim Harrington, Chuck Gagnon, Kathy Hussey, PJ McCann, Mimi Brown, Lisa Conley, Jeanne Cannata, Vivien Morris, Lester Hartman, Katherine Connolly, Chantay Robinson, Alexandra Prano, Naomi Robinson, Margurite Guillaume, Elena Apaza, Nick Cefola, Jeannette Carlyte, Renald Calixte, Bill Loesch, Margaret Reid, Gerry Thomas, Debra Paul, Osagie Ebekozien, Rita Nieves, Snehal Shah, Ken Farbstein, Nikysha Harding, Megan McClaire, David Susich, Maureen Onuorah, and Darcy Golulastos (? spelling).

Proceedings:

Chairwoman's Comments
Paula Johnson, MD, MPH

- Dr. Johnson welcomed everyone and called the meeting to order at 4:05p.m. She had a brief update on the search process which is moving along very smoothly. The Committee is very pleased with the direction it's moving in and hopefully will have more information available next month. 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 updates. We are very excited to have hired a new Director of Oral Health, Dr. Matthew Horan, who is the head of dentistry at the Dorchester House Health Center. He has also run the dental office at Codman Square Health Center for a very long time. Dr. Horan has a very strong and long history of providing community dental health. We are very excited to have him here. He'll be working part-time, one day a week. As the Board recognizes, dental health is one of the most important, but often forgotten part, of one's health. Again, we are excited to have his expertise on our staff to help strategize ways that these services are available to our residents.
- Also, since the last time the Board has met, Mayor Martin Walsh has announced a new Office of Recovery Services that will be based here at BPHC. The Mayor has named Jennifer Tracey as the new director of that office. The announcement was made at the Dimock Community Health Center.
- We are also happy to update the Board that after several months of a state where we have been using temporary facilities for the relocation of emergency shelter services on Long Island, we will soon be opening the full shelter facility at Southampton Street. The staff here has been working furiously to complete tasks to

have that happen and it will happen next week. We are very excited about it and thank Mayor Walsh and his leadership and all of the help we received from our sister agencies at City Hall, as well as, the construction crews for making this happen in such a timely way. Thank you to all of our staff who have worked very, very hard and will be working through the weekend to make this happen.

- Mr. Cox inquired if the South End Fitness center was now closed. Dr. Nguyen explained it continues to have about 200 shelter guests per night. The opening of the first floor and the remainder of the first floor of the Southampton shelter will allow those guests to move into the new space.
- Dr. Johnson thanked Dr. Nguyen. She stated the major topic on our agenda today is to discuss tobacco regulations and where there is opportunity for us to move this very important agenda forward. The Boston Public Health Commission has really been on the cutting edge of this work for many years. We have seen many of the health benefits to the health regulations over time. So, we'll begin with Nikysha Harding updating us, after we'll hear from Cheryl Sbarra.

Presentation: Opportunities to Update BPHC's Tobacco Regulation
Nikysha Harding, Director, Tobacco Prevention and Control Program
Cheryl Sbarra, Esq., Senior Staff Attorney and Director, Tobacco Prevention and Cessation Program and Chronic Disease Prevention Program, Massachusetts Association of Health Boards

