HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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Senate Bill 675

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House Human Services Committee

Main Capitol Building
Room 60, East Wing
Harrisburg, Pennsylvania

Tuesday, November 19, 2019 - 9:00 a.m.

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COMMITTEE MEMBERS PRESENT:

Honorable Gene DiGirolamo, Majority Chairman
Honorable Barbara Gleim
Honorable James Gregory
Honorable Natalie Mihalek
Honorable Lori Mizgorski
Honorable Marci Mustello
Honorable Eric Nelson
Honorable Todd Polinchock
Honorable James Struzzi
Honorable Angel Cruz, Minority Chairman
Honorable Joe Hohenstein
Honorable Kristine Howard
Honorable Steve Kinsey
Honorable Maureen Madden
Honorable Mike Schlossberg

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SUBMITTED WRITTEN TESTIMONY

(See other submitted testimony and handouts online.)

MAJORITY CHAIRMAN DiGIROLAMO: Good morning. Welcome. I'd like to call this hearing of the Human Services Committee to order.

I'd like to ask if everyone would stand for Pledge of Allegiance to the flag.

(Pledge of allegiance held off the record).

MAJORITY CHAIRMAN DiGIROLAMO: Thank you. A few housekeeping notes. The cameras are on and we're being recorded, so I just want to let everyone know.

Second, we have a very, very ambitious schedule today. I don't think in all of my years here in Harrisburg that I've got anywhere near as many requests of people to testify from around the state, not only on this bill, but on the issue of Suboxone.

So, we have a very ambitious agenda today. We have a lot of testifiers. I am going to ask all of the testifiers to try to keep your testimony between 5 and 7 minutes. We have to be done with this hearing at 11 o'clock, no later. That's our House rules. We go into voting session at 11, so we have to be finished by 11 o'clock.

What I would like to do to make sure we

get all the testimony in first is to have everybody testify. Then at the end, we'll open it up for questions and answers from the members that are here. I will make an exception for Doctor Levine, who is our first testifier, because she needs to be in State College at a certain time and must leave after she testifies. So, we might open it up for a few questions for Doctor Levine as soon as she gets started testifying.

I would just like to open it up and ask first, Chairman Cruz, if he has any opening comments before we get started.

MINORITY CHAIRMAN CRUZ: No.

MAJORITY CHAIRMAN DiGIROLAMO: I am going to -- I don't have any opening comments. I do have a lot of questions, but I hope to get to ask them. I do have comments from Senator Michelle Brooks, who is the prime sponsor of Senate Bill 675. She has some comments. I'm going to read them here at the beginning. She was not able to attend.

Good morning, Chairman DiGiolamo and Chairman Cruz and members of the committee: I regret that I am unable to attend this important hearing, but greatly appreciate the opportunity to

provide comments on my legislation.

Senate Bill 675 is intended to provide much needed oversight to try to prevent the misuse of medication, assisted treatment, such Suboxone, that were designed to treat individuals with opiate addiction, but have now become part of the crisis for some.

We have heard about incidents involving buprenorphine from around the state. From western Pennsylvania where a group of individuals, including physicians and a clinic operations manager, conspired to create and submit unlawful prescription for buprenorphine, and then unlawfully dispense over 18,000 doses of buprenorphine to other persons.

To Huntingdon, where a state trooper lost his life because Suboxone pills were traded for a gun, and to Philadelphia again for health care fraud where a physician admitted to earning $5 million through the illegal sale of Suboxone and Klonopin. These are just a few examples. But, do we really need to risk the likelihood of more.

I believe the use of medicated assisted treatment is a valuable tool in the fight against opiate use disorder. However, we also have a

responsibility to provide whatever additional state oversight is necessary to prevent the types of events that were mentioned previously.

I have been working and will continue to work with stakeholders to create a policy that will provide accountability and oversight while ensuring that individuals battling substance disorder have access to the treatment that they need.

Again, thank you, and I look forward to working with each of you. That's from Senator Michelle Brooks.

Before we get started, I'd like to give the members an opportunity to say hello and let you know who they are. We'll start with Barbara.

REPRESENTATIVE GLEIM: Hello. I'm Barb Gleim. I'm from the 199th District, Cumberland County.

REPRESENTATIVE STRUZZI: Good morning, Jim Struzzi, 62nd District, Indiana County.

REPRESENTATIVE NELSON: Good morning. Eric Nelson, Westmoreland County.

MAJORITY CHAIRMAN DiGIROLAMO: I'm Gene DiGirolamo from Bucks County and Republican Chairman of the committee.

MINORITY CHAIRMAN CRUZ: I'm the

Democratic Chairman Angel Cruz from Philadelphia, 180 Legislative District.

REPRESENTATIVE KINSEY: Good morning. Stephen Kinsey, Philadelphia County.

REPRESENTATIVE MADDEN: Good morning. Maureen Madden, 115th District, Monroe County.

REPRESENTATIVE HOHENSTEIN: Good morning. Joe Hohenstein, 177th District in Philadelphia.

REPRESENTATIVE HOWARD: Hi. I'm Kristine Howard from the 167th in Chester County.

MAJORITY CHAIRMAN DiGIROLAMO: And throughout the county, it's a very busy morning at the Capitol. There will be members that will be coming and going as the meeting progresses.

With that, I'd like to call up Doctor Rachel Levine, who is Secretary for the Department of Health. I know she has written testimony, but if you'd like to condense that, Doctor, and maybe we can get a few questions and answers before you have to leave.

SECRETARY LEVINE: Good morning. Thank you very much, Chairman DiGirolamo, Chairman Cruz, and members of the House Human Services Committee. I'm Doctor Rachel Levine, Secretary of Health and

Professor of Pediatrics and Psychiatry at the Penn State College of Medicine.

I'm grateful for the opportunity to join you today on behalf of the Department of Health and the Department of Human Services to discuss Senate Bill 675. Unfortunately, Secretary Smith is unable to be in attendance today, Secretary of DDAP, because she is hosting a conference, actually, on psychostimulants and potential drug abuse with methamphetamine, cocaine, and other risks that we have in the Commonwealth.

As you know, the opioid crisis remains the biggest public health crisis that we face in Pennsylvania and in possibly the nation. It is one of Governor Wolf's priorities to address this crisis, and that's why he has issued a diaster declaration starting in January 2018, and those are 90-day disaster declarations that continue and are continuing to be renewed.

That has allowed us to form the Opioid Command Center where we have 16 different agencies and the Attorney General's Office all working together to coordinate our response. That includes, of course, Health, Human Services, DDAP and Aging. But we have PEMA there. We have the

Pennsylvania State Police there. Again, the Attorney General's Office participates, PCCD, Department of Corrections; HIDTA, the High Intensity and Drug Trafficking Agency for the federal government, all working together to coordinate our response.

We are making progress. We have much more work to do. But we have just started to bend the curve through all of these different efforts in terms of overdose deaths. In 2017, there were approximately 5,400 overdose deaths in Pennsylvania. In 2018, there were approximately 4,400 overdose deaths, a decrease in 18 percent, but far too many. Still well over 10 people dying, almost 12 people dying each day of overdoses, so we have to keep up our pressure and remain fixed on our goals.

Unfortunately, Senate Bill 675 would take us backwards from those goals. We have three pillars to our response. We have robust prevention efforts, and I would highlight to that our prescription drug-monitoring program authorized by the legislature, actually, in 2014, which I'll get back to in a minute.

We have rescue efforts. We have the

medication, naloxone, from Act 139, also in 2014, and we have worked with the legislature and many stakeholders in terms of distribution of naloxone saving tens of thousands of lives.

And the third pillar to our response is treatment. So, we have to get people into treatment. That is called a warm handoff, and we have warm handoff clinical pathway and warm handoff summits throughout the state. Then we have expanded evidence-based quality, medication-assisted treatment for patients suffering from opioid use disorder. And from all federal agencies and medical professionals, medication-assisted treatment is a standard of care in treating opioid use disorder.

We have been able to expand access to medication-assisted treatment to 45 Centers of Excellence through the Department of Human Services for patients predominately with Medicaid. Some have satellites so there are approximately 70 offices now, and through a program called PacMAT, P-A-C-M-A-T, or Pennsylvania Coordinated Medication-Assisted Treatment.

This has been start-up money through our SAMHSA grants, through the Department of Drug and

Alcohol programs. For eight PacMAT programs, some of them are here today. They include Temple. They include The Wright Center, Geisinger, UPMC Pinnacle, Penn State Health, Wellspan Health, Allegheny and UPMC, which is a hub and spokes model for quality evidence-based medication-assisted treatment. All of these efforts would be hindered by barriers created in Senate Bill 675.

The Senate Bill 675 sets forth unnecessary administrative barriers for clinicians requiring state certification and annual licensing fee and would limit what we are actively trying to do, which is expand physician getting their waiver, their federal waiver for buprenorphine and expanding access to that drug as -- medication as well as other medication-assisted treatments. The three MATs include methadone, through methadone clinics licensed by DDAP, to buprenorphine medications, one brand which is called Suboxone, and then through Vivitrol which works in a different way.

The policies set forth in Senate Bill 675 are redundant and potentially detrimental to public health. It creates policies that get between the doctor and the patient and would --

could result in disciplinary action and unnecessarily hinder physician's clinical judgment and result in less physicians getting their buprenorphine waiver and less expansion of life-saving medication-assisted treatment.

The purpose of Senate Bill 675 is to decrease the potential for the misuse of buprenorphine medications. But, actually, buprenorphine is rarely seen in opioid overdoses and opioid overdose deaths. Only zero point one percent of overdose in Pennsylvania in 2018 were caused by buprenorphine.

Over two-thirds of the overdose deaths that are seen in Pennsylvania are because of synthetic fentanyl analogs sent into United States and into Pennsylvania. Another significant contributor, of course, is heroin. But, virtually none of the overdose deaths in Pennsylvania are due to buprenorphine.

In the same year buprenorphine was detected in combination with other drugs in less than one percent of overdose deaths, as opposed to well over two-thirds due to fentanyl.

675 adds barriers to patients, and its requirements would lead to fewer and fewer doctors

able to prescribe this medication. So, one of the concerns I know is about physicians or other medical providers that might run pill mills. The bad apples in the medical community that write -- might run pill mills.

What I want to put out is that, through the prescription drug monitoring program authorized by the legislature in 2014, our program is able to track buprenorphine prescriptions, so we know who the over-prescribers are.

As you know, the Department of State and the Board of Medicine have access to the prescription drug monitoring program, and the Attorney General's Office has access to the prescription drug monitoring program. And so, there are algorithms that have been developed with the Attorney General's Office and the Board of Medicine so that they can track whether there's a pill mill. They can use that as evidence and then obtain other evidence, and then make the appropriate arrests of those bad apples in the profession that are prescribing this.

This is not -- The requirements in 675 are not necessary. If you ask the Attorney General's Office, we are doing very well in terms

of -- and they are doing very well in terms of tracking bad apples and pill mills and making the necessary arrests.

We actually need more MAT providers in Pennsylvania; not less. We have a number of different programs to expand access. We just finished a whole series of MAT summits so that we can expand that.

