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Responses to Questions for the Record:
“What are the State Governments Doing to Combat the Opioid Epidemic?”
Thursday, May 21, 2015

Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations
United States House of Representatives

Attachment 1 – Additional Questions for the Record

The Honorable Michael C. Burgess

Q: Complaints regarding PDMPs suggest that these systems are not real time, not widely used, and are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?

A: PDMPs represent an important safety mechanism that we must all take full advantage of and invest in. In 2009, Massachusetts expanded pharmacy reporting requirements and went “live” with the Massachusetts Online Prescription Drug Monitoring Program or “PMP.” Four years later, Massachusetts conducted significant system upgrades, and began providing for automatic enrollment and local law enforcement training. In 2014, Massachusetts expanded mandated usage to all mid-level prescribers, including advanced practice nurses and physician assistants. I am proud that Massachusetts has made important progress with implementation of the state’s PMP.

However, we still have critical work to do to improve the usability and overall effectiveness of this tool. For example, it should not take 11 “clicks” – as it does in Massachusetts – to use this system. To your point, a fully functioning PMP must facilitate, not inhibit good clinical practice. In Massachusetts, I am working directly with the prescriber community to find ways to better streamline the functionality of the PMP and incorporation into the clinical workflow in order to ensure increased utilization by prescribers. To this end, we in the Baker Administration are advocating for 24-hour pharmacy reporting requirements (now 7-days in Massachusetts), representing just one of several important changes that we believe will make critical improvements to functionality and effectiveness of this clinical tool.

With regard to national standards, while there are national reporting standards for PDMPs published by the American Society for Automation in Pharmacy, the quality of data received from pharmacies could be improved with guidelines for standardized reporting. Additionally, creating some appropriate level of federal standardization may assist state PDMPs in furthering interstate data sharing as different statutes, technologies, and funding streams from state to state make data compatibility difficult. However, federal standardization efforts should be approached with a careful eye towards encouraging state innovation, while also increasing abilities and incentivizing implementation towards greater interstate interoperability.

Finally, Massachusetts and the federal government must look to incentivize and create improved environments for critical linkages and integration of PMPs within electronic health records or “EHRs.”

Q: Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with the interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Monitoring Program Interconnect effective?

A: While interstate data exchange will soon be one of the primary technical enhancements for states to advance, Massachusetts is still working towards the ability to share data with states.

The goal of interstate data sharing is to allow prescribers and other healthcare providers greater access to patient record/data to be able to make an informed educated clinical decision on patient diagnosis and treatment. However, interstate data sharing capabilities have a long way to go before they will be truly useful to end users, the biggest concern being that it will be difficult to retain good, unique identifiers. Additionally, it is unclear whether the current systems across the country are robust enough to meet their intended objectives.

To this end, there are three (3) PMP Interstate Hubs that allow PMP data sharing between states: RxCheck, PMPInterconnect or “PMPi”, and RxSentry Hub. Massachusetts is currently on the RxCheck hub developed by the Bureau of Justice Assistance. This hub is currently maintained by the Integrated Justice Information Systems Institute (IJIS) on behalf of the RxCheck member states which governs the RxCheck Hub. Of those participating states, four (4) states are actively sharing data (OK, AL, ME, KY) through the Hub.

As you have stressed, interoperability between states will be a key component to improved functionality of PDMP systems nationally.

Q: It is my understanding that obstacles to managing the opioid epidemic vary widely from state to state, ranging from stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the deferral response to the opioid epidemic has been sufficient?

A: Across the Commonwealth, there are challenges in several areas that can present very real roadblocks – both in policy and availability of services – and that hinder access to timely and effective care: insurance coverage, particularly for downstream services, post-detox care (both residential and outpatient medication treatment services); statewide bed capacity, the types of beds available, and how to access them; services for mothers and fathers in recovery; the double digit increase in the costs of pharmaceuticals including Naloxone and other drugs; insufficient resources for child care, stable housing, and employment training; access to timely treatment information; early intervention services within our schools; education of our parents and community leaders of available resources and the early signs of addiction; and perhaps most prominently – stigma.

Addressing the opioid crisis requires taking action across the spectrum of touch points: prevention, intervention, treatment, and recovery supports. Each of these points is accompanied by unique obstacles – that as a state and a nation – we must develop solutions and strategies to overcome.

1. Prevention and Intervention:

Prevention work should include informational campaigns to increase public awareness of the dangers of opioid use. Existing coalitions such as Massachusetts’ statewide regional Opioid Addictions Prevention Coalitions and Learn to Cope peer networks can be crucial resources.

In 2009, Massachusetts led the way, authorizing its first recovery high school. With the leadership of the Baker Administration, Massachusetts is poised to open its fifth recovery high school in Worcester, MA. While these efforts are critical to the state’s recovery system, the question facing Massachusetts is how and when do we reach our children within the education system. Data clearly shows that early use of drugs increases a youth’s chances of developing addiction. In addition, National Institute of Health data demonstrates that children as young as ten years old are having their first experiences with alcohol and drugs.

