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Introduction

Good afternoon Vice Chair Friedman and Vice Chair Donato and Honorable Members of the Committee, thank you for inviting me to testify before you today. My name is Dr. Monica Bharel and it is my privilege to continue to serve as your Commissioner of Public Health. It is an honor to be able to speak to you today and I appreciate the opportunity to share with you some of the essential work the Department of Public Health (DPH) has done in the past year. This year has been very difficult for all of us. Our staff at the Department of Public Health (Department) have been at the forefront of the Commonwealth's pandemic response for more than a year and I am so proud of the hard work done by everyone at the Department, not only to fight this public health pandemic, but also to continue to carry out all of our work and deliver our many programs.

I would like to take a moment to recognize the toll of this pandemic and acknowledge those we have lost over the last year. Like me, I'm sure many of you have known someone lost to COVID-19. Each day I take a moment to reflect on loved ones we now mourn and the immense suffering of isolation and pain this pandemic has caused. We must never lose sight of who we have lost and the many sacrifices the residents of Massachusetts have made over the past year as we continue to work towards ending this pandemic.

DPH Overview and Year in Review

As the devastation of COVID-19 surged, the Department has worked around the clock to combat the pandemic – we haven't lost sight of our core public health work that is critical to keeping our residents healthy and our communities strong. The Department has a budget of roughly $1.4 billion; with over half representing state appropriations and trusts. Even though much of the Department's focus over the past year has been on COVID-19, our core work involves so much more: from addressing health equity to sexual and domestic violence prevention, from disease and injury prevention to data collection and analysis, from lead screening to ensuring access to

WIC, from hospital oversight to licensing of health care professionals, and from food and water safety to combatting the continued opioid crisis.

We have maintained a laser focus on health equity and how we can continue to improve the overall health of our historically under-resourced communities. The foundation of our equity work is based on the use of our public health data to understand the impact of the social determinants of health and unearth disparities to help us target our resources. This year, COVID-19 amplified existing inequities and shed light on ways we must improve our focus on health equity. This pandemic has taught us so many lessons, including that addressing health inequities improves health for all of us. The pandemic has confirmed my commitment to using data to identify and address the underlying conditions that cause the health inequities in our most susceptible communities.

COVID-19 Year in Review

At last year's hearing, we were just beginning to see COVID-19 cases appear in the Commonwealth. We had little information on this novel virus and did not know how it would so profoundly affect our health and health care and day to day activities. To say it has consumed our lives would be an understatement. I would like to thank all of the healthcare workers, first responders, public health professionals, local boards of health, educators, business owners, and all residents of the Commonwealth for remaining steadfast with protecting themselves and each other through mask wearing and social distancing.

As of April 4, 2021, there have been 605,055 total cases and 16,938 deaths in the Commonwealth. One of our top priorities with handling the COVID-19 pandemic response was to ensure continuous communication with the residents of the Commonwealth. In collaboration with the Command Center, the Department provided consistent information sharing and guidance for the public and our partners in responding to the pandemic and made it a priority to answer questions on a broad range of public health and clinical issues related to COVID-19. During the height of the pandemic, the Department conducted:

- Twice weekly calls with local boards of health, hospitals, and community health centers
- Weekly calls with long term care facilities and assisted living residences
- Monthly calls with provider stakeholder groups
- Twice weekly calls with Higher Education Institutions and Department of Higher Education to provide technical assistance and support

We have issued thousands of Health and Homeland Alert Network (HHAN) alerts and listserv messages to more than 200,000 stakeholders.

Emergency Response

Since personal protective equipment (PPE) became scarce at the beginning of the pandemic, the Department along with the Command Center and MEMA has been dedicated to ensuring that there will be sufficient PPE for now and any future outbreaks. The Department's Resource Unit was able to respond to more than 4,000 requests for over 4.1 million pieces of PPE and testing supplies for hospitals, nursing homes, assisted living facilities, clinics, EMS and other healthcare entities. The Resource Unit also coordinated the delivery of 679 ventilators and over 36,000 doses of Remdesivir, an antiviral medication that interrupts production of COVID-19, to hospitals and long-term care facilities to help those who are the sickest.

Since the start of the pandemic, the more than 40,000 calls that have come in to our 24/7 epidemiologist telephone line have been answered personally, providing information and support to long term care facilities, hospitals, local health departments, schools, daycare centers, and public health departments in other states who called to report cases and outbreaks as well as obtain advice on responding to the pandemic. The Department's surveyors also have provided regular outreach and support to nursing homes and rest homes and have maintained frequent contact with these long-term care facilities to provide support on infection control strategies, as well as working with them to resolve PPE and staffing challenges as they may arise.

