Front Lines of the Fentanyl Crisis: Supporting Communities and Combating Addiction through Prevention and Treatment

May 23, 2024

Written Testimony for Jeanmarie Perrone, MD
Professor, Emergency Medicine and Medical Toxicology
Director, Center for Addiction Medicine and Policy
University of Pennsylvania
Philadelphia, PA

The opinions expressed in this testimony do not necessarily represent those of the University of Pennsylvania Health System or the Perelman School of Medicine.

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you inviting me to share my experiences as an emergency physician in a busy emergency department in Philadelphia, a city with the highest overdose death rate of any city in the country. Although statistics are dramatic, nothing is worse than facing a parent whose son or daughter has been brought to our hospital after a fentanyl overdose.

The struggles and anguish of a patient or parent battling opioid addiction and navigating the morass of lethal pitfalls in this chronic relapsing disease is heartbreaking. In the chaos of missed appointments, we recognized that the emergency department can be a gateway to same day treatment: initiating the first dose of life-saving treatment with suboxone or methadone while still in the emergency department. Multiple randomized control studies have built the evidence demonstrating that treatment with these medications can reduce the risk of fatal overdose by 65%.[1] Yet, only 11% of people with opioid use disorder (OUD) receive these medications due to provider and patient level barriers to treatment.[2] Appointments, insurance, transportation and pharmacies stand in the way of a first dose of this life saving medication.

We started a program to provide these medications in our emergency departments in 2018 and have treated thousands of patients. My colleagues have been trained in prescribing these medications and our nurses and staff help to identify and support patients to take that step. We have a grant funded peer led model that allows for someone with lived experience to guide the patient while they consider treatment options, and that peer can align with their next steps in getting the patient to the pharmacy, transitioning to a primary care doctor for continued medication, follow up appointments, transportation, reminders and insurance re-instatement. This is one component of low barrier treatment, meaning that the patient doesn't need an

[1] National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.

[2] https://ldi.upenn.edu/our-work/research-updates/lowering-the-barriers-to-medication-treatment-for-people-with-opioid-use-disorder/

insurance card, or identification or a primary care doctor. He/she doesn't need to wait weeks for an appointment or be subject to various scrutiny, all of which can derail early attempts at recovery.

In 2020, both COVID19 and fentanyl combined to make the drug epidemic more lethal. Patients feared coming to our emergency departments for treatment while social isolation compounded the risk of fatal overdose. Fentanyl was replacing heroin in the illicit opioid supply so typical dosing was suddenly resulting in overdoses and as fentanyl was more potent but shorter acting, patients were using more frequently, resulting in more infections and hospitalizations. However, swift changes in regulations allowed for temporizing treatment access with telehealth which allowed us to shift some of our resources to a virtual platform.

Telehealth has created a critical safety net more cost effective than the emergency department and more patient centered than typical care settings. Through funding from Philadelphia Department of Public Health, our CareConnect warmline offers free telehealth substance use navigation and same day clinician appointments to start treatment with buprenorphine. We leveraged our peer led model to staff 9AM-9PM 7 days/week. We have now treated over 1500 patients via telehealth, including 10% of our patients who report release from incarceration in the past 30 days. Creating this important medication safety net for citizens re-entering the community mitigates this high-risk period and is critical to closing the treatment gap that patients face when they leave carceral settings. We have also expanded other services for this vulnerable population including assistance with food, clothing, navigating insurance applications, phones and transportation to future appointments.

A Ryan White funding model could be used to establish regional networks of telehealth "addiction bridge" treatment to prevent gaps in care and continue patients on medication during care transitions such as hospitalization to outpatient, incarceration through release and pregnancy to parenting. We have found that 2/3 of our telehealth patients were recently on buprenorphine and were discharged from a rehabilitation facility without a timely follow up prescription or lost insurance or faced a life event where their care was disrupted. Experiencing opioid cravings without medications can drive patients back to the street only to face the most lethal supply and potentially overdose. Creating low barrier models such as telehealth bridges enhance retention in buprenorphine treatment. Telehealth can also solve long appointment wait times in rural areas due to provider gaps. We must sustain current exceptions to federal regulations for telehealth and create billing parity for services provided via telehealth comparable to in person.