We also are very -- realize, however, that in many cases patients need counseling and therapy, so that's -- and counter case management. That's exactly what the Centers of Excellence and the PacMAT programs are intended to do.

One report that I would like to highlight for you, and we can send this electronically--It's actually rather big to print it out, so we didn't want to do that--is a report called Medications for Opioid Use Disorder Saves Lives. This has been -- was published in March 2019 with support from the National Institute of Drug Abuse, the Substance Abuse and Mental Health Services Administration, or SAMHSA, and published by the National Academies of Science, Engineering and Medicine. Let me just read in conclusion what some of their conclusions were.

Opioid use disorder is a treatable chronic brain disorder. It is a medical condition, a disease that requires medical treatment. FDA approved medications to treat opioid disorder are effective and save lives. Long-term retention on medication for opioid use disorder is associated with improved outcomes. A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medicine to treat opioid use disorder.

Most people who can benefit from MAT for opioid use disorder unfortunately don't receive it and access is inequitable. MAT is effective across all treatment settings, and we have to confront the barriers to the use of medications to treat opioid use disorder.

And so, that is why we feel -- the Administration feels, the Department of Health, Department of Human Services, as well as the medical colleagues that have joined me today is that, Senate Bill 675 would be counterproductive to the efforts which are finally now baring fruit in terms of bending the curve from deaths from overdoses in Pennsylvania.

Thank you very much for your attention.

Thank you very much for the opportunity to answer some questions before I run to State College to address a rural health meeting.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you, Doctor.

A few other members have come in. I'd like them to just say hello. Mike, you wanna just --

REPRESENTATIVE SCHLOSSBERG: Good morning. Mike Schlossberg from (inaudible; no microphone).

REPRESENTATIVE MILGORSKI: Lori Milgorski from 30th District in Allegheny County.

REPRESENTATIVE MIHALEK: Natalie Mihalek from 40 District, Allegheny County.

REPRESENTATIVE POLINCHOCK: Representative Todd Polinchock from 144th District.

SECRETARY LEVINE: Thank you.

MAJORITY CHAIRMAN DiGIROLAMO: We're gonna open it up for questions and answers. I'm gonna have to ask the members to keep it short because I want to finish with Doctor Levine by 9:30 because she has to leave. I want to make sure we get the testimony in. I've got a lot of questions, but one quick question.

Senate Bill 675 passed out of the Senate, I don't know, by a vote of 44 to 6, was a pretty overwhelming vote. The bill came over here in the House, and it was like a 10-alarm fire went off. The number of people that came in and criticized the contents of the bill. I heard the word that you used was things in this bill are detrimental to addiction.

The two things in the bill that were criticized were the -- the counseling was the biggest issue that people did not want to see, and also the certification part for doctors who were prescribing buprenorphine. Let's put the certification off to the side and go to the counseling part.

I'm having a hard time understanding why that -- There's so much criticism on trying to get some type of counseling. We have two MATs that are opiates that are in use right now to fight opioid addiction. The one is methadone and the second is Suboxone.

I've been at many methadone clinics. A methadone clinic, the person goes to the clinic every day, gets their dose of methadone. I've been there, I've watched them. They go in a little

room. There's a nurse there, watch them take the dose. After they take the dose in liquid, they drink a glass of water to make sure that there's no diversion because they're walking out.

There's counseling involved; also drug testing involved. After a while people can be trusted, they get a take-home dose over the weekend which is usually three.

With the Suboxone, which is an opiate, they're going to a doctor's office, getting a prescription, and walking out with a 30-day supply of Suboxone.

Now, I've talked to a lot of doctors. Some of the docs are doing counseling along with it, but there's an awful lot that are not doing counseling because they called in and criticized the counseling part of this bill.

Why is there such an outcry about doing counseling with this opiate and Suboxone?

SECRETARY LEVINE: So, thank you for that question.

I think that we all feel that medication-assisted treatment means the medicine-assisted treatment, and that, especially for patients at the beginning it would be much better

for them to have counseling in case management. That is the standard for which the Centers of Excellence are participating; that the PacMAT programs are participating, et cetera.

I think the concern about the bill is the mandated counseling, is that, there are other patients where counseling might not be available; where the patient will take the medicine but refuse counseling. The evidence is very clear, and I refer back to this document, that the lack of availability or utilization of behavioral interventions is not a reason to withhold medicine, is that, some patients will do well with medication alone. I think that if we can get the patients into counseling and the counseling available, especially at the beginning, that would be better. But the question is, requiring the counseling, withholding medication if the counseling is either refused or not available.

The other issue is in terms of -- I mean, it would be wonderful if patients can use this medicine for a certain period of time and come off it. It is true that some patients can then be weaned off them, but some patients cannot. They will need medication for a long period of time. As

time goes by, they might not need intensive counseling after several years of buprenorphine.

So I think what you'll find from the medical -- medical professionals is that the mandated part of the counseling is what they object to it. I don't think anyone objects to --

MAJORITY CHAIRMAN DiGIROLAMO: Isn't it mandated with the methadone as well?

SECRETARY LEVINE: I think that you'll find that in methadone programs that it is especially used at the beginning and used a lot less as time goes by, but I don't license the methadone programs.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you, Doctor. Diversion, doesn't seem to be anybody concerned about diversion? I mean, I've actually talked to a number of doctors prescribing this who seemed to think that having diverted Suboxone is a good thing because then it will help the addicts on the street maybe when they can't find their heroin they'll be able to buy Suboxone.

I just can't get my hands around having diverted opiates illegally for sale on the street is a good thing, and it doesn't seem to be anybody concerned about the diversion at all.

SECRETARY LEVINE: It isn't that we're not concerned about diversion. We want the patients to take their medicine as prescribed. I think that you'll find, as I quoted the statistics in terms of the toxicology results in the coroner's reports, is that buprenorphine is almost never found with overdose deaths. And that, if you're looking at a population that is very hard to engage --

MAJORITY CHAIRMAN DiGIROLAMO: I would strongly disagree with that. And I think if you'd talk to the Coroners Association, I mean, we just passed -- we just passed a Suboxone Death Review bill, and we're doing that because we're really worried about Suboxone showing up in these deaths, whether it's a primary or a secondary cause.

SECRETARY LEVINE: Compared to fentanyl, it's very, very few. The biggest risk factor for overdose deaths in Pennsylvania, and by far two-thirds is fentanyl.

I think that the reason why certain medical professionals will say that they're less concerned about Suboxone diversion is from a concept of harm reduction; meaning that, if people, if they're using Suboxone, even if they didn't get

it the correct way but they're not using heroin, that Suboxone is preventing them from going into withdraw and keeping them alive.

But it isn't what we are trying to do. We don't want Suboxone diversion. But, it is less harmful than, for instance, getting little blue pills with fentanyl that look like OxyContin, which is one of the -- a big risk factor for overdose death.

MAJORITY CHAIRMAN DiGIROLAMO: One final question.

SECRETARY LEVINE: Sure.

MAJORITY CHAIRMAN DiGIROLAMO: Everybody has got to be concerned about people who are getting prescription of Suboxone and also using other drugs, whether it's benzodiazepines or maybe opiates.

Would you be in favor, which I think is a good idea and you mentioned the database, that when a doctor writes a prescription every time for Suboxone that they be required to check into the database to make sure that patient isn't on some other drugs?

SECRETARY LEVINE: They are required.

MAJORITY CHAIRMAN DiGIROLAMO: They are

required right now?

SECRETARY LEVINE: Suboxone is an opioid, and the legislation passed in 2015, states that whenever an opioid is prescribed, including Suboxone, the physician or the physician's office has to check the PDMP to see if other opioids or benzodiazepines are prescribed.

Through the PDMP, which was a fantastic legislation, which I know you all supported, we have decreased opioid prescriptions over 30 percent in three years. We have decreased the rate of prescriptions--Let me just finish this point--of benzodiazepines 25 percent in three years. We have decreased the co-prescription of opioids and benzodiazepines almost 45 percent in three years.

MAJORITY CHAIRMAN DiGIROLAMO: If that is the case that they check every time, what does a doctor do if when they check the database, they find out that the patient is -- got a prescription for a benzo or for another opiate? What does --

SECRETARY LEVINE: Well, they'll --

MAJORITY CHAIRMAN DiGIROLAMO: -- the doctor do then?

SECRETARY LEVINE: -- have to address that. If they had to be -- It wouldn't make sense

if they would have a prescription for another opiate, then the patient is -- then the other doctor didn't check the PDMP, right, because the doctor writing the prescription for the opioid had to check the PDMP. And so, the doctors needs to do an intervention. That person needs to get more intensive treatment.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. I'm taking up too much time. I'm gonna ask -- A few other members have questions.

Representative Nelson.

MR. NEALON: Thank you, Mr. Chairman.

Thank you for your testimony. This is a very confusing subject because we have worked so well together over the last several years to see the recovery and prevention community at such odds.

I tried -- We are very active in this space, and I try to listen to the people in the community that are working in there. There seems to be a lot of concern with this bill preventing access for people. But there also seemed to be -- I agree with the mandated portion of it; that there are a lot of concerns about the mandated treatment element.

But the issue of cash and cash

purchasing, can you touch on that because it does seem to be -- Like, there seems to be maybe an opportunity for a landing place. We don't want to limit, but we also are trying to --

And if you could also touch on, my understanding is that, addicts are using Suboxone to keep themselves from having to use heroin or other opiates. And so, it's actually, like, it's a lesser of two evils.

SECRETARY LEVINE: That's correct.

REPRESENTATIVE NELSON: It does float under the table, but it's to prevent the use of worse items.

SECRETARY LEVINE: That's correct.

So we're absolutely not in favor of cash clinics, right. One of the biggest things that the Governor did to expand access to -- for substance use disorder treatment is expand Medicaid when he started the Administration. So that means 720,000 people have access to health insurance, and approximately 120,000 people are using that access to get substance use disorder treatment.

And so, that's why the Department of Human Services started the Centers of Excellence so that patients could get counseling, could get case

management and get MAT and why we started the PacMAT programs.

One of things we wanted to do is to expand these types of evidence-based programs to get rid of the cash clinics. So we agree with you. We're trying to crowd them out of the market; that if people can get with Medicaid or with their insurance can get access -- or through the SCAs which will cover treatment, can get access to the standard of care treatment, then they don't have to go to these cash clinics. So we're trying to literally crowd them out of the market.

Then, again, the Attorney General's Office and the Board of Medicine are closely interacting with the PDMP to arrest the pill mills. So in the cases that you talked about, I mean, they're cases because they were arrested by the Attorney General. So, you can ask the Attorney General's Office to come, but they are very invested in terms of doing this.

And I would agree, the idea is harm reduction. There's a lot of harm reduction measures to do, including springe service programs. Now, we're not talking about safe and injection sites. We're gonna put that over there.

But, syringe service programs, in terms of interacting with people to get them -- until they are ready to get them into treatment. It isn't great that there's diversion of Suboxone, but it's better to be using diverted Sub -- Suboxone than to be getting heroin or fentanyl, which will lead them to death.

MAJORITY CHAIRMAN DiGIROLAMO: Representative Hohenstein.

