Geisinger

**Testimony on Drug & Alcohol Addiction with a Focus on Opioid/Heroin Abuse**
**By Dr. Margaret Jarvis, Marworth Alcohol & Chemical Dependency Treatment Center, Geisinger Health System**
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Thank you for the opportunity to provide written comments on drug and alcohol addiction, with a focus on opioid abuse. My name is Margaret Jarvis. For the last 16 years I have been 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 Scranton in Waverly. I am also a psychiatrist who has taken care of addicted patients for my entire career. I completed all of my training, including a fellowship in Substance Abuse Medicine, at the Medical College of Virginia in Richmond. I would like to thank Representative Kaufer, Chairman Benninghoff, and the House Policy Committee for the opportunity to share my experience and professional input on drug and alcohol addictions.

We are all reminded, on a daily basis, of the extent of the opiate epidemic, both in the numbers of people affected and the tolls taken in those lives. As you have heard in other testimony, there have been contributions to this epidemic from the prescription of medications used for pain. These practices started with well-intentioned campaigns to alleviate pain. Sadly, at the time that this started and to the present day, we do not know enough to be able to predict vulnerability to substance use disorders to continue these prescribing practices without consequence. Many physicians, and most especially primary care doctors, have been put into the position of being expected to alleviate pain, avoid contributing to addiction and to do this in less-than-15-minute office visits without having expertise in either pain or addiction. It truly is no wonder that we have arrived at this moment.

I am often asked by primary care physicians how they can get their patients off of opiates and other addicting medications. They don't have the tools or the infrastructure to do so, in most cases, and they are frustrated and disheartened by this. They know that their patients have an illness that they are unprepared to treat. Changes like the Prescription Drug Monitoring Program can help identify patients who are having behavioral problems around medication, and can help contain those behaviors. This will be useful to many primary care physicians.

Addiction specialty care is often not readily available, and the channels through which referrals are made to addiction specialty care are different than when the referral is to "medical" specialty care such as cardiology. This makes it that much more difficult for the primary care physician to get an addicted patient into treatment. Even if those referrals are consistently made, we know that the specialty physician workforce is nowhere near the capacity it needs to be in order to address this problem.

I hope that you will consider supporting physician education about the disease that is ravaging our country, especially at the level of specialty training. There has been much talk of continuing education training that could be associated with state or DEA licensing, and concern has been raised that this would be consciousness raising, at best, without much true transfer of knowledge. There has been debate about training associated with expansion of the number of buprenorphine patients an individual

doctor might have, and while that may go some way to address the current epidemic, it will not be so useful if the next epidemic is one of sedative-hypnotic drugs or stimulants.

Currently, there are 39 addiction medicine fellowships and 43 addiction psychiatry fellowships across the country. The American Board of Addiction Medicine has been working hard over the last 10 years to expand the number of fellowships, and to gain recognition by the American Board of Medical Specialties, and has been quite successful with this. Now, we need to encourage physicians to take advantage of these training opportunities, perhaps through loan forgiveness programs or other ways. We need these doctors to be able to lead teams of nurses, counselors and other healthcare professionals. We also need these specialist physicians to work side by side with other physicians in emergency departments, hospital wards and clinics. By seeing that addicted patients can be treated, that treatment can be successful, other doctors not only start to pick up the technical points of treatment, they can develop compassion for the addicted patient. By having a cadre of well-trained addiction specialist physicians, we can be address the current opiate epidemic and be prepared for the next chemical that gains popularity.

Emphasizing the need for specialty training, with attendant professionalism, quality improvement and maintenance of certification can also address the growth of untoward, often unethical, so-call addiction services where buprenorphine is prescribed in ways that are not therapeutic and can be quite harmful. Given the choice of sending patients to physicians whose only addiction training has been the 8 hours needed to get an x-waiver or to specialists who have had at least a year of training, most primary care doctors, health system administrators and insurers would prefer to see patients receiving true specialty care. Many geographic areas don’t afford that kind of choice.

Marworth/Geisinger has had an addiction medicine fellowship since 2007, and the first person to complete the fellowship has returned to be the fellowship director. All of the doctors who have completed the training have gone on to gain certification from the American Board of Addiction Medicine. We are very proud of our graduates, and we see them doing great things to take care of addicted patients across the country. We would believe that they are the doctors who will ultimately make addiction a disease that is treated in the same way that diabetes, coronary artery disease and schizophrenia are treated

We look forward to continuing to work with the state legislature, state agencies, and the Administration on developing smart healthcare policy that supports improving the experience of healthcare, improving the health of populations, and reducing per capita costs of healthcare.

Thank you.