Testimony for House Republican, House Democratic and Senate Democratic Policy Committee Hearing
Tuesday, August 16, 2016

Lisa Feldman, Director of Program Development
Resources for Human Development
4700 Wissahickon Avenue, Suite 126
Philadelphia, PA 19144

Good Afternoon, my name is Lisa Feldman and I work as the Director of Program Development for the PA Behavioral Health and Housing Division of Resources for Human Development. Thank you Representative Donatucci, Chairman Benninghoff, Chairman Sturla, Chairwoman Boscola and members of the PA-HOPE Caucus for inviting us to provide testimony today and for holding this very important hearing.

I am going to speak today about a number of barriers to treatment, and although we often see some or all of these barriers in many of our addiction treatment programs, for the purpose of this testimony, I will be referring specifically to one of our programs that works daily fighting the opiate and heroin epidemic, our newly designated Center of Excellence, the Montgomery County Recovery Program.

The main barriers would include the following:

1) Access to Treatment: People have difficulty navigating the system of providers as well as their specific insurance coverage. The process to access treatment can be circuitous, confusing and frustrating. Admission into a particular level of care for treatment is often denied or length of stay is not adequate especially with detoxification and rehabilitation beds.

PA are also very inconsistent in their approach to MAT. There are drug courts in certain counties in Pennsylvania that ban participants from using MAT and other counties that allow it. So, a person in a particular county may be faced with the choice of giving up a life-saving medication that helps them maintain their sobriety or go to jail to continue to receive said medication. While someone in a neighboring county with a different judge may not be faced with such a choice.

6) Inconsistent Coordination Between Providers: The system is fraught with breakdowns, some of which can be attributed to a lack of communication between providers and a complicated system for individuals to navigate. This can be an impediment to smooth transitions from one level of care to another and doesn't allow for a high level of continuity of care.

7) Physician Overprescribing: Another barrier is the lack of accountability for physicians regarding the number of prescriptions written for opiate pain medications. Most physicians prescribe responsibly, however, this crisis tells us that many do not.

8) Stigma: Prejudicial and discriminatory views of opiate addiction as well as MAT can contribute to fewer interventions or referrals.

I'd like to finish my testimony with a recent experience our program director had with a person seeking treatment at the Montgomery County Recovery Center.

Day 1) On July 21st 2016, a former client presented himself to our clinic for readmission. After an assessment was complete, it was determined that he was very much in need of stabilization prior to being readmitted to the clinic for methadone maintenance treatment, which is an outpatient level of care. The program director shared this recommendation with the client. He agreed. The Program

home. He thankfully came back to the clinic. The program director at this point called her local county for additional support. She explained the situation and asked if there was any way they could fund an admission for him to receive the treatment he so desperately needed and was clearly motivated for. They agreed. In order to get inpatient treatment with County funding, he needed to be assessed at an assessment center. No appointments were available that day, one was scheduled for the next day. She spent the rest of the day trying to locate available beds.

Day 6) He went for his assessment. No beds available that day.

Day 7) He was finally admitted to a rehab on Friday, July 29th, which is 9 days from when he first walked into the clinic seeking help. The rehab kept him until August 3rd and then discharged him. In totality, he ended up receiving treatment for less days (6, which includes his admission and discharge days) than it took for him to be admitted (9 days).

This man was actively using drugs with the help of a primary care doctor who according to the client was prescribing opiates, Fentanyl patches, Percocets and morphine. The client was also using street heroin. He suffers from mental health issues and has had ECT in the past for depression. He is also diabetic, has hypertension and neuropathy in his feet.

Had this person not had a prior relationship with the clinic and the program director, he probably wouldn't have remained as engaged with the clinic through this lengthy and exhausting process, and it is likely that we may have missed the opportunity to get this person the help he needed at that time.