Local public health partners have played a vital role. For example, nearly $15 million for DPH contracts was approved to assist local public health partners and support their on-the-ground work. We are grateful to our local boards for their tireless dedication to helping their communities.

Public Health Hospital System

As you know, there are four public health hospitals within the Department's system: Tewksbury State, Western MA, Shattuck and Pappas Rehabilitation Center for Children, as well as the Office of State Pharmacy Services (SOPS). With an average daily census of over 700 patients, these hospitals serve as the Commonwealth's medical safety net providing care for vulnerable patients whose complex medical and psychiatric co-morbidities prove to be a challenge to more traditional medical settings.

The Public Health Hospitals provide high quality medical care in a professional and caring manner. Each Public Health Hospital is Joint Commission certified, providing 24/7 nursing and medical services and a full range of ancillary services.

To help provide important care to patients, the Department's Hospital System works in collaboration with the Departments of Mental Health and Corrections. The State Office for Pharmacy Services, located on the Tewksbury Hospital campus, provides pharmacy services to 43 health and correctional facilities across the Commonwealth servicing a population in excess of 22,000 individuals.

Like all entities within the Commonwealth, our Public Health Hospitals were impacted by COVID 19. All four hospitals established an incident command structure through a collaboration with the Department of Mental Health and Commonwealth Medicine; strengthened their infection control policies including PPE use and distribution; reduced bed

capacity and office space for infection prevention and control standards; weekly COVID testing for all staff; new and/or enhanced clinical capacity to support surveillance testing, vaccination clinics, and contact tracing; visitation guidelines to ensure staff and patient safety; and ongoing education for frequently revised CDC guidelines.

Shattuck and Tewksbury adapted, by opening up COVID units and converting existing space to accommodate new units, incurring additional costs. All four hospitals were able to take extra steps to attend to the increased behavioral health needs of patients, for example, offering the use of computer tablets to increase communication among patients and family/friends.

During this pandemic, we have cared for 361 COVID positive patients. As of April 4, 2021, there are is only one COVID positive patient in the system. The majority of staff and patients have been vaccinated with the exception of the patients at Pappas under the age of 16 who are not yet eligible. This could not have been achieved without the dedication and compassion of the staff at each of these hospitals and I thank them for all of their efforts this past year.

Testing and Surveillance

Let's turn to another critical piece of our response to the COVID pandemic: testing and case surveillance. In the beginning of the pandemic, the entirety of Massachusetts had little to no COVID-19 testing and outreach capabilities. Some of the most important work we did in the Commonwealth was to expand testing capabilities and to grow our surveillance efforts, so we are able to know who has been infected and use community outreach to stop the spread. To date, the Commonwealth has collected over 19 million tests. The Massachusetts State Public Health Laboratory, in collaboration with the Broad Institute of MIT and Harvard, has logged over 1,571,699 COVID-19 specimens. To ensure that everyone had access to testing, especially the most impacted cities and towns in the Commonwealth, the Administration launched the initial Stop the Spread campaign in the eight most impacted communities and expanded across the state. These sites continue to operate today and support free testing for all residents and have helped identify 185,651 positive cases.

The Department, in conjunction with the Command Center, also created partnerships with the Massachusetts Health Connector, Accenture, and Partners in Health to create the Community Tracing Collaborative (CTC) to contact individuals who have tested positive for COVID-19 and ensure they have the support needed to properly isolate or quarantine. DPH also assisted local public health, the CTC, and over 160 institutions of Higher Education and K-12 schools to increase testing capacity, ensure complete and timely case investigation, and conduct contact tracing for COVID-19 on campuses. The Department provided rapid epidemiological support and public health recommendations directly to school leadership and local public health to help manage large outbreaks and clusters on and off campus.

Data

DPH takes a data-driven approach to programs and policies. In everything the Department does, we begin with the data. We emphasize precision public health, using evidence-based approaches to the public health challenges that face us. Data informs our decisions and helps target our resources.

When it comes to COVID-19, the Department has taken the same approach. The Department posts a COVID-19 Daily Dashboard (Dashboard) seven days a week, nearly 365 days last year, to ensure there is a consistent and single source of truth about the impact of the pandemic in the Commonwealth. The Dashboard includes confirmed cases, testing data, hospitalizations, hospital capacity, and deaths as well as raw data sets and archived reports. It contains data from elder care facilities, county houses of correction and Department of Correction facilities.

