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Chairman Murphy, Ranking Member DeGette, and members of the Committee, thank you for your warm welcome and for the opportunity to provide testimony on this pressing issue today. My name is Dr. Monica Bharel, and I am proud to have been appointed to serve the Commonwealth of Massachusetts and Governor Baker as its Commissioner of Public Health. I am honored to be here representing one of the nation's oldest public health departments – one that traces its roots to Commissioner Paul Revere – and one that has continually led the way for public health across the country.

The mission of the Massachusetts Department of Public Health (DPH) is to prevent illness, injury, and premature death; to ensure access to high quality public health and health care services; and to promote wellness and health equity for ***all*** people in Massachusetts.

More specifically I believe that we as a state must ensure that vulnerable populations – and those with behavioral health issues chief among them – receive better, integrated, and de-stigmatized care throughout the continuum of life.

That mission is more critical than ever as we face the rising tide of an opioid epidemic that is overwhelming communities across our nation, in each and every one of your districts.

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. We are watching our friends and family members die on our streets, driven by a lethal cocktail of trauma and underlying behavioral health issues. That is not something we, as a society, should accept as a norm.

This epidemic will be far from easy to tackle, but this challenge is precisely what drew me to this job: to work with our providers, community members, and leaders – like yourselves – to find data-driven, and evidence-based solutions.

To that end, we are already hard at work throughout the Baker Administration, redoubling our efforts to identify, triage, address, and treat the opioid epidemic.

Identifying the Problem

First, to identify the problem. Like so many states across the nation, Massachusetts is facing a growing epidemic of opioid addiction and overdose deaths.

In 2013, there were 967 unintentional opioid deaths, compared to 371 motor vehicle-related injury deaths. Let me state that again: In 2013, more than 2.5 times as

many people died from opioid abuse than from motor vehicle related injuries. And those numbers barely touch the reality of this tragedy. Behind those 967 deaths were more than 2,000 hospital stays, more than 4,500 emergency department visits, and unquantifiable human suffering.[1]

And in 2014, an estimated 1,008 people died of an opioid related overdose, or a 51% increase over the 668 deaths that occurred in 2012.[2]

Behind each case is a very human story. At a meeting with Governor Baker in February at Hope House in Roxbury, Massachusetts, I listened to the testimony of "Jimmy," a person in recovery and a client of the facility. Jimmy told us about his progression from prescription opioids to heroin; about the life he had destroyed and rebuilt multiple times; about friends he had lost, and others he is now supporting through peer-support programs.

For me, Jimmy's story highlighted an elemental truth – we will fail in our efforts to address this crisis if we do not fully involve partners from all sectors – law enforcement, public health, healthcare institutions, families, schools, and you, our elected leaders.

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[1] http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/burden-of-overdose-deaths.pdf. Hospital Stays/ED Visits Data Source: MA Inpatient Discharge Database, MA Observation Database, and MA Emergency Department Discharge Database, Center for Health Information and Analysis (CHIA). Data are submitted by and reported by fiscal year (October 1, 2012 through September 30, 2013).

[2] http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-apr-2015-overdose-county.pdf

Governor Baker prioritized the opioid epidemic early in his new administration. In February, Governor Baker appointed 18 individuals to serve on an Opioid Working Group chaired by his Health & Human Services Cabinet Secretary Marylou Sudders.[3] The group represents the many different perspectives that are important to this work and was charged with developing tangible recommendations.

The working group held listening sessions across the Commonwealth hearing from more than 1,100 individuals, and received hundreds of recommendations and emails.[4] We heard from parents of children who have died from addiction, friends and family members of individuals living with a substance use disorder, individuals who suffer from chronic pain, people currently coping with addiction, clinicians, advocates, teachers, judges, law enforcement officials, community leaders, and elected officials. No matter the lens you use to look at this epidemic - and that is what it is – it is obvious that opioids are impacting every city and town in the Commonwealth.

Our success getting to the underlying health issues and social determinants that are driving this epidemic – trauma and undiagnosed behavioral health issues chief among them – will directly correlate with our ability to successfully leverage data and measure results.

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[3] http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/governors-opioid-addiction-working-group-members.html

[4] http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/governors-opioid-addiction-working-group.html

The Commonwealth is committed to making data – from overdose deaths to Prescription Drug Monitoring data – more available, more frequently. This data will better allow us over time to effectively target key populations and 'hotspot' to better understand the impacts of our collective efforts.

Attached with my submitted testimony today, please find several charts and data underscoring the extent of this crisis in Massachusetts.

Utilization of data to combat the opioid crisis along with all areas of public health throughout all state health departments have a long way to go 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. The mechanisms put in place to secure information can be the barrier that allows our system to 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 – that 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, whether the work we do actually makes the difference our missions commit us to.

Triaging the Roadblocks to Recovery

Across the Commonwealth, I have heard of and witnessed very real roadblocks to access and care. Insurance, particularly with regards to downstream, post-detox care for both residential and outpatient medication treatment services; statewide bed capacity, the kinds of bed types available and how to access them; services for mothers and fathers in recovery who are attempting to reclaim their lives while trying to take care of their children; the double digit increase in the costs of pharmaceuticals including Naloxone and other drugs; child care; stable housing and employment training; access to timely treatment information; early intervention services within our schools; education of not only our parents and community leaders of available resources and the early signs of addiction but children as well about the dangers of prescription drugs; and perhaps most prominently – stigma.