REPRESENTATIVE HOHENSTEIN: Thank you, Mr. Chairman.

Thank you, Secretary --

SECRETARY LEVINE: Thank you.

REPRESENTATIVE HOHENSTEIN: -- for coming. I'll be honest with you. A lot of what I see espoused is MAT, it's just medication. What I see on the streets in Philadelphia is a prescription and a waive, and that's wrong. MAT is suppose to involve the treatment that comes after.

Here's why this concerns me; twofold. One is, people are making money off of the medication and the prescriptions. There's an incentive in the industry to have that be as long term as possible. I'll give you an example.

I had a constituent of mine successfully

on, I think methadone, for 14 years. She's been maintaining. She's been going and doing well. She had a glitch in her Medicaid because she received a particular type of insurance payment, and all of a sudden Medicaid said, wait a minute. You might not be eligible. Guess what happened? She was told, okay, it's ready to wean you -- we're ready to wean you off of your methadone.

That's not a decision made in the patient's best interest. That's a decision made based on economics. I see too much of that, and I worry that some of that is even at the higher levels.

And then the second piece of this, which is -- which is that, when we talk about addiction, opioid addiction is unique in the sense that it can be treated with medication. You just said Secretary Smith can't be here. She's at a different conference talking about all the other types of addictions that are hitting the state, methamphetamines, cocaine, everything else that doesn't have MAT as a standard.

And I thank you for not using the word gold standard, because that's a little bit of a trigger for us in Philadelphia. We had a football

owner use the word gold standard back in the early 2000s, and it scarred us for life.

But, no, I think MAT is an appropriate and effective treatment, and I recognize that for opioids.

But, for all of the other forms of addiction that remain out there, including opioids at certain levels, there are treatment programs that have to be and are required to be because we don't have the magic bullet of a pill much more behavioral based, patient centered, and, frankly, intensive and to my way of thinking that indicates we need to be emphasizing inpatient care over community care because the risk of sending people back into communities that trigger addiction.

So, with all that said, I think my big question to you is, how are we going to be effective regardless of the access we continue to provide to Suboxone? And I think we need to provide it. How are we going to make sure we continue the effective models for treatment that are effective in opioid treatment and cocaine treatment and methamphetamine treatment, marijuana, alcohol?

All of those types of programs need to

be remain strong because, frankly, I worry about them being weakened and then we're going to be in a position when the next waive hits that, not impacted by MAT, that we're going to be in a really bad position.

SECRETARY LEVINE: Thank you. There's several points to your question.

I would agree with you that someone being weaned off methadone because of financial considerations is wrong. So, I would please contact the Department of Drug and Alcohol programs about that methadone clinic because they regulate DDAP.

HONORABLE HOHENSTEIN: If I may, she was given a letter that specifically said, you should go camp out in your state legislator's office until they call DDAP or Medicaid or the welfare office. It was a crazy letter to read.

SECRETARY LEVINE: So, DDAP regulates the methadone clinics, and they shouldn't do that. Please, please -- I mean, if you let DDAP know, I'm sure Secretary Smith and her staff will address that robustly with that methadone clinic.

I agree with you a hundred percent about other drugs, such as stimulants, methamphetamine

and cocaine. Opioid use disorder is -- well, alcohol use disorder as well has medication. But in this context, we're talking about methadone, Suboxone and Vivitrol. It's for opioid use disorder.

There is no standard of care for medication-assisted treatment for stimulant use disorder. So we are not against counseling. We are not against case management. We are in favor -- I know DDAP regulates the rehab centers, are in favor of all forms of treatment. You need a continuum of care of treatment, which includes inpatient care, it includes partial hospitalization care, intensive outpatient care. It include outpatient care.

All that is absolutely necessary, because you're entirely correct. Other drugs we do not have these medications. But for opioid use disorder, which is still causing most of the overdose deaths in Pennsylvania, we do.

I would like to point out is that, the policies that I am expounding are strongly supported by SAMHSA and Health and Human Services and Secretary Azar and the Assistant Secretary of Health and the Assistant Secretary of SAMHSA, so

this is the standard of care throughout the country. This is not just Pennsylvania. This is the standard of care as proposed by the federal government in terms of treatment of opioid use disorder.

HONORABLE HOHENSTEIN: Thank you.

MAJORITY CHAIRMAN DiGIROLAMO: I've got to be respectful --

SECRETARY LEVINE: I understand.

MAJORITY CHAIRMAN DiGIROLAMO: -- of the Secretary's time. I have two more people who want questions. I ask both of them to please try to keep them brief.

SECRETARY LEVINE: And I'll keep my answers brief.

MAJORITY CHAIRMAN DiGIROLAMO: Also, there are chairs here in the corner right there. If some people want to get some chairs and sit down, please go ahead and do that.

Next, Representative Struzzi.

REPRESENTATIVE STRUZZI: Good morning.

SECRETARY LEVINE: Hi.

REPRESENTATIVE STRUZZI: Thank you for your very frank and poignant testimony. This bill, every time it comes up I sort of cringe. I have

not heard from one person in the treatment recovery in Indiana County that supports this bill. I appreciate -- there's --

As Representative Hohenstein said, there's not a pill to treat everything. I think if there's ever a case where you need to treat the entire person physically and spiritually, it's in this whole addiction crisis that we face, and there's definitely not a one size fits all.

I do think that when the general public hears about addiction and they hear about going out and treating with Narcan--and we've had this discussion--and everything else that the taxpayers are paying for, there needs to be some sort of trigger that says, okay, you're on this. You need to have this. Again, one size doesn't fit all, but I think there's needs to be some sort of steps to lead someone to recovery.

So, this bill, I'm not going to support it, as no one in my district has come to me and said, this is a good thing for our treatment opportunities. But I do think, and maybe your comments -- I'll keep this very brief. Maybe your comments on, not a mandate but a process.

SECRETARY LEVINE: Sure. So, in terms

of naloxone, thank you for Act 139. In that legislation, and then the ability for me to do the standing order prescriptions for first responders and for the public have saved tens of thousands of lives.

As you know, we just had three naloxone days where we handed out 14,000 kits of naloxone. In all of that, and our brave and courageous first responders are saving tens of thousands of lives, Naloxone is absolutely necessary, but it's not sufficient, and we have to get people into treatment.

EMS now is successfully across the state getting approximately 85 to 90 percent of people the EMSCs after an overdose to the emergency department. So we're doing much better getting people to the emergency department. Where people aren't going to the emergency department, we have a leave-behind program where they can leave behind the naloxone, and then maybe Doctor Lynch can talk about it. But, in many areas they're actually sending out paramedics the next day to check on that patient if they wouldn't go to the emergency department.

The next, though, is, we have a warm

handoff clinical pathway, and we had 14 warm handoff summits throughout the state, where the emergency departments are working with the FCAs to send a peer recovery specialist or other type of professional to get people into treatment.

I was just at Tower Health in Reading Hospital. Doctor Santoro was here from there. They were getting--Maybe he can quote the exact statistic--66 percent of people from the emergency department into treatment. We need to continue to push that and then not give up on people. Every time they are alive, there's a chance for life and a chance for recovery, and we have to continue to push that.

REPRESENTATIVE STRUZZI: I would agree.

MAJORITY CHAIRMAN DiGIROLAMO: Representative Schlossberg.

HONORABLE SCHLOSSBERG: Thank you, Chairman.

Thank you, Doctor Levine, for your testimony. A very quick statement and then a question.

I have found this entire conversation about Senate Bill 675, at least the current direction of it, more than a little disheartening

at moments. My emotions about this bill are geared largely around my own experience.

As many of you know, and I've spoken about very openly, my claim to fame is, if you will, that I've been very upfront with my own challenges with depression, with anxiety. I take medication on a daily basis, and I see a psychologist as needed. And no one has ever said to me, we're going to make sure that you can only take your pills if you're seeing your counselor. The reason for that is because the science supports the way in which I choose to take my medication and take care of myself.

Now, here we are in a different arena where Senate Bill 675 would put some pretty strict mandates on people despite the fact they may not have counseling available. They may not have the resources or the transportation opportunities to see counselor or that the transportation may exist.

And the reason I'm so fired up about this one is because it flies directly in the face of science. Medicated-assisted treatment, in conjunction with counseling when available and when prescribed by a doctor, is a good form and probably the best form according to the evidence of treating

people with opioid use disorder.

However, we also know that medicated-assisted treatment by itself can work. And I cannot fathom why we are considering putting a barrier in place of a treatment form that is accepted by science.

All of that being said, it's clear that the intent behind 675 and the intent behind everybody sitting here is good.

So, Doctor Levine, my question for you: How can we improve Senate Bill 675 in order to make it better and protect people from the genuine problems that redirection imposes?

SECRETARY LEVINE: How could you improve it? I'll defer to maybe some of my legislative colleagues at DDAP, et cetera, in terms of specific issues.

I mean, I think it's fine to encourage counseling and therapy when it's -- when it's available and when it's needed. I think the mandate is a real problem.

We do not need a registry of Suboxone providers. Anybody who prescribes Suboxone or other people in orphine compounds already are registered with the DEA. You have a specific --

Not only do you have to have your regular DEA license, you have to have a specific X waiver. You have to take extra training, and the DEA can tell you exactly who the Suboxone providers are in Pennsylvania. There is a list available, because you have to have a specific, extra, again, waiver on your DEA.

Anybody who prescribes Suboxone has to, when it's dispensed by the pharmacy, that is all in the prescription drug monitoring program which you all authorized. My staff here, my Deputy Secretary Meghna Patel, we can tell -- we can tell law enforcement or the Board of Medicine, they know precisely who the Suboxone providers are. We don't need another registry. We don't need to pay a fee to have another database. It's duplicative. And we want more people to be able to get their X waiver and to be able to prescribe Suboxone.

For instance, emergency department physicians and others, as well as physicians in FQHCs, et cetera. We want patients to be in therapy when it's necessary and available, and we want to be able to continue to expand access to this life-saving evidence-based treatment as recommended by SAMHSA and by science.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. Mike.

SECRETARY LEVINE: Thank you so much.

MAJORITY CHAIRMAN DiGIROLAMO: Doctor Levine, thank you very much. We very much appreciate you being and your testimony.

SECRETARY LEVINE: Thank you for your attention and your questions.

MAJORITY CHAIRMAN DiGIROLAMO: Okay.

Next we have a panel of five testifiers. I might ask them to all come up at the same time. I think there's chairs up front. We have Mike Lynch, who is Medical Director for Pittsburgh Poison Center; Perry Meadows, Medical Director, Government Programs, Geisinger; Bill Santoro, Pennsylvania Society of Addiction Medicine; Donna Eget, Pennsylvania Osteopathic Medical Association, and Mike Kowalski who's the Medical Director for the Emergency Department at Einstein Medical Center.

Okay. A very distinguished looking group of testifiers. Thank you all for being here today. I would ask you to please try to limit your testimony between 5 and 7 minutes, if you could, so we'll make sure we get everybody in. I'm gonna ask

Mike Lynch to start off.

DOCTOR LYNCH: Thank you, Chairman DiGirolamo and Chairman Cruz, and distinguished members of the committee.