We also prepare a Weekly Public Health report as part of our regular dashboard postings. The weekly report includes cases and testing by municipality with demographics, contact tracing and outreach, probable cases, individual released from isolation, cases and deaths at long-term care facilities, infection control at nursing homes, and PPE distribution. The Daily and Weekly dashboard total page views from March 6, 2020, the day the first data was published, to April 4, 2021 =29,711,335. In January, the Department updated the dashboard to be interactive allowing for a more user-friendly experience. The interactive COVID-19 dashboard combines a number of elements, such as the positivity rate and the testing rate for cities and towns. Using the interactive dashboard, the data can be customized, and users can explore specific periods of time to understand trends throughout the pandemic. The Department also reports "Chapter 93" data from elder care facilities collected daily. This data includes COVID-19 positive cases and deaths among staff and residents at these long-term care facilities.

From the beginning, it became clear that the pandemic was disproportionally affecting some of our historically under-resourced communities. To better understand the extent of this inequity, we needed better data about who was being tested. And so we issued a Public Health Order in April 2020 requiring that health care providers collect complete demographic information, including sex, race, and ethnicity, on patients with confirmed or suspected COVID-19 when ordering a laboratory test for the disease. This was important because we needed to understand the most heavily impacted communities so that we can target our resources where they are needed most. Following this order:

- Reporting of race/ethnicity increased 153% in cases from 30% with completed race/ethnicity data in April 2020 to 76% in February 2021.
- Reporting of race/ethnicity increased 102% in hospitalized cases from 45% with completed race/ethnicity data in April 2020 to 91% in November 2020.
- Reporting of race/ethnicity increased 255% in deaths from 28% with completed race/ethnicity data in April 2020 to 99.5% in November 2020.

Regulatory Waivers and COVID-19 Guidance

Throughout our continued response to the pandemic, we have issued public health orders, regulatory waivers, and COVID-19 guidance to bolster our COVID-19 response and mitigate the impacts of the pandemic. Our goal was to provide guidance and to reassure the public that quality and safety were – and continue to be – our priority throughout the pandemic.

The Department established an emergency waiver to allow for an expedited Determination of Need process for COVID-19-related projects. To ensure that the healthcare workforce was able

to meet the demand of the pandemic, the Department's boards of health professional licensure issued guidance to students, recent graduates, out of state professionals, and licensed thousands of professionals with innovative and flexible approaches to licensure and staffing, as well as expansion of qualified personnel to administer vaccines. The Board of Registration in Nursing alone processed over 14,000 permanent and temporary licenses under new and improved processes. Through collaboration with the federal DEA, we have been able to ensure the security of medications while also allowing temporary facilities and additional health care spaces, such as alternate care sites, to care for seriously ill patients and to provide a safe space for residents experiencing housing issues to recover.

COVID Health Equity

I also want to highlight the COVID-19 Health Equity Advisory Group, which the Department assembled in May 2020 to help address the inequities in communities disproportionately impacted by COVID. This 26-member group includes recognized health care professionals, faith-based leaders, nonprofit executives, and leaders from the communities disproportionately impacted. Each member provided their own unique view to help us better understand what we were seeing and how to begin to address the urgent problems at hand. The group met twice weekly throughout May and produced recommendations focused on data and metrics, COVID-19 mitigation, community engagement and support, and social determinants of health.

The Department deployed a large-scale statewide COVID Community Impact survey about our residents' perceptions, needs and experiences related to COVID-19 with targeted outreach to key populations to support the goal of better understanding how the COVID-19 crisis may be disproportionately impacting some populations more than others. Over 35,000 responses were received which are being used to inform policies, program responses, and local community planning efforts to address the specific needs today and prevent future negative impacts of COVID-19.

Vaccine Distribution

Our state vaccine distribution plan is based on three principles: preserving life, protecting our health care infrastructure, and addressing equity. From the start, we have prioritized equity, including being one of only a handful of states to prioritize prisons and jails, homeless shelters and domestic violence shelters, and all health care workers in the first phase of vaccine distribution.

As of today, Massachusetts has administered more than 3.9 million doses of vaccine, ranks third among states with at least 5M population for percent of population who have received their first dose (37%), is third among states with at least 5M population for percent of population fully vaccinated (21%), and ranks ninth among states for the percentage of doses of vaccine administered (86%).

The vaccine represents hope that we will soon see the end of this pandemic.

Let's now turn to the systems in place to manage this historic pandemic. It was in the Summer of 2020 that the Commonwealth built upon and expanded its state-of-the-art Massachusetts Immunization Information System or "MIIS." The MIIS is the product of over a decade of requirements gathering, which includes identifying the core functionalities, use cases, interoperabilities, federal investments, initial development, and ongoing maintenance and upgrading, and recent enhancements to meet COVID-19 vaccination needs. Prior to the 2009 H1N1 influenza pandemic, a less technically sophisticated vaccine registry in Massachusetts had been recently decommissioned.

