Einstein
HEALTHCARE NETWORK

TESTIMONY OF J. MICHAEL KOWALSKI, EINSTEIN MEDICAL CENTER PHILADELPHIA

Good morning Chairman DiGirolamo and members of the Human Services Committee. Thank you for the opportunity to testify this morning about the proposed SB675. My name is Michael Kowalski and I am the Medical Director of the Emergency Department at Einstein Medical Center Philadelphia. Our level 1 Trauma Center is the busiest ED in Philadelphia with more than 100,000 visits annually. Every day our ED treats some of the Commonwealth's most vulnerable residents; victims of violence, trauma, and conditions worsened by deep poverty. Many of these patients struggle to access healthcare in a meaningful way with a high percentage presenting with co-occurring mental health disorders. The result of this constant exposure to trauma and poverty too often results in the need to self-medicate with opioids or other substances.

As you know, the City of Philadelphia has been at the center of the opioid crisis with more than 1,100 deaths last year. Emergency Departments like Einstein are often intersecting with persons struggling with OUD at a pivotal moment in time. The right interaction can help move someone struggling with addiction into recovery services. One of the best options for long-term recovery is the use of Medication Assisted Treatment (MAT). Medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a comprehensive approach to the treatment of opioid dependency.

In the Emergency Department, our job is to stabilize the patient and move them to the next appropriate care setting. Our ED has invested a tremendous amount of resources developing pathways to effectively and respectfully treat patients with OUD. One of our best pathways is the warm-handoff for ongoing medication-assisted treatment after an ED induction of buprenorphine. At Einstein we hand-off to many of our City's experienced organizations such as Prevention Point. Although it is worth noting that in this moment, Prevention Point has stopped accepting new patients because they have reached capacity.

Fortunately, we have another option at Einstein. For the past two years, a group of dedicated primary care and behavioral health physicians have worked to build our Welcome MAT clinic. This MAT clinic is fully integrated into our Community Practice Clinic, treating medical and behavioral needs in one setting. This type of integration recognizes addiction as a chronic condition which requires ongoing treatment without stigma, much in the same way a person with diabetes should expect to be cared for. In fact, one of the biggest strengths to this model is that no patient in the waiting room knows that another is there for MAT. An MAT patient will look just like someone visiting for a routine check-up or blood pressure management. This lack of stigma is very different than someone standing outside a methadone treatment center and increases the likelihood of continued care.

While we are extremely proud of our program, I will be honest, it has not been easy to build. We continue to struggle with engaging our primary care physicians to prescribe buprenorphine.

Many already view the 8-hour X-waiver training as a cumbersome process. My concern with this legislation, in its current form, is that it will add yet another barrier to access crucial treatment for both prescribers and patients.

Diversion is a complicated issue. It is a problem and should be addressed. Diversion will probably go down with this legislation, but so will availability and so will the number of patients being treated. Many individuals do not buy heroin to get high, they use it to stave off withdrawal and function, but every use of an opioid increases their risk of death. I met a patient this past week who was a long-term user of opioids. This patient shared with me that buprenorphine on the street now costs $10 dollars, it is down from $30 and costs the same as a bag of heroin. This means that someone who wants to control their withdrawal no longer must buy heroin at a cheaper price just to function. He/she can buy diverted buprenorphine for the same price and not risk overdosing. Obviously, this is not ideal, but that person is still alive. We want to see this person get into treatment including behavioral health support.

On behalf of myself and my colleagues at Einstein we would 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;
- Removal of prior authorization requirements for use of monthly injectable buprenorphine.

I thank you for your support and respectfully request the Committee works closely with those of us on the frontlines of this epidemic to develop legislation that addresses diversion without imposing barriers on providers and patients which will result in fewer people accessing this life-saving treatment.

Thank you.

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