I appreciate the opportunity to address you today on this critical overall topic and Senate Bill 675 specifically.

My name is Doctor Michael Lynch. I'm an emergency physician and a medical toxicologist at UPMC. I work at five hospitals in the Pittsburgh area, primarily taking care of overdoses as a toxicologist, as well as doing inpatient addiction treatment programs in consultation. I'm also the Medical Director of the Pittsburgh Poison Center where we track overdoses throughout the state, and Medical Director for substance use disorder services at UPMC Health Plan.

I served on the Pain Management Best Practices Interagency Task Force of the Department of Health and Human Services. Been recognized by the Drug Enforcement Administration for contributions to narcotic investigations, and have led multiple programs at my institution, including system-wide Naloxone distribution, the emergency department, and inpatient side where we've given

away more than 1500 doses; initiation of buprenorphine in the emergency department, as well as the inpatient side at all hospitals, warm handoff programs and reduction in opioid prescribing throughout the system.

With that background, I first want to say, it's encouraging I think we're all on the same page, meaning, we all share the same goals. We are trying to help our patients, help our constituents and reduce death while also improving quality of life. I think we can all agree those are our goals.

Having said that and started with that, I appreciate the efforts of this committee, the legislature, the administration, the efforts of which have led to a reduction of 18 percent in overdose deaths in 2018. But with that, we have much more work to do.

From that background, I have to oppose Senate Bill 675. It's my firm belief based on my experience, but more importantly, based upon scientific evidence, that it will cost lives. People will die if Senate Bill 675 is passed.

As a personal experience, I took care of a patient who was admitted. She had chronic pain

issues; had gone on to develop an opioid use disorder. While she was in the hospital for something unrelated, we identified that; met with her, talked to her; started her on buprenorphine therapy. I was able to prescribe it, to bridge her to follow up with an internal medicine specialist within a week, and she followed up there.

She was a mom. She was reengaging with her family. Because of that work and the lack of availability, she wasn't able to make an appointment with a counselor for several weeks. According to the language in this bill, she would not have been able to get her medication for that time until she had seen her counselor and proven that she was participating in that treatment.

What would have happened in that time frame? She wouldn't have had buprenorphine. She wouldn't have had the opioid she's been prescribed. She had already gone to the street to seek pills, to seek heroin. And where I live, that means fentanyl. I truly am concerned that she would have died. And that's just one person. And, of course, that pulls at my heart.

But, more importantly, I have to think of globally, and to do that I look at scientific

evidence. So what does the science tell us? Meaning, multiple, multiple studies looking at large groups of people done scientifically in rigorous ways. It shows that treatment with methadone and buprenorphine is associated with a 50 percent reduction in overdose deaths. It reduces nonmedical opioid use. It's associated with declining rates of hepatitis C and HIV, improve social functioning, and decrease in associated health care costs. All of those with those medications.

Specifically, and I actually referenced the same report that Secretary Levine did several times, the truth behind medication is not just treating one addiction for another. It's a treatment of what happens in our brains as we adapt to consistent availability and access to medication. So, it's much more than that. And it saves lives, which is much more important.

As a result of that, they are considered first-line medical therapy. Specifically, buprenorphine is available through prescriptions. To your point, it's rare, much like methadone. You don't start off by getting a 30-day prescription. You're seen every week and you get drug screens,

and things like that are done as a monitoring mechanism, because diversion can be an issue, and we recognize that. But, at the same time, we know it saves lives.

At the same time, behavioral therapy, the addition of behavioral therapy to medication treatment has not been shown to improve outcomes or reduce the overdose death in addition to the medication. There were multiple studies that have looked at that and did not see a difference.

Nevertheless, I firmly believe that counseling and behavioral therapy are absolutely critical. I'm not attempting to minimize that. We know that the development of any use disorder, including opioid use disorder, as related to childhood trauma, adverse events throughout your life, coping mechanisms, as well as genetics, reinforcements, behavior, condition stimuli, et cetera. So there is absolutely a role for behavioral therapy, and I don't seek to minimize that.

Behavioral therapy alone for opioid use disorder has been proven to be worse than medication alone as far as relapse rates and adherence to treatment and illicit opioid use, with

a trend towards an increase in overdose death in the studies that have been done.

So the presumed benefits of behavioral therapy, which I do believe are there, should not be a contingency. You should not be required in order to get a medication, much like -- And I appreciate you sharing your story, Representative Slossberg. I think it's really important that we understand it.

The medication is a treatment of a medical problem. Like, I would not withhold insulin from a person with diabetes who continues to eat sweets or withhold chemotherapy from a patient with cancer who continues to smoke. I would not withhold medication therapy because of a behavior and because of not seeking counseling.

We know that the mandate for counseling in some cases reduces the likelihood that patients will be maintained in treatment. And in other cases, is it necessary? And in many cases, it's not easily available.

And as far as access, we've heard from Secretary Levine, and she references Department of Health and Human Services, SAMHSA, state and federal programs, to try to enhance and encourage

the availability of medication treatment, primary care and other health care providers.

Right now the main reasons that that hasn't expanded are a number of reasons. One is stigma among health care providers. Two is concerns about the cost and complexity of the care associated with it. And three is low reimbursements relative to what they're doing. So, take a primary care doctor, it doesn't add a lot of value to their practice to be providing this treatment.

So the addition of cost and regulation would have a further chilling effect on primary care doctors and physical health providers who we want to integral this care with as another medical problem in obtaining their X waiver and making this a part of the service that they offer to their patients.

And finally, diversion and safety. I think -- Sorry. I'm almost there.

Diversion and safety, absolutely important. We know that 4 out of 5 people who say they use diverted medications, use it to treat their own withdraw and would prefer to get it from a physician under supervised treatment. And

two-thirds of those people indicate they use it to maintain abstinence from other more dangerous opioids, or do it because they can't afford to go see their provider.

The other thing that I'd like to emphasize is that, buprenorphine's by far the safest opioid available. Far safer than any other prescription opioid because it only has partial agonist. It only partially turns on the opioid receptor and then stops. It has a ceiling effect. Every other prescribed opioid and certainly illicit opioid has a much greater potential of lowering the respiratory rate, which is how people die from an opioid overdose.

In 2017, of the nine prescription opioids that were found in drug overdose deaths, and more than five overdose deaths, buprenorphine was not one of them. To be found in an overdose death is not the same as causing it. You can tell it by yourself, in more than 10 years of practice of taking care of overdoses, I've never taken care of an adult who overdosed on buprenorphine alone and had serious toxicity or life-threatening toxicity as a result. And so, it is by far much safer than other opioids which are prescribed and,

of course, we've talked about the risks associated with that.

The other part is, because people are looking for it, it's a supply-and-demand issue. People are looking for it to treat themselves in the way that we want to treat them. Right now that demand can be met by providers who may not be as vigorous about following what we would consider best practice. But if we expand the availability, people would be less likely to turn towards the street or those practices. And by doing that, we would reduce diversion. And that has been shown that overdose deaths and diversion is reduced with increased access. And with that, I'll stop.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you, Doctor.

Next we have Doctor Perry Meadows, next, from Geisinger.

DOCTOR MEADOWS: Good morning, Mr. Chairman, and members of the House Human Services Committee.

I am Doctor Perry Meadows, Medical Director of Government Programs at Geisinger Health Plan. And until recently when we hired a psychiatrist, also the Interim Director of

Behavioral Health at the health plan as well.

I want to thank the committee for holding this hearing on Senate Bill 675. Today I speak with you not only as a family physician, but also as a physician that's waivered to prescribe buprenorphine. I'm licensed in multiple states, eight to be exact. But I also work with various community organizations as well.

We have a five-county coalition, among two United Ways in central Pennsylvania called United in Recovery. I'm also Chair of the Behavioral Health and Addiction Impact Council for the Greater Susquehanna Valley United Way; Chair of the Northumberland County Opioid Coalition, Vice-Chair of the Snyder-Union Opioid Coalition. But, most importantly, I'm a father; father of a stepson that has substance abuse disorder. So, I speak to you today from the heart.

Now, opioid use disorder is a chronic disease. There are those out there that think it's a moral failing or addiction to hard drugs only. It is a chronic disease. Nora Volkow with the National Institute of Drug Abuse, when she was there, did some amazing studies with imaging that showed chronic brain changes over time with the use

of opiates.

Even after an individual stopped using opiates, the chronic brain changes were still there. It's a chronic disease. It's no different than diabetes or hypertension. I mean, we all know someone that has diabetes or hypertension. For someone with diabetes and hypertension, as a family physician the first thing I'm going to do is tell them to modify their diet and exercise.

In most cases, that doesn't always do the job. At that point you have to add a medication. In some cases you have to add multiple medications. Think about how many people you know that have diabetes and hypertension that probably would not be with us today if we didn't add medication to the diet and exercise or the more conservative treatment. With these diseases, there is no one specific treatment that works. You have to individualize the treatment plan for each of these conditions.

Medication-assisted treatment is an effective evidence-based treatment plan for individuals with opioid use disorder. I mean, there's several different treatment options. Examples would include medication-assisted

treatment, abstinence only, hospitalization, partial hospitalization, counseling, or family-based therapy. These are services that can be used either individually or, more often, in combination.

There's no one-size-fits-all approach to treatment of individuals for substance use disorder. It's my opinion that the imposition of additional requirements and fees for waiver providers in the Commonwealth is ill-sided and also ill-fated for some of our citizens.

Addiction medicine providers will adapt to the new requirements. The use providers that are seeing, in some cases, up to the 275 allowed by their waiver.

Cash providers are the providers that seek cash payment for services. And, unfortunately, they'll adapt as well because they can make a $500 fee with one to two patients.

Providers that will be most affected are not the addiction medicine providers. The providers in the family practice office in a small county that has one or two providers doing medication-assisted treatment that are seeing the three to five patients that are already in their

practice, they're the ones that will be affected by an increased fee, an increased regulation, or an increased licensing requirements.

I've talked to a number of primary care providers across the Commonwealth. A number of them say that they will stop seeing patients if they have to pay additional fees and go through additional certification requirements.

Now, they can see their own patients, and they can provide total care for the patient. If they stop seeing the patients, then these patients will have to seek care somewhere else or seek alternatives on the street.

Now, this legislation or any legislation that would, even unintentionally, result in decreased access or remove it to vital treatment resource for individuals with opiate use disorder, especially in rural Pennsylvania, and that's the primary service area for Geisinger.

In fact, I talked to one provider recently who is a psychologist is the only addiction medicine provider in his rural county. I was talking to him about several things. He and I have had our differences over time, considering I'm on the insurance side, he's on the provider side,

but he's a very valuable resource.

When I was discussing this bill with him, he paused and then he said over the phone, people are going to die. That was basically the end of the conversation. People are going to die.

Now, other states -- Like I said, I'm licensed in multiple states. Other states have done a variety of things. West Virginia and Ohio have requirements where individuals are -- or practices or clinics are licensed by either the Board of Pharmacy or the Department of Health, and they limit that to providers that are seeing more than 30 patients that they're treating with medication-assisted treatment. Again, those are the Department of Health and Human Resources in West Virginia and the Board of Pharmacy in Ohio.