The 2009 H1N1 outbreak highlighted the challenges of tracking immunizations during a statewide, national, or global epidemic and prompted consideration and investment at the state and national levels. Building on state-of-art information technology, a new, secure, web-based system capable of communicating with emerging Electronic Health Record systems and the CDC's VTrcks vaccine ordering system was envisioned. Over the next several years, the MIIS was built, pilot tested, and rolled-out to providers and other users.

This process was supported nearly exclusively by the approximately $8M in direct federal (CDC) grant support. Ongoing maintenance of the system is supported by the contributions of health insurance carrier surcharge payors to the state Vaccine Purchase Trust Fund (authorized under M.G.L. Chapter 111 §24N), with recent specialized COVID-19 enhancements also supported with CDC immunization cooperative agreement funds. The system is currently hosted on the state's Virtual Gateway, but work is underway to transfer this hosting to the AWS cloud computing environment for enhanced security, reliability, and scalability.

In collaboration with the COVID Command Center, the Department implemented the Massachusetts COVID-19 Vaccination Program (MCVP). In October 2020, the Baker-Polito Administration announced a COVID-19 Vaccine Advisory Group to help inform the Department's planning for distributing the COVID-19 vaccine. The plan is online and is continually updated to reflect the current information.

When the state's vaccine rollout began, vaccine was in extremely short supply – even more so than today – and available only in a very limited number of locations, mainly hospitals. With each new eligibility phase that the Commonwealth enters, the vaccine distribution process continues to improve, and vaccinations are increasing. The state now has over 150 vaccination sites with vaccine available via hospitals, community health centers, regional sites, pharmacies, and mass vaccination sites.

In February, the Administration announced the COVID 19 Vaccine Equity Initiative – a partnership bringing resources directly to the 20 cities and towns most disproportionately impacted by COVID-19 to increase awareness of the vaccine's safety and efficacy and to reduce barriers to vaccination. To do this, the Department has identified DPH Liaisons to work with local leaders and community and faith-based groups to strengthen existing efforts to ensure that residents can get vaccinated when it's their turn. Each tailored community-based approach offers a customizable menu of options which may include:

- Identifying gaps and mapping available resources to reduce barriers to vaccination

- Coordinating and supporting key stakeholders including Local Board of Health, local Community and Faith Based Organizations, Community Health Centers, and Community Health Workers who can support grassroots outreach

- Deploying DPH Vaccine Ambassadors to provide support for town-halls and other community forums to share information and materials, including a DPH forum guide and toolkit

- Disseminating culturally appropriate translations of communications campaign materials, including: *Trust the Facts. Get the Vax.* campaign materials and vaccine FAQs in multiple languages

- Hiring local residents to provide "boots on the ground" for neighborhood and local business outreach, which may include a door-knocking campaign to provide information and answer questions about vaccine efficacy and safety

We will continue to add activities and support these communities via a number of federal and state funding opportunities.

Our efforts to engage with our communities, especially those hardest hit by COVID-19, have been nationally recognized, and we have made presentations to other New England states via the FEMA Collaborative and nationally to the CDC Vaccine Task Force and during the CDC COVID Vaccine Forum in February 2021.

Throughout the pandemic, the Department has created several statewide public awareness campaigns to educate the public on issues related to COVID-19, including numerous animated videos for use in social and paid media on topics ranging from Stop the Spread testing initiative to #GetBackMass to our newest campaign, Trust the Facts. Get the Vax.

Our innovative approach used not only our formative research findings, but also community feedback to inform our campaign messaging and selection of spokespeople. Meeting with community members enabled us to understand the very real barriers – both physical and otherwise – to obtaining vaccination. Our state public awareness campaign, Trust the Facts. Get the Vax includes several PSAs – the first one features doctors from diverse backgrounds speaking to efficacy and safety, as our research told us physicians are the most 'trusted messengers' for this information. We also assembled an external 19-member communications advisory group that was instrumental in helping ensure we were on target for our messaging to groups most hesitant to get the vaccine.

In its first two weeks, the PSA garnered over 600,000 completed video views and more than 29,000 website pageviews, much higher than national averages. This campaign was truly informed by our communities. It is grounded in our own research. It is out in 10 languages. It will continue to be updated as new information becomes available. It is scheduled to run through June of 2021.

We are optimistic that by June we will be in a different place than we are in today and that all of our efforts with the vaccine rollout plan will soon allow us to get back to a somewhat normal life.