Investing in the prevention of youth’s first use is critical to reducing opioid overdose deaths and rates of addiction. To this end, the Baker Administration is prioritizing support to our schools in order to implement substance use prevention curricula. While school districts should have the autonomy to choose the evidence-based curricula and grade levels most appropriate for their communities, these programs must be proven to reduce nonmedical opioid use. Finally, we must look at developing and targeting educational materials for school personnel, including our athletic coaching staff, and

parents about closely monitoring opioid use, as well as, signs and symptoms of drug and alcohol use.

Interventions should include expanding naloxone (or “Narcan”) availability to first responders, bystanders, and other community members. In Massachusetts, we are proud of the progress that has been made in the past several years to increase access to naloxone rescue kits. The cities of Quincy and Gloucester represent some of the first communities in the nation to arm our first-responders with this powerful overdose reversal agent. Since the start of these and other naloxone programs in 2009, our efforts have resulted in over 5,000 reported overdose reversals.

Beyond saving lives, this measure is starting to change attitudes. Police no longer see arresting as their only solution to this epidemic. Now, with each reversal, they see another opportunity to engage a person who is battling addiction – a disease.

We as a nation should support steps to increase access to, and lower the cost of, naloxone. Just as we would prescribe epinephrine for emergency response, we must identify, educate, and prescribe naloxone rescue kits to at-risk patients, and while doing so, we need to ensure we are employing strategies to reduce and contain cost.

We must employ careful prescribing practices for acute pain, especially for young people. According to SAMHSA, in 2011-2012 less than 5% of pain relievers used for nonmedical use were self-reported as coming from a drug dealer or online purchase. 21% were prescribed by one doctor, and more than 63% reported obtaining the pain relievers either free or through purchase from a friend or relative.¹ This means an overwhelming percentage of pain relievers come into the system of abuse from a legal prescription. Clinicians must shift their expectations and practices so that opioids are not the first line of defense against pain and are only introduced after other alternatives have been considered. In order to do this, alternate therapies must be available and covered by insurance. Public expectations must also shift away from a “quick fix” for pain, and we will need to improve our educational outreach about the expectations around pain and the role of the doctor’s office.

Simply put, prescribers need more education. To underscore this need, just this month, the Harvard School of Public Health released a poll that showed only 36% of Massachusetts adults prescribed pain killers reported being warned of the associated risks by their prescriber.² This education starts in the classroom. We in the Baker Administration will be looking to mandate pain management, safe prescribing training, and addiction training for all prescribers as a condition of licensure (physician assistants, nurses, physicians, dentists, oral surgeons, and veterinarians), while partnering with the medical and provider community to improve and increase educational offerings for prescribers and patients to promote safe prescribing.

¹ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011-2012

² <http://www.hsph.harvard.edu/news/press-releases/poll-many-americans-know-someone-who-has-abused-prescription-painkillers/>

To support this improved and expanded training, we need to be sure to arm our clinicians with tools. In Massachusetts, we have made progress with implementation of the needed improvements to the Prescription Drug Monitoring Program or “PMP.” We must all take advantage of this safety mechanism. However, it shouldn’t take 11 “clicks” – as it does in Massachusetts – to use this system; it must facilitate, not inhibit good clinical practice. To that end, I am working directly with the prescriber community to find ways to better streamline the end user experience to ensure increased utilization by prescribers. And in 2014, our state legislature mandated that all prescribers, including non-physician prescribers, must use the PMP.

2. Treatment:

Treatment should be tailored to an individual’s needs, and should include a wide array of options including inpatient and outpatient treatment, as well as equitable access and patient choice around medication assisted treatments – buprenorphine (i.e. Suboxone), naltrexone (i.e. Vivitrol), and medical methadone.

We must take greater advantage of the evidence-based treatments that we have at our disposal for opioid addiction. Access to all forms of Medication Assisted Treatment needs to improve by integrating these treatments into our practices, and making referrals as needed. Much like we treat diabetes and other chronic conditions, payment should ensure that treatment is tailored to the needs of the individual patient, and that it includes the full continuum of necessary wrap-around services.

3. Recovery

One of the greatest challenges facing our ability to address this epidemic is that, traditionally, it has been treated separately and differently from how we address other illnesses, too often, as a personal problem to be hidden away behind closed doors. Recovering from addiction requires a coordinated, community-wide range of support programs, resources, and tools.

To ensure that this support system is in place, to date, DPH has:

- Provided additional funding to increase the number of Recovery Support Centers statewide and to expand the hours during which these centers are open. Recovery Support Centers play a key role in providing community-based support to those in recovery from opioid addiction.
- Increased funding to peer-to-peer and parent-to-parent outreach efforts like Learn to Cope and the Massachusetts Organization for Addiction Recovery to support education, resources, peer support, and hope for parents and family members of people addicted to opioids and other drugs.

- Awarded funding for new Recovery High Schools, bringing the total number across the state to five. These high schools provide supportive environments to assist young people maintain their recovery while earning their high school diplomas.