Other states have put this under the medical board. In Virginia, the medical board has a document that covers not only medication-assisted treatment but also opiates.

In Kentucky, which actually is one of my favorites, the board has been very specific and very prescriptive on the treatment of individuals with buprenorphine products. They actually have in the Kentucky administrative regulations, the

reference to that is in the written testimony.

But, I think it's interesting in Kentucky, they also require any waiver provider to obtain 12 hours additional addiction medicine training every three years for the CME reporting period.

Both regulations from Kentucky and Virginia, they make it very clear that failure to comply will constitute a departure from the accepted and prevailing standards of medical practice and subject to sanctions. I think --

MAJORITY CHAIRMAN DiGIROLAMO: Okay. Thank you, Doctor. Next we have Doctor William Santoro from PSAM.

DOCTOR SANTORO: Good morning, Mr. Chairman, and the House/Senate, the House Human Services Committee.

My name is Doctor William Santoro. I'm a board certified addiction medicine specialist, a fellow of the American Society of Addiction Medicine, and a Diplomat of the American Board of Addiction Medicine. I am the Chief of the Section of Addiction Medicine at the Tower Health System located in Berks County. Thank you for the opportunity to testify on behalf of the

Pennsylvania Society of Addiction Medicine.

As an addiction medicine physician, I, along with other members of the Pennsylvania Society of Addiction Medicine specialize in the care for patients with addiction, including opioid use disorder. Addiction is a treatable chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's live experiences.

Treatment of this chronic decrease often includes the use of medications such as buprenorphine, methadone and naltrexone. Buprenorphine, otherwise known as Suboxone more commonly, being the focus of this bill.

Although well-intentioned, the regulations that would be imposed by Senate Bill 675 are likely to decrease access to evidence-based treatment for addiction and substance use disorder, as well as increase the likelihood of diversion of buprenorphine.

Our opposition to this bill is guided by two principles. First, office-based opioid treatment with buprenorphine saves lives. Far from substituting one addiction for another, buprenorphine works within the brain to diminish

withdraw symptoms and cravings, allowing patients to break the cycle of intoxication, withdraw, and craving does the Hallmark of addiction.

With buprenorphine, a patient's desire to use opioids is markedly reduced and allows them to address the medical, psychological and other barriers they face to achieve remission. Relative to treatment without medication, office-based opioid treatment with buprenorphine improves six-month treatment engagement, significantly reduces cravings, illicit opioid use and mortality, and improves psychosocial outcomes.

While buprenorphine is not a silver bullet to cure opioid use disorder, it is a valuable evidence-based tool that helps patients on the road to recovery.

Second, in treating addiction, as has been mentioned, one size does not fit all. The American Society of Addiction Medication National Practice Guidelines for the Use of Medications in the Treatment of Addiction involving opiate use state that psychosocial treatment is generally recommended for patients who are receiving opioid agonist or partial opioid agonist treatment, such as methadone or buprenorphine. Psychosocial in

this context can include a needs assessment, supportive counseling, links to family support, and referrals to community services.

It is important to differentiate, however, between practice guidelines and the state mandating a particular course or type of treatment.

Although many patients benefit from participation in state-licensed addiction treatment programs, others do not. Indeed, some patients succeed with more limited psychosocial support short of those offered at licensed treatment facilities. Others, if required to participate in counseling or other psychosocial interventions may avoid treatment altogether, depriving those patients of the opportunity to escape the cycle of addiction.

Mandating a one-size-fit-all approach, as proposed by Senate 675, will limit patient choices, impose nonevidence-based treatment standards and, ironically, discourage certain patients from seeking treatment altogether.

These two principles guide Pennsylvania Society of Addiction Medication to oppose SB 675 because of the potential harm that the bill may cause our patients. Duplicating existing federal

oversight will discourage providers from caring for patients with opioid use disorder, and mandating a single approach to treating addiction will prevent patients from accessing care tailored to their individual needs.

Patients with addiction already face numerous barriers to effective treatment, from stigma to inadequate insurance coverage, to a lack of access to care. Far from decreasing these burdens, SB 675 would exacerbate most of these challenges in a moment of crisis in Pennsylvania.

Finally, I want to take the opportunity to address the issue of buprenorphine diversion, as it has come up several times already today.

Pennsylvania Society of Addiction Medicine recognizes that this bill was introduced, in part, due to the concerns of diversion of buprenorphine. Pennsylvania Society of Addiction Medicine shares this committee's concerns about the diversion of controlled substances. The use of controlled substances to treat the disease of addiction, or any other medical disease for that matter, inherently introduce the possibility of misuse and diversion of the very medications used for treatment. Policies to address these concerns,

however, must be developed from the perspective of what is best for the patient and what is most feasible for the providers.

Other states, as has been mentioned before, such as Virginia and Kentucky, have taken a preferable approach by empowering the state's medical board to develop evidence-based treatment guidelines. Unlike the duplicative oversight imposed by SB 675, these guidelines are better able to guide physician practice, address diversion risk, and improve the quality of addiction treatment provided by the state.

Pennsylvania Society of Addiction Medicine is happy to work with this board, with this body, to address buprenorphine diversion in a way that poses less of a risk to patient care. There are many other things that can be done to reduce diversion. There are new formulations of buprenorphine that have come out.

People will keep mentioning Suboxone. Suboxone is one product. It's not the only product out there. We now have injectable monthly buprenorphine; not Vivitrol, which have been -- which would then completely eliminate any chance of diversion.

I also want to mention that, the representative to my right here had mentioned, not using the word gold standard, and I'm in the same category with not mentioning gold standard. However, I would say that medication-assisted treatment should not be called medication-assisted treatment. My assistant takes care of my calendar and makes sure I get here on places like this on time.

Medication-assisted treatment does not exist. This should be called medication-based treatment. When we have medication that can be used for a disease, such as the gentleman in front of me, thank you for sharing what you did earlier before, nobody ever said to you, well, you're not really doing well until you get off your medication. That would be absurd.

Nobody has ever said to a person with diabetes, well, your sugar went up this month. Well, that's it. Your sugar is too high and, therefore, we're not gonna give you any more medication until that sugar comes down, and we're going to limit the medication that we give you to one year or two years.

This is a chronic disease. This is a

disease that will be there for life, and many people will need to be treated for life. I do have many patients that I have taken off of medication-based treatment. However, the bulk of the majority of my patients will be remain on it for their entire life.

Again, thank you for listening. I'll be happy to answer any questions as they arise.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you, Doctor.

Next we have Donna Eget from the Osteopathic Medical Association and the Lackawanna Opioid Coalition.

DOCTOR EGET: Good morning, and thank you, Chairman DiGirolamo, and committee members. Thank you very much for the opportunity to be here today.

This is a topic about which I feel very passionate. I also have a family member who's been affected by this disease, my godchild, so I take this very personally as well.

My name is Doctor Donna Eget. I'm a board certified emergency physician. I'm here today on behalf of the Pennsylvania Osteopathic Medical Association.

For the past 10 years, I've been practicing urgent care medicine, and for the past five years I have been treating patients with substance abuse disorder with the medication buprenorphine. My office is one of the spokes of the Wright Center that Doctor Levine spoke about earlier. My practice is in Dunmore, Pennsylvania, which is in Lackawanna County.

Because we accept Medical Assistance at my practice, and because the surrounding areas are somewhat rural where there's a lack of access to physicians who accept Medical Assistance and physicians in general, these being Wyoming County, Susquehanna County, Monroe, Wayne, Pike and Luzerne, I see a lot of patients. I'm here to talk on their behalf because sometimes my patients have limitations to access.

I also have the unique hat at this table because, understanding that there is a need for counseling, about a year ago my office opened a counseling center. We are a certified drug -- or a licensed drug and alcohol counseling facility. So by sitting here before you today telling you to shoot down this bill, I'm actually shooting myself in the foot because I have a financial stake in

this bill passing, but that's not why I went into medicine. I don't think this is going to help my patients.

My experience treating patients limits -- to where their access to resources is limited suggest that this bill, as it is written, will make it very difficult for physicians to provide care for their patients. If the intention is to help people, I think it's going to be a colossal failure.

The access to behavioral health services is just not available. There are more people in need of counseling than there are counselors available, especially in my area.

I have worked with the Lackawanna Recovery Coalition for the past two years, and one of our big projects was the warm handoff project at the community medical center in Scranton. So, if this bill were to take effect as it is written, what that would require is the presence of a certified drug and alcohol counselor to be present in the ER.

While that is not feasible -- Even if it were feasible, the receptance or ability of a patient in a crisis situation, someone who just

overdosed, for example, to be counseled effectively, somebody who may be experiencing the effects of withdraw because they have a precipitated withdraw from Narcan, this means terrible body aches, nausea, vomiting, excruciating anxiety. For them to engage in a meaningful way with a counselor during that time of crisis, it is just not realistic.

Will they benefit from counseling? Certainly. When we understand the things that have already been mentioned that are the comorbidities, or the cofactors that attribute to addiction, such as childhood abuse, emotional trauma, PTSD, and above all, in my practice, patients with mental health disorders, when we look at all of those things, patients need counseling. But to require them to get that counseling before they're able to receive life-saving medication is detrimental to their well-being, and people will die if this legislation is passed.

Another example I can give you is somebody who I just saw in my office 10 days ago. This patient called on a Saturday morning, and he said, I'm really in trouble here. Can someone see me? I see that your office prescribes Suboxone.

So I said, come on in. This patient's name is David.

David suffers from rheumatoid arthritis. And through the course of escalation of his pain over many years, he came to be taking what is the equivalent of 40 Percocet tablets a day. If you're unfamiliar with Percocet, I would tell you that if one of you fell and broke your ankle, your doctor would probably give you four a day, and David was taking 40.

Then we passed legislation that said, we're gonna monitor the PDMP, meaning that, before doctors can prescribe medication, we have to watch what patients are already getting. Doctors became afraid to prescribe medications. One day, literally, David's doctor just said to him, I can't prescribe this to you anymore.

I already described the effects of withdraw from opioids. If opioid withdraw was easy, we would have very few addicts. It is not. So David did what many patients do, he went to the streets. The night before he came in to see me, he was arrested or, actually, pre-arrested in a new program by the Scranton Police Department working with the Lackawanna Recovery Coalition, and also

with our Judge Barrasse who is very active in a drug court.

He has the pre-arrest citation now, which means that if he gets help and is engaged in counseling and passes his drug screen that he won't have this on his record, which means he gets to keep his job and support his family. Because, in spite of all of these opioids, he still is working and very functional.

So, Dave came in and his drug screen showed fentanyl. As Doctor Levine mentioned, three-quarters of patients who are dying of opioid overdoses have fentanyl as a contributing drug. So, seeing fentanyl in someone's drug screen is alarming to me. I started him on buprenorphine immediately. I saw him back a few days later, at which point he said, yes, I still have back pain. I'm having trouble sleeping, but otherwise, I feel pretty normal. No withdraw, and I'm doing okay.