Non-COVID-19 Focus

COVID-19 has been a primary focus of the Department this past year. However, the mission of the Department is to prevent illness, injury, and premature death, to assure access to high quality public health and health care services, and to promote wellness and health equity for all people in the Commonwealth. We have not lost sight of this in the midst of the pandemic.

Precision Public Health

Data-driven decision-making enables us to best target our public health resources. Our precision public health approach includes a focus on communities historically underserved.

The reality is that even before the pandemic, serious inequities existed in the prevalence of chronic health conditions and how each of us experiences access to care. The Department has and continues to take steps to combat these inequities.

Examples of our work in this area include creation of the Population Health Information Tool (PHIT), the Public Health Data Warehouse, and completion of the Racial Equity Data Road Map. All of these resources offer assistance to better identify, understand, and act to address racial inequities. The Department also recently released the first Health Equity Dashboard, focused on Race/Hispanic Ethnicity, to address the need for more available public health data to address inequities experienced by our priority populations.

Community Engagement and Support

We are also funding partner groups addressing health inequities. For example, the Department awarded $14.7 million in Community Health and Healthy Aging Grants in the inaugural year of the Massachusetts Community Health and Healthy Aging Funds. The Department will partner with 32 organizations and 35 of their community partners across Massachusetts to lead the effort in addressing the root causes of health inequities by disrupting systemic barriers to health and tackling institutional and structural racism. The goal of the funds is to work with community partners to create long-term, meaningful changes in population health outcomes, including mental health and chronic disease. This includes working to ensure that our communities are age-friendly by creating healthy community environments for everyone across the life-spectrum.

The Moving Massachusetts Upstream, or the MassUP initiative, an interagency initiative formed by DPH, MassHealth, the Executive Office of Elder Affairs, the Health Policy Commission and the Office of the Attorney General, was able to award $2.5 million in grants to support partnerships between healthcare providers and community organizations. This will help enable sustainable improvements in community health and health equity by moving upstream to address the social determinant of health. The four awards, selected through a competitive application and

review process, focus on two significant social determinants of health: food system security as well as economic stability and mobility.

Other examples of important non-COVID work that continues include:

- The average WIC caseload increased 9.3% from March 2020 to February 2021; the program is currently serving ~115,000 participants each month

- A total of 485,369 WIC appointments were completed by local WIC program staff between March 2020 and January 2021

- An October 2020 survey of EI families indicated that 94% of respondents were receiving a variety of telehealth services, including home visits, IFSP meetings, and/or evaluations

- Childhood Lead Poisoning Prevention Program provided community health worker services through telehealth without any disruption during the pandemic, including monitoring, outreach, individual assessments, and connecting families to critical resources.

Opioid Crisis

Too many families in the Commonwealth continue to grapple with the opioid crisis, worsened by the COVID pandemic. We understand that we must continue to build upon years of concerted, important work by the Administration and the Legislature. To prevent and mitigate the spread of COVID-19 in the substance use disorder (SUD) treatment system, the Department has worked closely with providers to distribute guidance on surveillance testing, screening and isolation of patients/staff, and increasing flexibility in bed allocation between different service settings.

During the pandemic, the Department was able to increase access to naloxone, with over 90,000 naloxone kits distributed to Opioid Treatment Programs, Syringe Service Programs, community health centers, hospital emergency departments, and county Houses of Correction.

The Department has also implemented take-home doses for Medication for Opioid Use Disorder (MOUD) for all Massachusetts Opioid Treatment Programs (OTP) via a blanket exception from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Take home dosing allows greater access for patients caring for children, and those who have transportation issues, anxiety, and/or other co-morbid medical concerns that could have previously prevented them from seeking treatment; and during the pandemic, this flexibility limited the number of individuals needing to go to an OTP thereby reducing risk of COVID-19 transmission. I am happy to report that this has been extremely successful: 52% of OTP patients received take home doses as of June 2020, compared to the average of 15.6% of patients in December 2019. Early findings believe that we will see similar numbers throughout the rest of 2020 when the data is compiled and analyzed.

The Department expanded the Overdose Education and Naloxone Distribution (OEND) programs to address opioid overdoses in populations/communities with the highest rates of fatal and non-fatal overdoses and continued support for Post-Overdose Support Teams (POST) to provide outreach to people who have experienced an overdose. The Department also implemented the Mobile Addiction Services Program for rollout in November 2020, which has provided mobile low-barrier, low-threshold clinical care and harm reduction services and partnered with the New England Association of Drug Court Professionals to provide training and technical assistance regarding Substance Use Disorder to MA drug courts and Veterans courts.