4. Data

It has become clear that Massachusetts' ability to address the underlying health issues and social determinants that are driving this epidemic – trauma and undiagnosed behavioral health conditions chief among them – is dependent on the state's ability to successfully leverage data and measure results.

The Commonwealth is committed to making data – from overdose deaths to Prescription Drug Monitoring data – more available, more frequently, more timely. Over time, this data will better allow us to effectively 'hotspot' by targeting key populations in order to better understand the impacts of our collective efforts.

Utilization of data to combat our many public health challenges, including the opioid epidemic, has a long way to go – across all states – before we can truly say we are fully leveraging data across program silos. For example, currently at DPH, we have more than 300 different internal data sources that have been developed by individual programs using a variety of different formats for a variety of different purposes. They are managed by different staff, reside on different servers, and don't talk to each other.

This is not unique to Massachusetts. Across the country, public health needs to double down on data, and on interoperable, secure IT solutions. I look forward to exploring ways we can better achieve that level of success by harnessing new technologies – such as data warehousing – to create better linkages between siloed data sets. Doing so will allow us to better "hotspot" for highest areas of need for public health interventions; and most importantly, to measure whether our strategies and efforts are actually making the difference our missions commit us to.

Attachment 2 – Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable David McKinley

Q: You spoke in great detail about the measures you have taken in Massachusetts to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

A: As a frontline physician and as the former Chief Medical Officer at Boston Health Care for the Homeless Program – the largest of its kind in the nation – I have seen first-hand what this disease can do to our communities here in Massachusetts and across the country. We are watching our friends and family members die on our streets, driven by a lethal cocktail of trauma and underlying behavioral health conditions. This is a reality I am sure you too have witnessed in all too real of terms at home in your district as well.

This epidemic will be far from easy to tackle, but we will fail if we do not fully involve partners from all sectors – law enforcement, public health, healthcare institutions, families, schools, and you, our elected leaders.

To this end, I would encourage public awareness campaigns to increase knowledge about the dangers of opioid use and to break down the barriers built by stigma. Addiction is a chronic disease, and one that does not discriminate. All of us know a family, loved one, friend, or colleague who is suffering from this chronic disease.

Treatment capacity is an issue that is facing every state in the nation. Treatment should include a wide array of options depending on the individual's needs including inpatient and outpatient treatment, as well as equitable access and patient choice around medication assisted treatments – buprenorphine (i.e. Suboxone), naltrexone (i.e. Vivitrol), and medical methadone. We need to improve access to all forms of Medication Assisted Treatment by better integrating these treatments into our practices, and looking at the way we pay for these medications to ensure true patient choice.

Finally, existing coalitions such as the Commonwealth's many regional Opioid Abuse Prevention Collaboratives – as well as our District Attorneys, mayors, and health care systems that have developed task forces and localized capacity – offer important examples of frontline organizations which offer crucial resources and policy development at the community level. These collaboratives largely rely on federal funding from SAMHSA and maintaining these local, community-level organizations will be key to every state's ability to address this epidemic head on.

The Honorable Larry Bucshon

Q: What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

A: Opioid overdoses have increased significantly in Massachusetts over the past ten years. Opioids include heroin and prescription drugs such as oxycodone (oxycontin), fentanyl, hydrocodone, and codeine. In response to this growing problem, Massachusetts has implemented a number of approaches to reduce the number of overdoses.

Interventions should include expanding naloxone (or “Narcan”) availability to first responders, bystanders, and other community members. In Massachusetts, we are proud of the progress that has been made to increase access to naloxone rescue kits in the past several years. The cities of Quincy and Gloucester represent some of the first communities in the nation to arm our first-responders with this powerful overdose reversal agent. Our efforts have resulted in over 5,000 reported overdose reversals.

Naloxone is an opioid antagonist that blocks the effects of opioids such as heroin, oxycodone, hydrocodone, fentanyl, and codeine. In response to the increasing number of opioid-related fatal overdoses in Massachusetts in the past decade, the Department of Public Health is sponsoring a pilot program that is distributing intra-nasal naloxone, along with opioid overdose prevention education, to opioid users and to trusted people in their lives such as family, friends, and staff of human services programs.

Emergency responders including paramedics and emergency room physicians have been using naloxone since the 1970's to revive people who are experiencing an opioid overdose. While naloxone is an important emergency lifesaving tool, it is important to remember that it is a temporary measure. The use of naloxone must be coupled with other interventions including medical evaluation, medication assisted treatment, counseling and other supports.

Beyond saving lives, this measure has changed attitudes. Police no longer see arresting their way out of this epidemic as a solution. Now, with each reversal, they see another opportunity to engage a person who is battling addiction – a disease.

We as a nation should support steps to increase access to, and lower the cost of, naloxone. Just as we would prescribe epinephrine for emergency response, we must identify, educate, and prescribe naloxone rescue kits to at-risk patients, and while doing so, we need to ensure we are employing strategies to reduce and contain cost.