He had not yet been to counseling, because the earliest counseling appointment he could get was a week later. I saw him within two hours of his phone call for medication, but the counseling was tremendously delayed. This is pretty typical of what my patients face in

Lackawanna County. Because of the rural area that I practice in and the patients I treat from surrounding counties, I think their experience with access to counseling would be similar.

So, I am here to tell you the perspective that I experience on an almost everyday basis in treating patients with a very devastating disease. I understand that there are problems in the system that we now operate in. I understand that there's diversion of prescriptions. I understand that there are cash-only doctors who may be causing more harm than good. But, I don't think that this bill is going to help those situations. I think it's just going to hurt patients.

I, and other physicians that you see before you today, the committees or organizations that we represent, such as the Pennsylvania Osteopathic Medical Association, the Society of Addiction Medicine, the Pennsylvania Medical Association, we all want to help, and our input can help you write a much better bill that will not only help our patients, but maybe reduce the further incidents of addiction that's going to occur in the next generation.

Thank you for the opportunity to speak

today, and I'll be happy to answer questions when we're through.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you, Doctor.

Next we have Doctor Mike Kowalski, Emergency Medicine at Einstein Medical Center.

I also want to give a shout out to my good friend Bill Ryan, who's here today and who represents Einstein up here in Harrisburg and does a terrific job on their behalf.

Doctor, whenever you're ready.

DOCTOR KOWALSKI: Thank you. I'm going to edit a little bit, because there's been great information. That's the problem with going last, is, everything's been said before it gets to you. But, hopefully, I'll be able to share some first-hand perspectives of what we're experiencing; many of my colleagues across the Greater Philadelphia area are also experiencing.

So, good morning, Chairman DiGirolamo, and members of the Health and Human Services Committee. I appreciate the opportunity to testify and give our perspective.

I'm Mike Kowalski. Thank you for introducing me, and I'm boarded in addiction

medicine toxicology, medical toxicology, and also emergency medicine, addiction medicine and medical toxicology. I'm the Medical Director of the Emergency Department at Einstein in Philadelphia. We're a level 1 trauma center, and one of the busiest CDs in the Philadelphia area. We see about a hundred thousand visits per year.

We treat some of the Commonwealth's most vulnerable population that are subjected to repeated violence, trauma, and conditions exacerbated by deep poverty. Some of these patients struggle to access health care in a meaningful way, just for routine blood pressure, diabetes, routine health care. And so, the result of this content exposure to trauma and poverty often results in the need to self-medicate with opioids and other substances.

In the emergency department, our job is to stabilize the patient and move them on to the next appropriate care setting. And oftentimes, that's encompassed in a warm handoff if we identify somebody who has recently overdosed or has a risk of opioid use disorder and get them hooked up with a program either at our hospital or a Prevention Point or other programs around the city.

One of the best pathways is for getting this initiated in the emergency department is the medication-assisted treatment. While not perfect, it's one of the best tools that we have at the present moment. And so, we'll do an ED induction in the emergency department, and then get them set up in social work to get a warm handoff to one of the other programs.

At Einstein, we hand off to many of our city's experienced organizations, Prevention Point is one of the ones I mentioned, but it's worth noting that at this moment, Prevention Point has stopped accepting new patients because they've reached capacity, so we're looking elsewhere to other programs that are available.

We also have another option. At Einstein over the past two years, a group of dedicated primary care doctors and behavioral health physicians have worked to build our welcome MAT clinic. This is fully integrated into our community practice clinic. And just as an aside, I had the benefit of spending time there, and I worked side by side with these colleagues in the smooth transition from the ED to our community practice clinic.

This type of integration recognizes addiction as a chronic condition, as my colleagues here have mentioned before, which requires ongoing treatment without stigma, the same way diabetes should be.

One of the biggest strengths to this model that we've seen as opposed to maybe a methadone clinic, while that has benefits too, is that, no patient in the waiting room knows that another is there for MAT, and this greatly reduces the stigma. An MAT patient will just look like someone visiting for routine checkup or blood pressure management. It's very different than somebody standing outside a treatment center and people really driving by and walking by know why they're there. But it increases the likelihood for many patients of continued care and repeated visits to our clinic.

We are extremely proud of our program, but it hasn't been easy to build. We continue to struggle with engaging our primary care physicians in getting them X waivered. It's a very burdensome process. It's 8 hours of treatment, training either online or in person. While there's several ways to do it, it's still a workday for most

people, and some hospitals and some programs are not willing to subsidize it, and people have to do it on their own because they believe in it.

My concern with this legislation in its current form is that, it will add yet another barrier to access crucial treatment for prescriber and patients.

We mentioned diversion several times today, and I have the benefit of providing bedside consult. With the patient's permission, I was able to bring the story to you today because I think it really highlights what is happening with diversion on the street.

It is a problem and should be addressed. It will probably go down with this legislation, but so will availability and so will the number of patients that are able to be treated. Many individuals do not buy heroin to get high. They use it to stave off withdrawal symptoms and function in their everyday life. But every use of an opioid increases the risk of death.

I met a patient, like I mentioned, that's a long-term user of opioids. The patient shared with me that buprenorphine on the street now costs $10 down from $30. It cost the same as a bag

of heroin. This means that, someone who wants to control the withdraw no longer must buy heroin at a cheaper price just to function in their everyday life. He or she can buy diverted buprenorphine for the same price and not risk overdosing.

Obviously, this is not ideal, but that person is still alive to go on to get counseling and go on to get a better option when one becomes available. We want to see this person get into treatment, including behavioral health support. But, let's not let the perfect be the enemy of the good. Let's work with the tools that we have right now.

On behalf of myself and my colleagues at Einstein, we'd like to offer the following suggestions to address buprenorphine diversion:

Prescription of the fewest number of strips or tablets that still accomplishes the target dose for the patient;

Urine drug screens performed with every prescription;

Measures that improve access to point of care urine drug screens;

Intermittent direct observed treatment in select individuals, and;

Removal of prior authorization requirements for use of monthly injectable buprenorphine.

I thank you for your support, and respectfully request the committee work closely with us and our other colleagues around the Commonwealth on the front lines of this epidemic to develop legislation that addresses diversion without imposing further barriers.

We really want to make sure that the results in fewer people able to die from opioid overdose, and more people able to access this life-saving treatment.

Thank you.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. Thank you all for testifying. We appreciate it very much.

I'd like to call up next our next panel. We have Tom Farley, who is the Philadelphia Health Commissioner; Susan Friedberg Kalson, who's the CEO of Squirrel Hill Health Center; and Jason Snyder, who is the -- from Pinnacle Treatment Centers, the Regional Director.

We have exactly 35 minutes left. We have three on this panel and two on the second --

the last panel. I'm going to ask you to please try to stay between 5 and 7 minutes, if possible. We're going to have to do that to make sure everybody testifies. Please no longer than 7 minutes.

Doctor Farley, please, if you would begin. Thank you.

DOCTOR FARLEY: Chairman DiGirolamo, members of the committee, I'm Doctor Thomas Farley, Health Commissioner for the City of Philadelphia.

You have my written testimony. I'll shorten it in the interest of time.

Philadelphia has been hit particularly hard by the epidemic of opioid use, addiction and overdose. Between 2017 and 2018, more than 2300 people died of drug overdose. In 2019, we are on track to suffer another 1100 overdose deaths, giving Philadelphia the highest overdose mortality rate by far of any large city in the nation. Nearly 90 percent of the drug overdose deaths involve opioids.

To combat this crisis, we are working to reduce unnecessary prescribing of oxycodone and other pharmaceutical opioids, increase access to medication-assisted treatment for opioid use

disorder, OUD, and making naloxone, or Narcan, more widely available to reverse overdoses.

Buprenorphine is a safe and highly effective medication for the treatment of opioid addiction. Let me underscore something that was said by a previous testifier that buprenorphine is unique relative to the other opioids that are out there. Unlike, say, OxyContin, it has a ceiling effect, beyond which, if you take a greater dose of buprenorphine, you don't get an additional effect.

It is because of this, the buprenorphine is almost never seen in drug overdoses, and I don't think it ever causes a drug overdose. That is why one of the central local, state, and federal strategies to combat the opioid crisis is to increase access to buprenorphine treatment.

Most patients with opioid use disorder do not currently have access to medication treatment, and fewer than 4 percent of qualifying practitioners in the United States are licensed to prescribe buprenorphine. In Pennsylvania, there are six counties without a single practitioner certified to prescribe buprenorphine, and seven other counties with only one certified practitioner.

Senate Bill 675 would create extremely burdensome requirements for qualified practitioners in Pennsylvania to prescribe buprenorphine. These include additional constraints -- These additional constraints would force many practitioners currently offering buprenorphine treatment to stop doing so, prevent new providers from obtaining certification, and significantly increase barriers to patients seeking treatment.

By reducing access to medication-assisted treatment, this bill would reverse much of the progress we have made in combating the opioid crisis. I believe this would, in turn, increase the number of people dying of opioid overdose.

Lack of treatment availability is directly linked to increases in rates of misuse and diversion of buprenorphine. Individuals primarily use buprenorphine because they lack access to a provider or prescription medication coverage while seeking treatment for opioid use disorder. According to one study, among those who use diverted buprenorphine, 79 percent report doing so to prevent withdraw; 67 percent report using it to abstain from other more dangerous illicit opioids, and 53 percent report using it in an attempt to

self-wean from illicit opioids.

What's more, 81 percent of those who use diverted buprenorphine reported that they would prefer taking it as prescribed by a medical professional. Further reducing available treatment would increase the demand and value of diverted buprenorphine, whereas, expanding and improving access to care would allow these patients to receive the supervised medical therapy they need and desire.

While many patients benefit from treatment programs that include substance use disorder counseling, others benefit from treatment with buprenorphine without confinements to residential settings or outpatient counseling. Community-based providers, such as primary care physicians and community health centers are essential to treating those with opioid use disorder.

According to the National Academies of Sciences, Engineering, and Medicine's 2019 report mentioned earlier, that medication for opioid use disorder saves lives, a lack of availability of behavioral intervention is not sufficient justification to withhold medications to treat

opioid use disorder.

In summary, when someone with OUD decides they are ready for treatment, it is our responsibility to ensure evidence-based treatment is readily available. To do this, we must reduce rather than increase barriers to treatment.

Thank you for the opportunity to testify. I'm happy to answer your questions.

MAJORITY CHAIRMAN DiGIROLAMO: Good timing, Tom. Next, Susan.

MS. KALSON: Thank you, Mr. Chairman, and members of the committee.

I'm very grateful for the opportunity to be here today. I've submitted lengthy testimony, which I am not going to read. Instead, I want to tell you why I'm here.

I am the CEO of Squirrel Hill Health Center, which is a federally-qualified health center in Pittsburgh. And I'm here representing our organization, but also on behalf of the nearly 50 community health centers across Pennsylvania all operating under the same federal mandates, regulations and funding, that have 300 sites and collectively care for 900,000 residents of our Commonwealth, including those in some of the most

isolated urban -- isolated rural areas and underserved urban communities.

Squirrel Hill Health Center takes very seriously our federal directives that we must provide primary and preventive, medical, behavioral health and dental care to everybody, either directly or by providing them with access. And everybody means everybody regardless of insurance status or ability to pay.