Telehealth can also address important treatment access disparities. In the Philadelphia area, there has been a 30% increase in fatal overdoses in communities of color since 2020. Fentanyl adulteration of the stimulant drug supply has yielded a new cohort of patients with opioid exposures. Qualitative interviews from our community advisory board share that they want more privacy in their substance use treatment options—they don't want treatment in public addiction clinics or opioid treatment programs. We need to focus on developing culturally informed treatment options, medication preferences and harm reduction tools to address these disparities. Telehealth can help establish care with more privacy and then transition patients to a primary care integrated model where patients can have their addiction medication with their hypertension and diabetes medication all from one trusted provider.

Our patients transition from our ED or telehealth bridge to our primary care colleagues that have integrated addiction care into their treatment expertise This integrated primary care model needs to be expanded and reimbursed to sustain discrete treatment options. This will require investment in clinician workforce including expanding addiction medicine training in graduate medical education as well as support for expanding training programs and trainees for addiction medicine fellowships.

Federal strategies for consideration

As Congress considers next steps to addressing this issue, my colleagues from Penn Leonard Davis Institute and I offer several points for consideration:

1. Integration of Care and Lowering Barriers: Patients who use substances present for care at a variety of touchpoints, including hospitals and emergency departments, primary care offices, harm reduction organizations, jails and prisons, and many settings outside of traditional substance use treatment settings. Patents may also have complex medical, behavioral health and social needs that are not well-addressed in the current relatively siloed treatment system.
    a. Increased funding, including higher levels of reimbursement, for more integrated services at all of these locations.
    b. Requirements for specific settings such as post-acute care and skilled nursing facilities to provide needed medical and substance use care (e.g., medications for opioid use disorder like buprenorphine and methadone).
    c. Welcoming, patient centered care for people with substance use disorders at whatever locations they happen to seek care, which may involve funding for evidence-based stigma reduction continuing education programs for staff.
    d. Requirements for criminal legal system to provide treatment for substance use disorders, including buprenorphine and methadone, in their facilities.

2. Methadone Access: This is a dynamic area of policy with recent changes in SAMHSA guidance and pending legislation about expanding access for methadone. Although we remain hopeful that legislative action will further expand access to methadone and integrate it within the care continuum, there are many opportunities within current regulatory standards to increase methadone access and retention and to better integrate methadone within the broader care continuum.[3]
    a. Improvement of existing methadone clinics requires stronger mechanisms for quality assessment in line with the most up-to-date scientific evidence, including mandates that require clinics to adopt rapid access protocols.

[3] Samet, J.H., Botticelli, M. & Bharel, M. (2018). Methadone in primary care — one small step for Congress, one giant leap for addiction treatment. *N Engl J Med* 2018; 379:7-8 DOI: 10.1056/NEJMp1803982

b. Consider policy changes allowing for methadone access at primary care clinics and pharmacies, which would significantly improve access and lessen the burden on patients.

3. Billing: Current billing mechanisms that don't provide reimbursement for registered nurses and certified recovery specialists seriously limit robust, evidence-based interdisciplinary approaches to substance use disorder treatment.
    a. Create billing mechanisms for reimbursement of nursing and certified recovery specialist services.[4]
    b. Provide equal or higher reimbursement rates for mobile or street-based substance use disorder care. These settings reach patients where they are and deliver essential care

4. Harm Reduction: Harm reduction services such as syringe access, overdose prevention[5], and drug checking are evidence-based interventions in the substance use disorder treatment continuum. These programs are vastly underfunded.
    a. Allow for federal funding for every aspect of syringe access programs, including safer use supplies such as syringes and pipes.
    b. Increase the availability of low-barrier small grant programs that allow community organizations without complex grant infrastructure to apply for funding.
    c. Expand drug checking and surveillance programs to ensure that experts across the country can keep abreast of changes to their local drug supplies.

In closing, I want to underscore the importance of funding interventions that work at scale, through Medicaid, Medicare and private insurance, and to focus on the importance of peer recovery services. Our programs utilize the wisdom and experience of peer recovery specialists, people in recovery from opioid use, who build alliances with patients and help them navigate the early treatment journey. Peer training programs provide a pathway to employment for people in recovery. We must expand this workforce by developing billing and reimbursement strategies for these services that can be initiated in ED visits, primary care and inpatient hospitalizations so we can grow opportunities for people with lived experience. Their journeys destigmatize and provide role models to our community members and patients struggling with addiction and are a source of inspiration—people do recover and we need to share that narrative.

Thank you again for the opportunity to share this with you today, and look forward to your questions.

---

[4] Kaur, M., & Melville, R.H. (2021). Emergency department peer support specialist program. *Psychiatr Serv*, 72(2), 230–230.

[5] Walley, A.Y., Xuan, Z., Hackman, H.H., et al. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*, 346.