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HEALTH SYSTEM

Testimony on Heroin before the Center for Rural Pennsylvania
By Dr. Margaret Jarvis, Marworth Alcohol & Chemical Dependency Treatment Center, Geisinger Health System
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Good afternoon. My name is Margaret Jarvis. I am the Medical Director for Marworth, an alcohol and chemical dependency treatment center which is part of the Geisinger Health System and located just north of us in Waverly. I would like to thank Senator Gene Yaw and the Center for Rural Pennsylvania for the opportunity to participate in today's discussion on heroin addiction and treatment.

The work that you did last summer proves that this is a group which can get things done. I hope, as all of you do, that Pennsylvania's Prescription Drug Monitoring Program ("PDMP") will soon be funded and operational. This is a crucial tool.

As this epidemic has affected the nation, many of my professional colleagues have been pulling their hair out trying to address it. What we are seeing is that many of the tools that we have used to treat other addictions have not worked well in this population, and we don't really know why. There's a great deal of speculation, but we really don't know.

- Could there be something about the pharmacology of opiates that affects the brain more vigorously than other abusable chemicals?

- With the current epidemic, where many of the affected people began using opiates as teenagers, is there something about the effect of the chemical on the still-developing brain that causes a different disease trajectory from other chemicals?

Over the last 5-8 years, the demographics of the patients that we've seen at Marworth has changed from about 80 percent middle-aged alcohol addicted people to 60 percent young, opiate-addicted people. Addiction is a chronic, relapsing disease, and we've always seen obituaries for people we've treated over the years, but we are seeing this happen much more frequently now. It seems like, compared to other chemical addictions, addiction involving opiates has a telescoped trajectory, moving from first use to death more quickly than with other chemicals.

Here's what we do know:
People using opiates are dying in huge numbers.

Those opiate-dependent people who do access treatment often don't engage and commit to psychosocial aspects of treatment such as therapy and 12-step work. They don't show up, and if they do, they don't participate well.

Using agonist, (methadone) partial agonist (buprenorphine) or antagonist (naltrexone) medications seems to help maintain engagement with treatment IF THE MEDICATION IS HANDLED WELL. We hope that, if they maintain engagement, eventually some of the therapy will take hold.

It takes specialized knowledge and experience to handle these medications well.

- The agonist and partial agonist medications are abusable and get diverted to the street.
- The antagonist medication scares most opiate addicts and convincing them to use it requires time.

There are very few doctors who know how to handle these medications.

- Addiction is a stigmatized disease and very little training about it occurs in medical school or residency, even in those residencies where you might expect it (i.e., psychiatry).
- A study done in 2009 predicted need for 7,000 full time addiction medicine doctors by 2020. By the end of this year, there will be 3,900 doctors who have the American Board of Addiction Medicine certification. Many of these doctors practice Addiction Medicine part-time.
- There are doctors who do not handle these medications well, who prescribe, anyway, and this has led to further addiction.
- There are some certifications that indicate that a doctor has the extra knowledge needed: American Board of Addiction Medicine certification; American Board of Psychiatry and Neurology Addiction Psychiatry certification.

Naloxone is a short acting antagonist medication that is used to reverse overdose and can be put into the hands of first responders and the lay public.

What can policy makers do to address this:

1. Support having these medications available IN THE RIGHT HANDS – in these circumstances, there is no sensible, evidence-based way to limit dosage or time that a person might be on these medications.
    a. There are places in PA where there are pharmacies that are putting up barriers to the use of these medications by doctors who do know what they are doing.
    b. Consider adding methadone maintenance to Medicaid benefits.
2. Support the education of doctors who will know how to handle these medications and how to treat this addiction.
    a. New York State provides financial support to the University of Buffalo Addiction Medicine Fellowship – perhaps PA could help fund more fellowships.
        i. Geisinger Marworth Addiction Medicine

        ii. UPenn Addiction Psychiatry
        iii. UPitt Addiction Psychiatry
    b. Help offer loan forgiveness to addiction medicine doctors who practice in rural PA.
    c. Several other states have made CME about addiction a requirement for relicensure.
    d. Encourage increased numbers of primary care doctors to use these medications IF IT CAN BE DONE WELL.
3. Support the safe and effective practice of medicine around this.
    a. ASAM recently published the Guideline for Use of Medications in the Treatment of Addiction Involving Opioid Use.
    b. FDA REMS program for buprenorphine.
4. Continue to support use of naloxone (Narcan) by first responders and lay people.
    a. Enabled this legally last year.
    b. Could this be a Medicaid benefit?

We look forward to continuing to partner with the various state and local agencies, the General Assembly, and the Administration on developing smart healthcare policy that supports each person's unique circumstances and needs on the road to recovery.

Thank you and I'm happy to answer any questions that you may have.