Collectively, again, we care for the majority of Medicaid insured patients in this Commonwealth. We also are the provider for folks who are underinsured or uninsured, and we are able to do this through a sliding fee scale which is based on household income; again, operates under strict federal regulations, and does include sometimes cash payments for services. I just wanted to be very specific about that point.

At Squirrel Hill Health Center, which was started in 2006, we have piloted the idea of integrated behavioral health services. We launched them in early 2007, before there was federal funding to do this, really ahead of the curve, by adding to our team of medical providers, psychiatrists, therapists.

That program has grown expediential ly since that time. It is available only to our primary care patients, and it is not just an integrated system. We like to call it a fused system where the providers from the different disciplines meet together regularly to discuss patient's care. With patient's permission, they are able to chart a single record. The information flows freely, and it means all of our patients have access to psychiatric evaluations, medications, therapy, group supports, and a tremendous amount of care coordination.

When we recognized the effect that the opioid epidemic was having on our community and our patients and their families, we realized that we had to do something about that, and we chose to integrate MAT, medication-assisted treatment, into our existing program.

We created another additional team of MAT-trained professionals. We have gone beyond that now. Every single one of our primary care providers is wavered to prescribe buprenorphine, and we have peers who are specific to this affliction. We meet together as a team. That includes our dental providers.

This is comprehensive patient-focused health care, and we need the ability to tailor our services to each individual patient as they present themselves to us.

Many of my -- The people who have spoken this morning already talked about the evidence that shows that buprenorphine can be effective even in the absence of other services. We make available all of those services. We have drug screening on site, lab services on site, access to affordable medication, medication counseling, coordination that connects our patients to other services that we don't provide directly.

If somebody enters our treatment program and we know that we can't provide an appropriate level of care, we have referral resources, and we refer them elsewhere.

But, we have been working really hard to pilot this program. We are directed by ERISA, our federal funding agency, to provide MAT. We are taking this extremely seriously. We are now collaborating with the Allegheny County Health Department on a CDC funded grant which will take us out into the community to train other (inaudible word) in the work that we are doing.

Many primary care providers are reluctant to take this on. They are fearful of it. Some buy into the stigma that society holds; that somehow people suffering with addictions are bad or different or too difficult to treat. We want to prove that that's not true. We are working to lower the barriers of care, to normalize it; to treat this illness as a chronic condition that as others have said may continue over an entire lifetime. We need all the tools available in our toolbox in order to do this.

Our program is still small. We only care for about 60 patients. It's small because it's very labor intensive, and because we've been working to make sure we're doing it well before we ramp it up. We are now ready to ramp it up. Unfortunately, this bill would knock the legs out from under this.

First and foremost is, again, everyone else has said, our clinicians have already -- they're licensed practitioners. They are DEA. They have their DEA certification. They have their waivers to prescribe buprenorphine. We have HRSA breathing down our necks. We report every which ways on clinical outcomes, financial outcomes.

We are the polar opposite of the pill mill. We wrap our arms around each and every patient, and we are not a licensed drug and alcohol facility. Those do good work. What we do is primary care. And we beg you not to deflect us from this very important work, which is truly saving lives in our community.

Thank you.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you, Susan. Next we have Jason Snyder from Pinnacle Treatment Centers. Jason, welcome.

MR. SNYDER: Thank you, Chairman. I want to thank the committee for the opportunity to be here today. I want to take a quick second to say to Representative DiGirolamo, the Commonwealth will miss your leadership. I, especially on this issue from Harrisburg, but you're on to great things and want to thank you for your service here.

My name is Jason Snyder. I'm Regional Director of Strategic Partnerships for Pinnacle Treatment Centers. Pinnacle Treatment Centers provides the continuum of addiction treatment services across six states. You all know the continuum can start with detox and moves through residential, halfway housing, partial

hospitalization, intensive patient and outpatients.

(Video interruption) -- treatment programs, which, by regulation, means that at each of those 13 facilities we provide methadone, as well as varying levels of outpatient counseling. Through those facilities we also provide buprenorphine and naltrexone.

Prior to my current role, I was Regional Director of Operations for Pinnacle. I oversaw seven of our eastern Pennsylvania facilities. And prior to that, I was special assistant to the Secretary of the state Department of Human Services where I oversaw implementation and operation of the Centers of Excellence, which I'm sure all of you know is the Governor's -- at the time, at least, the Governor's and supported by the legislature signature investment in addressing the opioid epidemic. This was three years ago, 45 centers were granted 500,000 annually to expand access to treatment, especially evidence-based treatment.

I'm proud to say that three of our 13 Pennsylvania facilities were designated as Centers of Excellence and continue to operate as such today.

And lastly, prior to that role, I was

Communications Director for the state Department of Drug and Alcohol programs. So, I've been in the middle of what the state has been doing to address this epidemic, really, since the state began to address it. In late '14, I watched from a distance as Act 139 was passed, and was thankful, grateful, and impressed with the work that many of the people in this room here did to get that law passed.

I am not here with a formal position, but rather, I am here to share my personal story and the perspective I have developed as a result of the last several years walking this path that I just described to you. In essence, what I'm really here today to do is demonstrate the potentially far-reaching consequences of barriers to accessing evidence-based care.

I am a life-long Pennsylvanian. I was born and raised in Cambria County, the oldest of three boys. My parents had been married to each other for 48 years and gave their children every opportunity to succeed. Despite our upbringing, in 2005, my brother Todd at age 28 years old died of a heroin overdose. Todd was a college graduate with a degree in accounting who left behind a 6-year old daughter at the time. I was the second person on

the scene of Todd's death. And as such, what to this day has been the most difficult phone call I've ever made, and that was to my parents to tell them their son was dead.

Even with Todd's death our nightmare was not over. In 2007, my 25-year old brother, Josh, died of a drug overdose. His son was born exactly two months after Josh's death, and my family at that point was dismantled and reeling. As the last man standing, the last living child of my parents, in 2011 I told them that I needed treatment for my opioid addiction.

Fortunately and obviously for me, since then my story has been much different than my brothers, and today I identify as a person in long-term recovery from the disease of addiction, which, for me, means that I have not had a drink or drug in nearly eight years.

As I walked my path over the last several years, I've crossed the Commonwealth countless times in each of those roles I have been privileged to hold. I have encountered parents just like mine who have either buried children or who are on pins and needles waiting for the dreadful phone call I had to make.

I have heard stories from mothers of children who have left residential treatment stays only to die days later, and I have seen firsthand others, besides my brother, friends of mine who have died from this disease. A common thread through many of these deaths was the lack of medication as part of a treatment plan.

At the same time, I have also seen the transformative power of medications like buprenorphine and methadone in helping people to recover from their addition to opioids.

Addiction has surely touched many in this room today. We hear it all the time. It's almost impossible to find someone who hasn't in some way been affected by the disease.

Some of you, I know, have very inspiring redeeming stories of loved ones who have overcome addition to live beautiful lives of recovery today. That is part of my story as well. Some in this room may be living the nightmare of addiction as they sit here today, afraid every time their phone rings what they might have to hear. That is part of my family's story as well.

But, unless you have buried a child, sibling or spouse, you cannot know the finality of

that death. Sympathize, as you may, if you have not buried a close one to this disease, you will never feel the longing in your soul for that person, and a sickness of heart that comes with knowing that you will never get one more chance on this earth to be with them. You will never know the heartache. You will not have the dark days during which you ask the agonizingly ask the question, what if. You will not be smothered by the shame and guilt of, if only.

It's no secret there is a rift in the addiction world between the pro-MAT camp and abstinence-only camp. In the name of one's own philosophy, it is easy to risk someone else's life by creating barriers to tools that are proven to keep people alive and give them a chance to move along a path of recovery. In doing so, we are conceding that death is very possible and, in essence, saying we are okay with it.

That said, I am an active member of a 12-step fellowship and a strong proponent of such programs. But I also believe we should enable access to all tools available to us to keep people alive and put them on a path to recovery.

I can guarantee you this. My parents

would much rather have their two dead sons alive today and on a medication that puts them on a potential path to recovery than laying side by side dead in a graveyard in Portage, Pennsylvania, which is where they lay today. I implore this committee to consider that as they make decisions that will have far-reaching consequences.

Thank you.

MAJORITY CHAIRMAN DiGIROLAMO: Thank you very much for your testimony today. We appreciate it very much.

Next we have our last panel. Deb Beck, who's the President of the Drug and Alcohol Service Providers Association of Pennsylvania, and Ken Dickinson, who was a co-founder and board member Emeritus of the PA Pharmaceutical Peer Assistance Program and the PA Nurses Assistance Program.

We have about 15 minutes before we're gonna have to stop. So, Deb, I don't know if you want to go first or let Ken go first. Okay, Ken, you're up.

MR. DICKINSON: Thank you, Mr. Chairman, and everyone on the committee.

I'm an advocate for buprenorphine. I remember when buprenorphine was successful in

Europe before it came here, and I researched it. It's an evidence-based best practice when it's practiced correctly.

Criteria demands motivation for recovery when not motivated or possibly ambivalent. We see misuse, abuse, adulteration and diversion when the motivation isn't there.

Suboxone works for people, and I quote, who are sick and tired of the ravages of addiction, end quote. That was Doctor H. Westley Clark, former director of SAMHSA.

The issue is that too often it is not being used in accordance with the principles of MAT. The principles of MAT require psychosocial, spiritual, familial counseling.

Guidelines were at fault initially with Suboxone. Prescribers were not mandated to refer to treatment, and that's how we ended up seeing all the diversion and misuse that we saw.

I have to mention that, in 2005, came on the market. In 2007, that time the Bureau of Drug and Alcohol Programs, now the department, asked me to attend a training of trainers, and I became a SAMHSA trainer on buprenorphine for the nonmedical professional. And since 2007, I have trained and

educated hundreds and hundreds of people that work in counseling and in the recovery movement. A lot of what I'm going to share is based upon what I've heard from those individuals.

Additionally, I participate with the National Alliance of Advocates for Buprenorphine Treatment. On their website they state: The purpose of buprenorphine treatment to suppress the debilitating symptoms of cravings and withdrawal, enabling the patient to engage in therapy, counseling and support so they can then implement positive long-term changes in their lives which develops into the new healthy patterns of behavior necessary to achieve sustained addiction remission.

They go on to say: Buprenorphine is only a small part of treatment.

They close out this session of their web page by saying: Buprenorphine allows the brain's neuroplasticity to develop new patterns and pathways while allowing old ones to disappear by suppressing the cravings and withdrawal that were just mentioned. But they close this sentence out with: But it is the deliberate self-reconditioning process, which is actually the recovery of the brain disease and the neuronal pathways in

recovery.

Many addicts have high-jacked buprenorphine so that, instead of it being used to manage their recovery, it's been used to manage their addiction. And that is a quote, a direct quote from a SAMHSA physician and a buprenorphine waiver physician who attended one of my trainings.

While presenting to the state correctional prison wardens in the State of Maryland, I was informed that buprenorphine is the number 1 drug of abuse behind the walls. I understand it's the same in Pennsylvania, rivaling K2. And in many cases behind the walls, it's the combination product K2 and BUP.