- Ms. Harding introduced herself and said she would provide some updates and recent data for the Board. She explained that currently there are three (3) separate regulations that are enforced by the Tobacco Control Program: Smoke Free Workplace Regulation (e-cigarettes added in 2011); Youth Access Regulation (sets permit requirements, prohibits singles, regulates product placement, cigar packaging, signage (e-cigarettes added in 2011); and Restricting the Sale of Tobacco Products (prohibits Blunt Wraps, prohibits tobacco sales at Health and Educational Institutions, does not include e-cigarettes).
- Ms. Harding continued stating that despite our efforts to reduce youth access, we have not seen a decrease in overall tobacco use among Boston youth between 2010 and 2013. Youth reporting cigarette use in the last 30 days is lower than cigar use (6.2% vs. 11.6%). The CDC reports 3-cigarette use among high school students increased from 4.5% in 2013 to 13.4% in 2014, surpassing every other tobacco product. Boston e-cigarette youth use is following a similar trend.
- Ms. Harding showed comparison maps from 2011 and 2014 depicting the availability of single cigars in Boston neighborhoods. There has been an overall decrease in most neighborhoods with the exceptions of Jamaica Plain and South Dorchester. In general, most retailers have been in compliance. Dr. Minter-Jordan asked what are the consequences of violation. Ms. Harding explained there is a $200 fine for the first offense over a two year period; a second offense during that time results in a $400 fine and 7 day permit suspension; the third offense in a two year period results in a $600 fine and 30-day suspension; additional offenses result in higher fines and possibility of permit being revoked.
- The sale of tobacco products was prohibited at health and educational institutions in 2008. We were the first to pass this restriction; now there are more than 100 municipalities that have adopted the restriction across the state. Health and educational institutions are still technically allowed to sell e-cigarettes. Currently, none of the educational institutions are selling e-cigarettes. Of the pharmacies, only one chain sought permits to sell e-cigarettes. Of the 17 permits that this chain obtained, only 6 of the locations actually carry e-cigarettes.
- Ms. Harding commented on three recommended updates to address gaps in the regulations. The first is to consolidate the ***Restricting the Sale of Tobacco Products Regulation*** (Pharmacy ban) into the ***Youth Access Regulation*** to eliminate the loophole that allows to the sale of e-cigarettes and nicotine delivery products in pharmacies and educational institutions. Combining would also streamline the regulations, making them easier to understand and administer. The next recommendation would be to clarify the requirement that all tobacco sales need to be face-to-face and at the permitted location to prohibit emerging tobacco delivery services. The last recommendation is to address the relatively few "bad actors" responsible for most of the violations by adding language giving the Tobacco Control Program more discretion to review applicants' suitability when they apply or reapply for permits.
- Mr. Cox had a question regarding the face-to-face recommendation and how could it be applied to internet sales. Mr. McCann commented as to internet sales, enforcement would be challenging and difficult to track. Ms. Sbarra stated the Attorney General's office addresses internet sales since they are better equipped to deal with that issue. Ms. Harding turned the presentation over to Cheryl Sbarra, Senior Staff Attorney for the Massachusetts Association of Health Boards.

