Hello. My name is Dr. Adam Brooks and I am a Senior Scientist and Director of Research at Public Health Management Corporation's Research & Evaluation Group. PHMC is a nonprofit public health institute with a mission to create and sustain healthier communities. Since 1972 we have worked in partnership with government, foundations, businesses and community-based organizations to serve public health needs throughout the Commonwealth of Pennsylvania and beyond. PHMC serves as both Pennsylvania's state-designated Public Health Institute as well as the state-affiliated Pennsylvania Public Health Association. Prior to joining PHMC, I was a Senior Scientist and Chief Executive Officer at the Treatment Research Institute in Philadelphia.

I have been conducting addiction treatment research for fifteen years, and my research focus has been on the development of tools to equip the addiction treatment field to provide meaningful assessment and monitoring of patient outcomes, and to deliver evidence-based interventions. Much of my recent work has focused on equipping counselors and patients with evidence-based content about medications and evaluating strategies to deliver those interventions more effectively.

I am very pleased to be able to offer some comments and testimony on the House Bill 596. I commend the legislature on this effort. As someone who investigates the use of basic and simple tools to make the jobs of treatment providers more streamlined and effective, I can assure you that this tool is direly needed. The Bed Registry will make it simpler for intake workers and evaluators at Crisis Response Centers, Intake Units, and in emergency settings to identify which detoxification program or residential facility a patient can be referred, and one that is ready to receive them at the moment when they are most ready for care. I have no doubt that the HB596 will streamline the placement and referral process.

I represent PHMC in making suggestions that have the opportunity improve the impact of the Bed Registry on patient care. I ask that you consider the three following recommendations for the Bill: 1). Widen its scope to include outpatient and methadone programs; 2) shift its focus to move away

from the concept of detoxification to withdrawal management; and 3). augment requirements with patient-centered information that will make it more useful to a patient participating in decisions on their own course of care.

1) Widen the Scope to Include Outpatient and Methadone Treatment: As it is currently configured, the Bed Registry is limited to tracking and informing intake workers about the availability of residential and detoxification placement availability. This is an important step forward. However, one byproduct is that the Bed Registry might reinforce the mindset amongst intake workers and patients that being admitted to an inpatient or residential facility is the preferred way to be treated for addiction. Meanwhile, methadone providers, intensive outpatient providers, and partial hospital programs have made great strides in formatting programs that meet the urgent needs of patients who do not need to be detoxified or required to be housed or in a controlled environment for their addiction care. Intake workers should have the full panoply of service levels available to them when researching a patient's treatment and referral options. The legislation should be expanded to include a listing of outpatient treatment service options, as well as current MAT slots available at that facility. This promotes more flexible thinking on the part of intake workers, evaluators, and patients in deciding on best referral options.

2) Shift the Focus from Detoxification to Withdrawal Management: My second suggestion on this legislation is to promote new terminology and a new mindset away from the mentality of "detoxifying" a patient towards managing the withdrawal symptoms they will experience. "Withdrawal management" is a more encompassing term that is descriptive of how addiction medicine is being practiced, particularly when addressing opioid use disorder. For example, patients may check into a residential program, and be placed on a maintenance dose of a legal FDA approved medication to manage their withdrawal, such as methadone or buprenorphine. One patient may be maintained on that dose throughout their entire residential experience and be discharged to an outpatient provider

who will maintain that dose at an outpatient facility. Other patients might be slowly tapered off that dose during their respective residential stays so that they can be discharged opioid-free, with decisions to taper or discontinue medication based on the patient's withdrawal symptoms. Furthermore, patients and providers may decide that patients might be discharged after being given a protective injection of slow-release naltrexone to protect against relapse immediately after discharge. As this illustrates, the course of care around medication differs based on patient needs and provider willingness and capacity to meet those needs. Importantly, withdrawal management can be accomplished in methadone maintenance and outpatient settings as well, and this shift in thinking widens the possibilities for patient care.

Therefore, each participating agency on the registry should also disclose what their withdrawal management capabilities and philosophy are, so that intake workers and patients can make informed decisions about course of care. Is the agency prepared to maintain a patient on agonist medication? Does the agency only perform short term detoxification? This is important descriptive information.

3) Augment the Registry with Patient-Centered Information to Inform Care Decisions: Because withdrawal management can take numerous paths for patients, it is important that mandated participants in the registry should also provide up-to-date statistics indicating typical course of care related to withdrawal management and patient outcomes. This information should be made available to a patient who is considering complying with a referral to the listed facility. This information should include completion rates, as well as retention rates at 30 and 90 day thresholds. In addition, the treatment participants should disclose what percentage of their patients who qualify for MAT are offered it and choose to receive it, and this should be broken down by what percentage of patients are offered medication to taper off of addictive substances, and what percentage are offered maintenance doses of FDA approved medications to manage withdrawal. Percentages of patients who are discharged

on maintenance doses versus those who have been tapered off of addictive substances should be disclosed. Finally, providers should disclose what percentage of patients who qualify for a relapse prevention agent like naltrexone are offered the medication, and what percentage accepts the injection.

This information represents important quality indicators that should impact a patient's willingness to receive a referral and paint a clearer picture of what a patient can expect when they are referred to a treatment facility. While this information is somewhat more difficult to compile, it represents important outcome information to which the public should have access; it should be updated every six months at minimum to be kept up to date.

Thank you for the opportunity to provide testimony and perspective on the Bed Registry legislation. PHMC is pleased to be part of the conversation and I am happy to answer any questions you might have.