Legislative Hearing of the Center of Rural Pennsylvania
October 16, 2024
Kutztown University

Written testimony:

Thank you for the opportunity to speak with you today about an issue that is close to my heart and affects millions of Americans—the opioid crisis. As an addiction medicine physician, I've seen firsthand the devastating toll this illness has taken on individuals, families, and communities. But I've also seen hope, and I believe that with your support, we can make significant strides in addressing this crisis.

One of the key areas we need to focus on is harm reduction. Harm reduction acknowledges that addiction is a complex, chronic condition and that people struggling with opioid use disorder (OUD) need options that meet them where they are. It means accepting that not everyone is ready or able to stop using substances immediately, and that's okay. Our goal should be to keep people alive long enough to engage them in treatment and, ultimately, recovery. We cannot engage with a person after that person dies from an overdose.

Naloxone, for example, is a life-saving medication that reverses opioid overdoses. Naloxone is not treatment, but when we make naloxone widely available, we reduce deaths. Safe consumption sites, needle exchanges, and fentanyl test strips all work in a similar way. They don't condone drug use; they keep people alive while offering them a bridge to treatment. I urge you to consider legislation that supports harm reduction programs, as they are one of the most effective tools we have to prevent deaths from opioid overdose.

I want to address a serious misunderstanding that medication for opioid use disorder (MOUD) is somehow not real recovery or that it is incompatible with the 12-step programs. There is this idea that someone who uses medication is not truly "sober" or "clean," but this is a false dichotomy. The 12-step philosophy and MOUD can, and should, coexist. When used together, they are even more powerful and successful. When the treatment philosophies fight each other, only the patient loses. We cannot afford to perpetuate division in how we approach recovery.

Medication is treatment. Just as we would treat diabetes with insulin or high blood pressure with antihypertensives, we must treat OUD with the tools we know work, and that includes medication like buprenorphine, methadone, and naltrexone. Just as a person on medication for diabetes will also utilize lifestyle changes, so too a person with opioid use disorder will utilize both medication and lifestyle changes. I spoke at a senate committee several years ago, where the final speaker highlighted the benefits of 12 step programs and then equated Buprenorphine to OxyContin, simply because both were made by pharmaceutical companies. This type of talk simply reinforces the stigma of the illness and misinformation.

Concerning treatment access, one of the biggest barriers to overcoming this crisis is that many people simply cannot access the treatment they need. We need to expand access by funding treatment facilities, mobile treatment units, and telemedicine services that can reach people where they live. We need to offer medication treatment to all persons needing it. This includes the incarcerated. Inmates are treated for every other disease identified while incarcerated. Opioid use disorder should not be the exception. We also need to address the workforce shortage in addiction medicine. We must invest in training healthcare providers, including doctors, nurse practitioners, and physician assistants, to diagnose and treat opioid use disorder. Without an adequate workforce, even the best policies fall short of meeting the needs of our communities.

Medication for opioid use disorder (MOUD) is an essential part of treatment, yet we still face barriers that prevent people from accessing it. There was a time when many believed that medications were simply replacing one addiction with another. But science has shown us that these medications stabilize brain chemistry, reduce cravings, and lower the risk of relapse and overdose. Patients who use MOUD are more likely to stay in treatment and achieve long-term recovery.

One medication that needs modernization in how it’s delivered is methadone. This is starting to be addressed with MOTA, the modernization of opioid treatment access. Methadone is a highly effective treatment for opioid use disorder, but its accessibility is outdated and heavily regulated. Currently, patients must go to specialized clinics, often daily, just to get their medication. This can be incredibly burdensome, especially for those who live in rural areas or lack transportation.

We need to update methadone maintenance treatment to reflect the realities of modern life. We can allow primary care physicians to prescribe methadone, just as they can with buprenorphine. This would bring treatment to the people, instead of forcing people to navigate a fragmented and often inaccessible system. By expanding methadone access to regular healthcare settings and utilizing telehealth for maintenance care, we can remove unnecessary barriers and help people stay in recovery. There is precedent for this—during the pandemic, regulations were relaxed to allow patients to take home larger quantities of methadone, and outcomes did not only not get worse, they improved. I will admit to you that I was not always a believer in telehealth. In fact, during the pandemic as telehealth was increasing, I got together with colleagues from multiple health systems. We decided to do a study on telehealth to prove that this form of treatment was not appropriate for patients with substance use disorder. We collected data from multiple health systems comparing the rates of continued engagement and the rates of positive urine drug screens from patients who were seen by telehealth to patients who were seen in person. We proved our concern was overstated. The rates were not statistically different. In the end we were published in a medical journal demonstrating that telehealth was just as good as in person treatment in patients with opioid use disorder. Let's not go backward, but of course, let’s not let the pendulum swing to far or too quickly. Appropriate guidelines need to be in place

along with appropriate oversight to ensure that we do not allow the equivalent of pill mills to run methadone delivery.

Buprenorphine originally was released as a sublingual medication that was taken every day. We now have once monthly injectable Buprenorphine. When taking medication sublingually a patient must decide 365 times a year whether or not they wanted to be in treatment. With an injectable, a patient only has to make that decision 12 times a year. Furthermore, there's no worry of diversion or inappropriate discontinuation of the medication. Buprenorphine should be easier to prescribe. We've made progress, but there are still too many barriers—like prior authorizations, training requirements, and stigma that deter healthcare providers from prescribing it. We need to streamline regulations so that all healthcare providers can treat patients with OUD using medications without excessive red tape. Historically, when buprenorphine first came to the United States, legislation was placed that limited the number of patients any doctor could treat to 30. At the time I sarcastically argued that this restriction would be appropriate if, and only if, we limited pain management physicians to only being allowed to treat 30 patients each year. I was immediately told that limiting the number of patients a Pain Management physician could treat to 30 would be unethical. I only made this point to stress how unethical it was to limit an Addictionist to treating only 30 patients. Today, thankfully, there is no limit to the number of patients an Addictionist or a pain management physician can treat.

However, we are still facing resistance. The 12-step philosophy and programs, which have helped millions, is often seen as incompatible with medication treatment. There is this idea that someone who uses medication is not truly "sober" or "clean," but this is a false dichotomy. The 12-step philosophy and MOUD can, and should, coexist. Both have a place in our treatment arsenal. When used together, they are even more powerful and successful. When the treatment philosophies fight each other, only the patient loses. We cannot afford to perpetuate division in how we approach recovery. Recovery is not one-size-fits-all, and we must give individuals the freedom to choose the path that works best for them.

To you, the legislators, I say this: support the integration of these two powerful treatment modalities. Help us move beyond outdated thinking and align public policy with what we know works. We need your support to:

- Fund harm reduction initiatives that keep people alive.
- Expand access to medication for opioid use disorder, including the support of long-acting injectable buprenorphine, through increased training for healthcare providers, and removal of unnecessary barriers like prior authorizations.
-Support the use of telehealth when appropriate.
- Modernize methadone access by allowing primary care providers to prescribe it and utilizing telehealth to make treatment more convenient and accessible.
-Support the use of fentanyl test strips (and other test strips as they become available)

- Promote education that dispels the myth that 12-step programs and medication treatment are at odds.
-Be open to discussions about needle exchange programs and safe consumption sites

Together, we can make a difference. The opioid crisis is not a moral failure; it's a public health crisis, and we need to treat it as such—with compassion, science, and evidence-based strategies. By embracing harm reduction, supporting medications for opioid use disorder, and promoting the integration of all effective treatment modalities, we can save lives and offer people a path to recovery.

Thank you

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