- Ms. Sbarra began explaining some of the emerging tobacco control policies such as prohibiting the sale of flavored tobacco products. The ***Family Smoking Prevention Tobacco Control Act*** (2009) granted the Food and Drug Administration ("FDA") the authority to regulate tobacco. The FDA prohibited candy and fruit flavored cigarettes because these flavored products were marketed to youth and younger smokers were more likely to have tried these products than older smokers.
- The FDA only addressed "cigarettes"; the other flavored tobacco products were not regulated. The industry expanded its niche to flavored little cigars. Not your Grandfather's cigar: they resemble cigarettes; smoke like cigarettes (are inhaled); come in flavors like bubblegum, tutti fruitti; have filters, tips and names like DaBomb Blueberry, Pinkberry and Purple Haze. 95.1% of 12-17 year olds who smoked cigars reported smoking cigar brands that were flavored.
- The tobacco industry has aggressive marketing in retail environments. The industry spends more than 94% or $8.3 Billion of their total marketing budget in convenience stores, gas stations and other retail outlets. Two-thirds of teenagers visit a convenience store or other neighborhood retailer at least once a week. Exposure to tobacco marketing in stores and price discounting increase your smoking. It's not just about illegal sales to youth.
- The FDA and U.S. Surgeon General both stated that flavored tobacco products are considered to be "starter" products that help establish smoking habits that can lead to long-term addiction. It's the same rationale used by FDA when it banned flavored cigarettes. Flavored products should not be available in retail environments that youth frequent.
- New York City ("NYC") conducted a controlled evaluation of the impact of their ban on the sale of flavored non-cigarette tobacco products. The ban was implemented in January, 2011 and provided scanner data on non-cigarette tobacco products sales from 891 NYC and 1,665 similar comparison-area stores in 10 proximal counties from January, 2010 through January, 2014. The NYC ban has had a specific, sustained impact on flavored non-cigarette tobacco products.
- In 2013, The 2nd Circuit Court in the matter of U.S. Smokeless Tobacco Mfg. Co. LLC vs. City of New York upheld ban of sale of any flavored tobacco product except in tobacco bars; 8 tobacco bars in Manhattan and none sold flavored smokeless (effective ban in NYC). Federal law does not displace state/local law unless Congress made intent to preempt clear, especially when state/locality is protecting health and safety; if ambiguity, presumption in favor of state/locality.
- Also in 2013, the 1st Circuit Court in the matter of National Association of Tobacco Outlets, Inc. vs. City of Providence, Rhode Island upheld ban on flavored tobacco products except in a smoking bar. The rationale was it's not a blanket prohibition and permits sales in smoking bars. Youth are vulnerable to flavored tobacco products. Providence is not preempted and Massachusetts sits within 1st Circuit. We would be wise to mirror the language Providence used in their ban.
- At the request of the FDA, the Institute of Medicine convened a committee to study the effects of raising the minimum legal sales age ("MLA") for tobacco products; its March 2015 report found: increasing MLA to 21 will prevent or delay initiation of tobacco use, especially among 15 to 17 year olds; MLA of 21 would effectively remove tobacco from high schools; delayed initiation will decrease prevalence of tobacco use by 12%; and would decrease tobacco-related disease and death, improve health across lifespan, and save lives.
- Needham, MA was the first US jurisdiction to pass a 21 MLA regulation in 2005. Before implementing, Needham's youth smoking rate was 12.9% compared with 14.9 5 in neighboring towns. By 2010, Needham's youth smoking rate fell to 6.7%, compared with 12.4% in neighboring towns (a percentage of decline triples that of the other towns; by 2012, Needham rate fell to 5.5%).
- Exposure during periods of developmental vulnerability can impair development of neurons and brain circuits, leading to changes in brain architecture, chemistry, and neurobehavioral function (brain development). It can cause long-term structural and functional changes in the brain. Adolescent smokers are more likely to become dependent on nicotine. Nicotine acts as a gateway rug, exerting a priming effect on cocaine.
- A Philip Morris report from January 21, 1986 stated: "Raising the legal minimum age for cigarette purchaser to 21 could gut our key young adult market (17-20 year olds) where we sell about 25 Billion cigarettes and enjoy a 70 percent market." There was a similar R.J. Reynolds report from September 10, 1982: "If a man has never smoked by age 18, the odds are three-to-one he never will. By age 24, the odds are twenty-to-one."
- The current status of the MLA 21 in effect: approximately 63 municipalities in MA; NYC; Suffolk County, NY; Hawaii County; Evanston, IL; Santa Clara, CA; Healdsburg, CA; Upper Arlington, OH; 7 municipalities in NJ; California, Hawaii and New Jersey are considering making it state law.

Presentation: Strategic Planning Process
Huy Nguyen, MD, Interim Executive Director and Medical Director
Vivien Morris, MS, RD, MPH, LDN, Director, Office of Racial Equity and Health Improvement