Many patients are polysubstance abusers and, therefore, we see many drug-to-drug interactions which should be closely monitored. The website, drugs dot com, are reliable, lists 601 specific drug-to-drug interactions between buprenorphine and other prescriptions and over-the-counter drugs. 178 of them are major.

I've had many, many patients because I've also worked in treatment. Currently, I'm a consultant to several treatment facilities; actually retired from full time in 2017. I've been

a counselor. I've been a certified employee assistance professional, so I've been hands-on clinically involved.

During admissions process, during treatment, in workshops and trainings, I've been told by patients or by clinicians about the patients who sell after their prescription to get money to buy their heroin or fentanyl; not to give it to other people to detox, but to be abused.

Additionally, there is a black market for buprenorphine, but something I want to mention that I haven't heard people touch on this at all at this point. We live in this virtual world. There's major, major websites: Reddit, Bluelight, Erowid. I pose as a drug abuser and go into these forums and interchange and talk. I find out what's going on in the world with these individuals.

Studies show that contributors to these discussions which trust each other more than they trust pharmacists and prescribing physicians. And for those not familiar with, these are the how-to websites of how to abuse drugs. They tell each other how to use this drug just like they're using drugs like Imodium and Kratom to minimize their opioid withdrawal effects.

Now, Naloxone was added to buprenorphine to deter abuse. On these websites, and many other websites, they go into details about how to separate the Naloxone so that the buprenorphine can be more readily abused. The film which was alleged to decrease adulteration has proven to be a dosage form more prone to abuse. It is the drug, as I mentioned behind the walls, it's so easy to smuggle.

I'd just like to close to say, I've heard individuals say, life-long usage. As a pharmacologist, as a pharmacist, I do not advocate psychoactive substances to be used daily for the rest of one's life. The brain should be allowed to regenerate and to come back to its homeostatic condition.

Thank you.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. Deb Beck from DASPOP, and you have exactly 8 minutes.

MS. BECK: Here we go. Pennsylvania a few years ago was 17th in per capita deaths from opioids. We're now number 3, folks. We're now number 3. In aggregate numbers we are number 1, if you don't do per capita.

So, I'm looking right at you all, thank you for Narcan. You guys have saved 20,000 lives according to the press release I saw from Governor Wolf. Without you, we would probably, unfortunately, be even higher. We have a long way to go. Don't stop on the Narcan.

I also, just listening to this process, and maybe it's my age, I think you're gonna solve the problem, guys. I think Senator Brooks' bill drew attention to a problem. We have a problem with diversion. We need to solve the problem with diversion. We need to make sure counseling occurs wherever possible, and I think you're gonna find a way.

Representative Schlossberg, I heard of one proposal you have made to help with the legislation, which I think is outstanding. It was not something that ever crossed my mind. I think your process is working, and I look forward to whatever product comes out of here.

I don't agree that there's a rift in the field over this issue. We've been using buprenorphine in detox and multiple other levels of treatment for many years in the field.

And also, 24 overdose deaths in three

days in Dauphin County area just a couple of days ago. This is a serious problem. So, here we go.

Our programs provide counseling and use Suboxone and buprenorphine, and I'm gonna call it Suboxone, as appropriate, but only based on an individualized assessment. For example, you've got a bad liver. This may not be a good choice. Guess what? Lots of our folks have an alcohol problem so they have a bad liver. This is really something doctors need to look at, individualize assessment determination.

So let me repeat. We use it.

But with that being said, we're deeply worried about what Pennsylvania's direction is with this, and it's heavily about diversion. You need to know that most addicted people are multi-drug addicted, so we can go after this like whack-a-mole, and we're gonna have to keep coming, I guess, up with another drug each time.

Folks are shifting now to methamphetamine, as I think you know. That doesn't mean buprenorphine doesn't have a role. It certainly does.

So, I think we can remedy the diversion, and I hope that's what you do, and make sure

counseling occurs, however, and as soon as you can possibly do it. I think that's -- You will find the words for that. I won't be the wordsmith in that.

Please read carefully number 1 in my testimony. A large study of thousands of medicated recipients who are getting buprenorphine in Pennsylvania were getting, at the same time, 25 percent, a third, had no diagnosis for an opioid use disorder...zero. If you want to guess where the diversion problem is, there it is. It's also something you can do something about.

Look at the next one. The same group sample--there is Pennsylvania folks--Pennsylvania Medicaid is paying for my buprenorphine prescription, and over a third to a quarter -- third or more are also simultaneously getting prescriptions for other opiates and for benzodiazepines. That's dangerous as hell. We're gonna kill people. Let's talk about killing people.

Our tax money is paying for this. You've gotta tell me if that looks like good treatment to you. I'm getting care from the buprenorphine for the one hand. On the other hand,

I'm getting Medicaid payments paying for other opiates. We can do something about that. That's a report from Pennsylvania Medicaid. We can do something about that. You can't tell me that's good treatment.

So, here we go. No diagnosis, I can get it, and also, I'm getting all these other drugs. The writers of the report include Pennsylvanians. They notified you of some other poor -- indicators of poor quality. I'm going to jump on.

The next big study I looked at was Johns Hopkins. They found the same thing going on, only in a different population. More than 2 in 5 got buprenorphine and were also getting prescriptions for opiate painkillers. I'm worried about the coming together of that. Two-thirds also got prescription opiates after completing the treatment with buprenorphine. You can't tell me that's good treatment.

Now number 3, here we go. High rates of opiate prescriptions for people, even after they have been hospitalized for an overdose to buprenorphine or another opiate.

And look at number 4, 50 percent report sharing BUP or 28 percent selling it. This is

after they get it generally through Medicaid.

The next two studies are emergency room studies. They're emergency room studies, folks. Neither study finds that there was a significant decrease in the use of IV heroin use afterwards. That doesn't mean it's not a good medication if used properly. Please hear me. It can be used properly. It could be a bridge to recovery.

Now, I'm not going to repeat number 8 for reasons that I think you can see. But I think I would give you a very good reason why a lot of people don't stay on buprenorphine two to four months later. Retention is a problem two to four months later. But, if I'm getting the full array of counseling, that could take over.

Keep in mind we're treating the human condition, and we keep thinking we can do this with a drug. It can be a bridge to recovery, no question about it. I kept being approached by people about number 8 on here, saying, this is blah, blah. I did a little research around this study.

This kind of stuff that I've given you should be ringing alarms all over the country. And again, it doesn't mean it can't be used right.

My whole next section--And I'm jumping ahead like crazy--is all about law enforcement. Look at this. Indivior, they made a point of connecting opiate-addicted patients to the very doctors they knew were doing misprescribing and in a clinically-unwarranted manner.

You've got Department of Justice. You've got eastern and western U.S. Attorneys. You've got a 1.4 million settlement, again, marketing, and look at all these clips. And there's a lot of studies. They're arresting people all over the state: Pennsylvania, West Virginia, for fraud, distribution of Suboxone, drug dealing in south Philly. There's the story from them.

In Blair County, I note that Attorney General Josh Shapiro noted that Suboxone is hand-in-hand with opioid addiction in this area, and he has arrested a bunch of people there.

I want to go down to the FDA study, which is deep in here. It's simply not true that people aren't dying from this. The FDA, for reasons I don't understand--Somebody smarter than me has to figure out--was not reporting the overdose deaths where Suboxone or buprenorphine products were a primary element. Suddenly, they

did. Almost 20,000 deaths nationally.

Now, it's not the leading drug, thank God. You know, it's not the leading drug. But let me also tell you this, methadone overdose deaths was only 5,700, and also Naltrexone deaths were under 600. Vioxx which had deaths of 6,000 was removed from the market, but this one stays there.

By the way, this drug can be used properly. There's no question about it. It means we have a diversion problem.

I want to go to the Auditor General's report. The Auditor General looked at this, and he looked quickly: Monitoring these physicians and their writing practice is important because of the high potential for diversion among their patients. One way to deal with this is additional licensing through DDAP to enable physician treatment practice to ensure this was legitimate use and not pill mills.

We agree. My association, we use this drug throughout the association. We hope we use it properly. We agree with the concerns raised by the Auditor General and with his recommendations. We also agree and support any legislation that will ensure that Suboxone is prescribed in the context,

however you do it, and you may want to play with the words of that, and I trust you, you will figure that out, in the context of addiction treatment. That could be a lot or a little.

Finally, friends, where's the pressure coming from? We feel this pressure, all this thing. It's a gold standard. It's whatever everyone should do.

I want to draw your attention to legal documents filed by the Attorney General of Massachusetts. Purdue Pharma developed Project Tango, a secret plan for Purdue to expand to in the business of selling drugs to treat opiate addiction. By that, they meant Suboxone. Sackler and Purdue Pharma concluded that millions of people become addicted to opiates, and were the Sacklers' family's next business opportunity.

They identified eight ways they sold and got people to use opiates, and these same ways could be now be used to sell treatment for opioid addiction. A plan that was presented to the board was a joint venture controlled by the Sacklers to sell the addiction medication Suboxone. Purdue's staff noted that after the patients were done buying it the first time, 40 to 60 percent are

gonna relapse and they're gonna have to buy it again.

A couple years after that, the makers Purdue, came out and had begun to dangle Suboxone as the major kind of thing in the bargaining about the litigation about OxyContin in the country. They're dangling it like carrots in front of hungry rabbits. Hey, we'll give away free Suboxone.

Now, finally, McKinsey Corporation, which I didn't know a lot about, advised Purdue Pharma, here's the quote, how to turbocharge opiate sales, a lawsuit that's been filed again in Massachusetts said they advised Purdue on how to turbocharge sale of OxyContin, how to counter the work of law enforcement, and how to counter the emotional messages from parents and mothers who had lost their teenagers to overdoses. There's more about that.

Now, according to the New York Times, February '19, in 2018, after spending years advising Purdue on how to increase sales of OxyContin, McKinsey has published a new report entitled, Why We Need Bolder Action. In that report, one of the six recommendations is, of course, to increase medication-assisted treatment

capacity.

Friends, almost 5,000 Pennsylvanians a year have died needlessly due to the unspeakable, irresponsible marketing of OxyContin in the state, and now we're gonna take advice from Purdue and also from McKinsey Company. I think we'll do better than that.

Once again, Suboxone products can play a wonderful role in addressing the addiction treatment problem in this state, but it's got to be used right.

Thank you for your time.

MAJORITY CHAIRMAN DiGIROLAMO: Okay. That's just 11 o'clock. We're gonna have to wrap this up.

I want to thank everybody for being here today. Thank you for the testifiers. And if anybody wants to submit questions, the members will try to get answers to the questions. I know a lot of people have questions. I had a hundred.

This meeting of the Human Services Committee is now adjourned. Thank you.

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C E R T I F I C A T E

I, Karen J. Meister, Reporter, Notary Public, duly commissioned and qualified in and for the County of York, Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript, to the best of my ability, of a public hearing taken from a videotape recording and reduced to computer printout under my supervision.

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Karen J. Meister
Reporter, Notary Public