As you may recall in 2018, the Legislature passed a law to create a pilot program for Houses of Corrections to have broad access to all forms of FDA-approved Medication for Opioid Use Disorder (MOUD). The first report in September 2020 showed over 4,000 individuals across seven Houses of Correction (Essex, Franklin, Hampshire, Hampden, Middlesex, Norfolk, and Suffolk Bristol and Berkshire) began receiving this critical medication.

Eastern Equine Encephalitis (EEE)

Over the summer, we focused efforts on addressing Eastern Equine Encephalitis (EEE). For the second year in a row, the Department led the Commonwealth's response to EEE, a serious mosquito-borne illness. Collaborating with the Massachusetts Department of Agricultural Resources (MDAR), we were able to ensure a timely and meaningful response to the EEE outbreak as well as operationalize the new EEE law, implementing the Arbovirus Surveillance and Response Plan, leading efforts on additional EEE surveillance in high-risk areas of the state, early stakeholder engagement to ensure coordination, and more expansive social media and website messaging.

The State Public Health Laboratory tested 7,155 mosquito samples finding 97 positive for West Nile Virus and 66 positive with EEE. The Lab was also tested 235 human samples and 12 veterinary samples. With this testing, we were able to identify and inform high-risk communities to disseminate critical prevention messages. At the height of EEE activity, the Commonwealth had four communities at critical risk and ten communities at high risk. With the data we received from the samples and lessons learned from previous years, the Department was able to support MDAR's aerial spray operations across 25 municipalities.

We continue to collaborate across agencies to conduct comprehensive and thorough assessments of surveillance, operations, policy, communications, and response plans. This builds upon lessons learned from engaging local boards of health and other essential stakeholders and partners. We also continue to revise procedures, messaging, and communications planning to incorporate best practices based on feedback we solicited from communities, specific groups such as the state's beekeepers and organic farmers, school personnel, and members of the public.

Tobacco Prevention

Last June, thanks to the collaboration with the Legislature, Massachusetts led the nation in implementing the first state law that takes the sale of menthol tobacco products out of all stores other than age 21+ smoke shops, protecting the health of all communities, especially those that

are overwhelmingly and unjustly targeted by the tobacco and vaping industries. The legislation also restricts the selling of vaping products with nicotine content greater than 35mg/ml to adult retail tobacco stores and smoking bars.

We continue to work closely with our partners in local health to ensure the enforcement of the Commonwealth's tobacco laws and regulations. This includes engaging 35 boards of health, providing additional resources to the existing network which includes funding programs representing 200 cities and towns covering 72.3% of the population and 77% of all tobacco retailers in the Commonwealth. It also includes providing case-by-case technical assistance to non-funded communities and conducting investigations and enforcing regulations in the absence of local enforcement.

To support those impacted by the menthol restrictions, the Department has increased assistance for menthol users at the Massachusetts Smokers' Helpline, developed a coaching support incentive program, and conducted community and provider education to increase awareness of these resources.

To continue anti-tobacco efforts, a statewide movement of youth fighting tobacco in Massachusetts known as "the 84", has virtually shifted programming and continues to engage youth during the pandemic. The virtual trainings are a space for youth to be engaged in topics of their interest and choosing. Space is also provided for adults working with youth in the 84 to support them during this challenging time.

Massachusetts led the nation with the adoption of the new tobacco law. Because of this, the Massachusetts Tobacco Cessation and Prevention Program (MTCP) has been contacted by multiple research partners across the country seeking to evaluate the impact of the statewide flavor restriction law. The MTCP is engaging communities, researchers, and partners to evaluate several areas of the law, including access, impact on use and cessation.

There is always work to be done to make sure that tobacco products remain out of the hands of children and the Department continues to work on this important public health issue and we are grateful for Legislature's continued support.

Data Infrastructure & Surveillance

This past year, we have made critical upgrades to our data systems. The Department successfully replaced two significantly aging data systems with the Early Intervention (EI) Client System. This will allow the Early Intervention program to offer streamlined, paperless support of activities at both the state agency and state contracted provider level; real time data collection with capacity to monitor and analyze effectiveness and quality of EI service delivery; better compliance and alignment with Federal reporting requirements; and common data storage with ability to connect data across functionality within the application while supporting future interfaces with other state and contracted provider systems.

The Department completed a two-year project to develop a new centralized, automated process to provide hospital discharge ("Case Mix") data from Center for Health Information and

Analysis (CHIA) to over 70 epidemiologists across the Department who use these files. The project generated needed data dictionaries, quality reports, and process explanations to facilitate the use of Case Mix data and promote standardized data analysis practices.