- Dr. Nguyen began with a recap of the Strategic Planning Process: to define BPHC's roles, priorities and direction over the next three years; to define what BPHC plans to achieve, how we will achieve it, and how we will know if we have achieved it; to focus the entire health department; to link the other planning findings, recommendations, and activities; to develop the third prerequisite for Public Health Accreditation Board (PHAB) recognition; and to help to sustain BPHC progress during transitions.
- The process has 6 key components: 1) Mission, Vision, Values; 2) Internal and External Data sources; 3) Selection of Priority Focus Areas; 4) Development of Goals and Objectives with measurable and time-framed targets; 5) Adoption and implementation; and 6) Assessment of progress and revision.
- Focus Area: Strategic Leadership Goals and Objectives. Goal 1: Public health leadership results in improved health of the City of Boston residents through equity-based policies and interventions. Goal 2: Boston's leaders and residents value and understand core public health functions and the City's role in ensuring and providing the ten essential public health services. Objective 1: By July 2016, implement at least 2 city-wide initiatives that increase capacity and knowledge of public health functions and programs. Objective 2: By January 2016, develop a plan to engage the community in decision making about BPHC services, aligned with racial justice and health equity principles. Objective 3: By Many 2016, develop and implement a Commission-wide communication plan (inclusive of a risk communication plan) for BPHC's key audiences.
- Focus Area: Health Equity Goals and Objectives. Goal 1: Strong community and government partnerships support City-wide health equity efforts. Goal 2: BPHC's programs, practices and organizational policies are aligned with racial justice and health equity principles. Objective 1: By July 2016, assess the capacity of partnering community organizations and coalitions in underserved Boston communities. Objective 2: By July 2016, identify and/or develop and implement training opportunities for 25 partnering community organizations and coalitions to address needs identified by assessment. Objective 3: By December 2018, 75% of BPHC staff will participate in opportunities to apply a racial justice and health equity framework to their work.
- Focus Area: Public Health Informatics and Surveillance Goals and Objectives. Goal 1: Boston residents and policy makers have access to information they need to support informed decision making on programs and policies affecting the health of Boston residents, with particular emphasis on populations at elevated risk. Goal 2: BPHC programs and policies are shaped by data reflecting the health needs of Boston residents and are rigorously monitored and evaluated to assure quality and efficacy. Goal 3. BPHC programs make optimal use of technology, informatics and analytic techniques, to measure and report on health status, health risks and health resources, and to inform Boston residents and policy makers on health related concerns. Objective 1: By July 2016, implement standard data collection and management protocols for program data. Objective 2: By July 2016, implement standards for regular program data review by programs, division and bureau. Objective 3: By July 2018, complete the business requirements and implement the infrastructure that will support the development of enterprise level systems to widely disseminate surveillance and program data to support data driven decision making by the public health system. Objective 4: By July 2017, ensure there is at least two staff skilled in informatics in every bureau.
- Focus Area: High-Performing Public Health Programs Goals and Objectives. Goal: Increase BPHC capacity to achieve health and health equity performance standards. Objective1: By January 2017, develop and implement BPHC Performance Management System that can drive improvement in health outcomes and health equity. Objective 2: By December 2018, promote a work culture that values organizational learning, focuses on effective processes and empowers staff to continuously improve the quality of programs. Objective 3: By December 2018, achieve Public Health Accreditation Board (PHAB) local health department accreditation.
- Focus Area: Workforce Development Goals and Objectives. Goal 1: BPHC's workforce is trained to effectively monitor and respond to the current and future public health needs of Boston's residents. Goal 2: BPHC's policies and procedures support the recruitment, retention and advancement of a qualified and prepared workforce that is reflective of the community we serve. Objective 1: By January 2017, develop a competency-based workforce development plan that increases program effectiveness and supports the training needs of and career pathways for BPHC employees. Objective 2: By July 2016, pilot at least one policy and/or procedure that increases access for staff from across the BPHC to training opportunities, with particular focus on lowest wage workers. Objective 3: By December 2016, assess the implementation and impact of BPHC

organizational policies (adopted 2013-2014) that promote racial justice, health equity and quality improvement in hiring, promotion, and retention. Objective 4: By November 2017, develop at least 3 recommendations on organizational policies, practices, structures and systems that promote racial justice and health equity and ensure quality improvement in hiring, promotion, and retention. Objective 5: By January 2018, implement at least two policies or practices that support the BPHC's ability to measure and improve the retention of diverse and qualified employees.

- Dr. Nguyen made a point of acknowledging the individuals who have been members of the Strategic Planning Committee: Deborah Allen, Director, Child, Adolescent and Family Health Bureau, Maia BrodyField, Director of Planning and Strategy, Community Initiatives Bureau; Jeanne Cannata, Chief Information Officer; Klein Fernandez, Global Health Fellow; Jeanne Lin, Policy Analyst; Megan McClaire, Chief of Staff (former); Vivien Morris, Director, Office of Racial Equity and Health Improvement; Bradley Seeman, Grant Writer; Snehal Shah, Director, Research and Evaluation Office; and Gerry Thomas, Director, Community Initiatives Bureau.

Acceptance and Approval of April 2015 Board Meeting Minutes

- Dr. Johnson asked for a motion to approve the minutes from the April 30, 2015 meeting. Mr. Lopes and Mr. Cox 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