Center for Rural Pennsylvania – Public Hearing

"Heroin Crisis Affecting Rural Pennsylvania"

Testimony by Community Care Behavioral Health Organization
August 13, 2014

My name is James Schuster and I am the Chief Medical Officer for Community Care Behavioral Health Organization. Community Care is a 501(c)3 not-for-profit managed care company that is part of the Insurance Division of UPMC. We manage HealthChoices Medicaid behavioral health services on behalf of OMHSAS and 39 Pennsylvania counties, most of which are considered rural. (Please see slides 2 and 3).

Pennsylvania has the third highest number of heroin users in the United States, numbering approximately 40,000[1]. For the first time in many years, heroin use is on the rise nationally, as is prescription opioid use and addiction. (Please see slide 4). It is believed that the upswing in the numbers of individuals with a heroin addiction is at least partially attributable to prescription opioid users switching to a street drug that is more readily available and cheaper. Whatever the reason for the rise of both problems, they are serious and result in loss of life and other negative effects on the lives of our members, families and our communities. Community Care recognizes that some factors make this problem especially difficult to address in rural Pennsylvania. These items include sometimes limited access to a full range of quality prevention, early intervention and treatment service options as well as access to the community based recovery support services necessary to support long term recovery.

We are working to address these many challenges through the framework of a recovery-oriented system of care (ROSC). This approach demands that we first recognize substance use disorders

[1] Retrieved from NewsWorks http://www.newsworks.org/index.php/local/item/60847-heroin October 14, 2013

as a major community health problem that requires a collaborative approach with all of the systems working together to enhance our treatment and recovery support services. This is a very challenging process as there remains much stigma directed towards those with substance use disorders, particularly opioid users, and this is certainly a factor that deters those who need treatment from seeking care. We know that most individuals who need treatment do not receive it, and that most of those who do not receive treatment do not believe that they need treatment.

Quality recovery management of this chronic disease of addiction demands that we acknowledge many pathways to treatment and recovery. To move forward we need to expand prevention and early intervention approaches, including harm reduction approaches that meet individuals where they are. This includes, for example, expansion in the use of naloxone to prevent deaths due to accidental overdoses. We need to make sure that treatment is easily accessible and we need to expand the treatment approaches that have been shown to work with those who are addicted to opioids—both prescription drugs and heroin.

These approaches include pathways through what is often referred to as "drug free" treatment in residential and outpatient care and we must ensure that all levels of this care are readily available to residents of our rural communities. Medication-assisted treatment (MAT) also provides opportunities for many individuals and I want to spend a few minutes this morning discussing that intervention, as it has the strongest evidence base for addressing heroin and other opiate addictions. Methadone, buprenorphine and Vivitrol are three medications to consider that are particularly important in addressing the current heroin epidemic. Historically, both methadone and buprenorphine treatments are been questioned by some as to the effectiveness of these services, particularly as stand-alone services. For example, we have seen significant growth in the number of individuals receiving Suboxone, but many individuals who are prescribed this medication do not also receiving the psychosocial services they need. (Please see slides 5 and 6). There are other concerns about treatment with methadone which I will also touch on

Community Care has committed to quality improvement initiatives in a number of areas including medication-assisted treatment. This effort includes the publication of best practice guidelines for Suboxone. Created with extensive input from regional stakeholders and national experts, these

guidelines are serving as an important reference for quality improvement efforts in the use of Suboxone in Pennsylvania. There are currently a number of efforts underway involving counties, providers, DPW and DDAP to identify strategies that can support effective treatment models. Community Care also recently issued guidelines for methadone treatment strategies that will support individuals' recovery. These guidelines include a focus on areas which are sometimes concerning in methadone treatment, such as concurrent psychosocial interventions, a focus on individuals' recovery goals, and an assessment of eventual transition off of methadone. We will be using this methadone information to develop quality guidelines with providers and counties. Finally, in partnership with Community Behavioral Health (the Philadelphia County owned behavioral health MCO) and IRETA, we have developed best practice guidelines addressing the issue of concurrent use of methadone (and other opioids) and benzodiazepines. It is the combination of opioids and benzodiazepines that has been the cause of many overdose deaths and these guidelines provider multiple strategies for providers to use to minimize this risk in individuals receiving methadone treatment.

Several years ago, we initiated a quality improvement initiative with methadone providers to reduce the concurrent use of methadone and benzodiazepines, as well as concurrent prescribing of other opioids and are pleased to report that this has resulted in a reduction in this problem. (The attached slide 7 shows results from Allegheny County which has the longest history of this effort). We do believe that partnerships such as these consensus efforts on best practice guidelines and quality improvement initiatives with providers and other stakeholders can result in improved care; and that such partnerships are critical to addressing the current epidemic.

In conclusion, I would like to list some key themes for the committee to consider as it moves to develop recommendations:

1. Recovery-oriented systems of care are the strongest framework for prevention, intervention, treatment and recovery services in this state; embracing person centered enhancements that can improve recovery outcomes for all.

2. Medication assisted treatment, despite the quality challenges associated with them, are likely to remain an important part of the treatment system and at least many of the quality concerns can be ameliorated with sustained, multi-stakeholder efforts.
3. Engagement and retention strategies that can increase the number of individuals entering into treatment and recovery. NIDA has identified 90 days as the time for a minimum episode of care, and many individuals will need years of connection. Enhancing the strength of our community based treatment, peer, and case management services will be useful interventions.
4. Expanded use of naloxone can prevent deaths from accidental overdose, including availability to family members and friends and available for distribution through providers and pharmacies.
5. Leadership of a sustained statewide strategic initiative that involves all stakeholders—government, funders, advocates, providers and persons with lived experience—can help us move forward with an agenda that ensures that individuals addicted to opioids are given the opportunity to participate in effective treatments and the necessary recovery support services for long term recovery.

Thank you for the opportunity to give testimony today on behalf of Community Care and our members. We appreciate your efforts to address this crisis and look forward to opportunities to support the implementation of your recommendations.