I have heard how the stigma associated with substance use disorder can drive a sufferer to find that one more hit, that one more pill, allowing them the brief relief and escape from the reality that is fraught with societal scorn. What this hearing alone represents is an important step towards societal recovery. We need to talk about this disease. This ***is*** a disease. And as a community and a nation, we will treat it and we will find pathways to recovery.

These and many other areas reflect needed conversations and reforms:

- We have to stop the “spin dry” cycle where individuals are admitted for short term detox and then are discharged without appropriate follow up services.
- We need to re-examine Massachusetts’ court ordered treatment provisions known as “Section 35” – courts and incarceration should not be the default substance use disorder treatment system.
- We need to improve access to treatment and we need to provide better, real-time, information to individuals with substance use disorders and their families.
- We need to work with physicians and other prescribers to decrease the number of opioid prescriptions in the Commonwealth while ensuring that individuals with chronic pain are protected.

Treating the Disease to Combat the Epidemic

From bedside to the halls of government, addressing the opioid crisis requires taking action across the spectrum of touch points: prevention, intervention, treatment, and recovery supports.

Prevention work should include a public awareness campaign to increase knowledge about the dangers of opioid use. Existing coalitions such at the Commonwealth’s statewide regional Opioid Addictions Prevention Coalitions and Learn to Cope peer networks can be crucial resources. Interventions should include expanding naloxone (or “Narcan”) availability to first responder, bystanders and other community members. Treatment should include a wide array of options depending on the individual

needs including inpatient and outpatient treatment, including equitable access and patient choice around medication assisted treatments – buprenorphine (i.e. Suboxone) and naltrexone (i.e. Vivitrol) and medical methadone. And we must expand our capacity to support patients once they are in recovery. These and other tools such as information and education are our chief defense in battling this disease.

And the road out of this heartbreaking situation will require active participation from many sectors of society – communities, schools, public safety, the addiction treatment and recovery community, and especially the medical community.

At DPH, we are proud of the progress that has been made to access to naloxone rescue kits in the past several years.[5] The cities of Quincy and Gloucester represented 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. Narcan is becoming as familiar as EPI pens.

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 an addiction – a disease. We wouldn't leave a stroke patient on the roadside.

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[5] http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/intervention.html

Today, I want to enlist your support in taking the next 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 take greater advantage of the evidence-based treatments that we have at our disposal for opioid addiction. We need to improve access to all forms of Medication Assisted Treatment by integrating these treatments into our practices and making referrals as needed. This means looking at the way we pay for these medication to ensure true patient choice, ensuring whichever medication – like we treat diabetes and other chronic conditions – works best for that individual is provided with the full continuum of necessary wrap-around services.

As a medical community, we must do our part – all of us – and employ careful prescribing for acute pain, especially for young people. Clinicians must shift the expectations and practices so that opioids are not the first line of defense again pain, but are only introduced after other methods have failed. Our job as clinicians is to make people well and keep our patients safe. When more than 20% of pain relievers for nonmedical use are coming directly from clinicians, we – all clinicians alike – must shift our expectations and practice so that opioids are not the first line of defense against pain, but are only introduced after other methods have been considered.[6]

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

However, to be able to do this there must be adequate availability and insurance coverage for alternate therapies. There will also need to be a shift in public expectations of a “quick fix” for pain with pills received in the doctor’s office. And we will need to improve our educational outreach about the expectations around pain and the role of the doctor’s office. To underscore this need, just this past weekend, 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.[7] This education starts in the classroom.

However, as our national data demonstrates, more than 80% of these lethal pain killers came from non-clinicians – in fact nearly 70% from family and friends.[8] And so again, this story highlights an elemental truth: we will fail in our efforts to address this crisis if we do not fully involve ***all*** partners from all sectors – family and community of all ages and walks, law enforcement, public health, healthcare, schools, and you, our elected leaders.

Universal screening can help identify those patients whose use of alcohol and other drugs may lead to problems. Screening may also identify patients who are in recovery and this provides an opportunity to give ongoing recovery support. In addition, this is an opportunity to work with patients on addressing their health conditions without prescribing medications that might compromise their recovery.

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[7] http://www.hsph.harvard.edu/news/press-releases/poll-many-americans-know-someone-who-has-abused-prescription-painkillers/

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

DPH has also 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. In Massachusetts, 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 mid-level prescribers, must use the PMP.

Finally, with the Governor’s leadership, that conversation will include a focus on achieving greater behavioral health parity and increased support systems, including early interventions within our schools.

In closing, these and other examples reflect the approach of this Administration: work smarter, not harder, by focusing our shared efforts and resources on those most evidence-based and proven programs that truly impact the public’s health. And in doing so, show data to demonstrate which programs make the biggest difference.

Thank you for your hard work and dedication to this issue. I look forward to working together to build a stronger public health framework to tackle this epidemic head on.

Thank you.