Electronic Prescribing (e-prescribing)

In 2019, the Legislature passed the STEP Act which required that all prescriptions for controlled substances and medical devices to be issued electronically. Originally required to be implemented in January 2020, the Department asked for an extension to allow small providers and pharmacies to complete the necessary technological requirements. We know that e-prescribing is more secure than paper prescriptions, with less opportunity for forging of prescriptions, and will enhance patient safety, reduce medication errors and improve pharmacy workflow. As of January 2021, the transition was completed with few issues reported.

Registry of Vital Records and Statistics

We continue our efforts to expand access to our Vital Records Registry. The Registry of Vital Records & Statistics translated 12 vital record registration forms into four languages- Spanish, Chinese Simplified (Mandarin), Portuguese and Haitian Creole. This will make the forms more accessible to the public and help improve data collection quality. It will incorporate the changes into an electronic reporting system to uniformly implement changes to "Acknowledgments of Parentage." This allows for administrative establishment of parentage for non-biological second parents, an important equity issue for parents and their children.

Gun Violence Prevention Program

In the second year of the innovative gun violence prevention program, the Department awarded funding to five additional community-based organizations, for a total of 15 programs that provide prevention, intervention, treatment, and recovery services for youth impacted by gun violence, within a racial justice framework. Grantees continued to implement strategies during the COVID-19 pandemic to provide virtual programming in all component areas, including increasing virtual workforce development, education, and behavioral health sessions and youth contacts.

FY21 Budget Investments

The FY21 Budget demonstrated the Legislature's commitment to the critical role of public health and public health investments, ensuring that the Department has the resources it needed to continue our significant scope of work.

Local and Regional Public Health

Local boards of health continue to be key partners. Through the local and regional public health grants, the Department was able to provide $10 million more in grants to these boards of health to combat the pandemic. This money is being used to guarantee that not just bigger boards of health are able to help their residents, and we are making sure that these grants will be geographically equitable to all.

The Department awarded $1,700,000 in grants to strengthen the local public health system under a shared services program. Created in response to the recommendations of the Special Commission of Local and Regional Public Health (SCLRPH), the State Action for Public Health Excellence, or SAPHE, Grant Program enabled ten groups of cities and towns to plan for or to expand the sharing of staff and resources to improve local public health effectiveness and efficiency. In its *Blueprint for Public Health Excellence* report, the Special Commission, which I chaired, recommended that the Commonwealth "increase cross-jurisdictional sharing of public health services to strengthen the service delivery capacities of local public health departments." The SAPHE Grant Program strengthens local public health services and protections to residents in 79 cities and towns through cross-jurisdictional sharing. We expect to continue this excellent program and look forward to encouraging more communities to work together to address their local public health needs.

Sexual Assault and Domestic Violence

Throughout the pandemic, the Departments Sexual Assault Nurse Examiner (SANE) program focused on patients reluctant to seek hospital care due to COVID-19 through implementation of alternative out-patient services in 3 clinics (Brockton, Plymouth, Worcester). SANE also expanded outreach to agencies serving those patients who are reluctant to seek care in an emergency setting for a variety of reasons (CSEC/HT patients, LGBTQ individuals, Persons with Disabilities). The Department also was able to designate one state-wide phone number for sexual assault and domestic violence to promote easy access, especially during the pandemic. The statewide hotline SafeLink expanded their capabilities to sexual assault as well as domestic violence survivors, with crisis support, triage and warm handoff to local rape crisis hotlines and domestic violence programs. Advocates speak English, Spanish, Portuguese, with translation available in 130 languages. The Governors commitment to address sexual assault and domestic violence continues by providing annualizing the FY21 funding of $96 million towards this important work.

Supporting Young Parents

The Massachusetts Pregnant and Parenting Teen Initiative (MPPTI) is a unique program at the Department with the goal of increasing life opportunities and enhancing family stability for expectant and parenting adolescents ages 14 through 24. The focus of this program is on youth in priority communities who may not be eligible for other young parent programs. The initiative uses a positive youth development approach that builds on participants' strengths to increase life opportunities and enhance family stability among young families. This past year, the program was able to support 267 young parents and 287 children. On average, of adolescents who participated in this program, 98% were enrolled in insurance, contraceptive use increased from 37% to 50%, 58% made progress toward individualized academic and/or career goals and employment increased from 26% to 37%. I am happy that an additional $2.5 million has been provided to the Department to continue this important program. We will be able to provide a great service for many young parents.

Environmental Funding

The Department was able to use the Bureau of Environmental Health's $1.2 million investment to help ensure the safety of our food and water. Polyfluoroalkyl substances, otherwise known as PFAS, is a contaminant, dangerous at high levels, that has been found in bottled water and other sources. This funding was used to complement the Department of Environmental Protection's strategy of testing public and private wells to strengthen DPH's regulatory oversight of food and bottled water by automating the inspecting and testing of laboratory results.

H1 Investments and Proposals

Let's now turn to several priorities included in the Governor's H1 budget. These are critical investments and key initiatives for the Department in FY22.

Nuclear Power Plant Assessment

With current statutory language, the Department is unable to assess all costs associated with environmental monitoring and emergency planning throughout the decommissioning of the Pilgrim Nuclear Powerplant. Beginning in 2022 and through at least 2026, the Bureau of Environmental Health Radiation Control Program (RCP) will need an additional $150,000 each year. This increase is needed due to the Attorney General's Office settlement agreement with Holtec, the owner of the powerplant, decreases from approximately $522,000 currently to $386,000 by 2022, leaving an annual shortfall of $150,000. The powerplant which is anticipated to be fully decommissioned in eight years, still requires the RCP staff to conduct environmental monitoring and operation of the state Environmental Radiation Laboratory (MERL).

Holtec has said in their documents that they expect they can fully decommission the plant in 8 years. If Holtec meets its decommissioning schedule, and DEP and DPH approve its release plan, then Pilgrim could be fully decommissioned in 2027.

The Governor's proposal, consistent with last year's H2, allows the Department to assess the operators of nuclear reactors that are in the process of being decommissioned for associated radiation monitoring and emergency planning costs.

Changes to clinical lab

The clinical lab authorizing statute is not consistent with federal requirements and interpretation between federal law and state law is creating confusion in the application of the statute. This has become more evident throughout the COVID-19 pandemic due to increased demands for clinical laboratory waivers.

Governor Baker's proposal aligns the statute with federal requirements and allows the Department more flexibility for lab director qualifications and increase the number of CLIA-waived labs a lab director can oversee. These changes will not only decrease wait times for CLIA-waivers but will also eliminate confusion between the state and federal process.

Public Health Council

The Department seeks to modernize the regularity of Public Health Council (PHC) meetings. Due to changes in the frequency of required PHC votes, such as through updates to the Department's determination of need process, the regulatory structure, and the delegation of council responsibilities to the Department, there are some months when no votes are required by the Council. We feel that mandatory monthly meetings can be burdensome and unnecessary for council members if no votes are required.

The Governor's proposal is consistent with H2 from last session and proposes changes to the PHC statute that will modify the required meeting frequency from monthly to at least quarterly, while maintaining language in the current law that authorizes the DPH Commissioner or four members to call additional meetings on a more frequent basis if necessary.

Academic Partnership

It is essential to the Department to have a working relationship with the vast academic resources that Boston and Massachusetts colleges and universities provide. In H1. Governor Baker has proposed to create an Academic Health Department Partnerships Trust Fund to help with these relationships.

The goal of the Academic Health Department Partnerships Trust Fund is to promote the collaboration and partnership with the members of the DPH Academic Health Department Consortium (AHD). The AHD consists of eight local schools and programs of public health and the Academic Public Health Volunteer Corps. This partnership allows the Commonwealth to leverage public/private partnerships and build capacity for local health – even more critical during the COVID-19 pandemic.

The Partnership would support programs of the AHD such as the Academic Public Health Volunteer Corps, which was launched during COVID-19, to be able to respond to both the current and future emergencies. There is a continuous need to recruit and train students, collaborate with local public health and to track outcomes. Students can assist with activities such as contact tracing, data review, planning, community education, and inspections. This corps of students has proven to be extremely helpful during the pandemic. Establishing a pipeline of trained professionals who are prepared to become part of the local public health workforce is essential given the large numbers of local public health professionals expected to retire within in the next five years.

Establishing the Trust Fund would allow the Department to receive funding from colleges and universities that participate in the Academic Health Department Partnerships Trust Fund.

In Closing

In closing, I want to reiterate my thanks to you for your support and assistance during this most unusual, most challenging year for our state and our nation. An overwhelming amount of our attention, focus, resources, and staff have been dedicated to responding to the public health pandemic of our lifetime. The pandemic has placed a spotlight on public health and our public health system and infrastructure. The pandemic has shown that the public health system needs to

be fortified, strengthened, and prepared for any future pandemic or other significant public health challenge.

I hope that we will continue to work together to ensure that Massachusetts remains a public health leader and innovator and continues to strive towards excellence in public health and in all of our endeavors. Thank you.