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Pennsylvania Osteopathic Medical Association
Testimony, House Human Services Committee on Senate Bill 675
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Good morning Chairman DiGirolamo and Chairman Cruz. Thank you for the opportunity to provide testimony this morning on Senate Bill 675 and on behalf of the Pennsylvania Osteopathic Medical Association (POMA).

My name is Dr. Donna Eget and I am an osteopathic physician trained in emergency medicine. I practiced emergency medicine for fourteen years in three different hospitals in northeast Pennsylvania before opening Medicus Urgent Care in Dunmore, in 2009. Dunmore is a small borough just north of Scranton, in Lackawanna County.

In addition to treating urgent care patients, for the past five and a half years, I have also been treating patients with Substance Abuse Disorder with the medication buprenorphine.

Medicus also provides counseling services to patients. My office is licensed by the state for D&A counselling, so I have a vested interest in patients receiving counseling while taking buprenorphine, and I suspect I would benefit financially if this bill passes. That, however, is not the reason I went into medicine, so I have to speak out against this bill.

My experience with treating patients in a setting where resources are limited suggests that Senate Bill 675, as it is written, will make it extremely difficult for physicians to provide care to patients. If the intention of this bill is to help patients in need, I think it will be a failure.

The access to behavior health services is just not available in the scenarios providers encounter every day in treating opioid addicted patients.

For example, I have worked with the Lackawanna Recovery Coalition to establish a WARM HAND-OFF program in our local ERS. Patients who overdose and are revived with Narcan are in a crisis state. These patients need help immediately, often in the form of buprenorphine. This Warm Hand-off program and others like it are helping patients in crisis to transition into recovery. It is saving lives. Senate Bill 675 would require the presence of a certified D&A counsellor in the ER to help these patients. Even if a counsellor was available, he probably wouldn't help much. How can someone in withdrawal—with their brain impaired by disease, with vomiting, diarrhea, sweating, excruciating muscle pain, and horrible anxiety—How can they engage with a counsellor?

Once this patient type is stabilized, counselling will be a vital part of his recovery. But not when he's in crisis.

Another scenario is the patient who I just saw last Saturday, 10 days ago. His name is David and he became dependent on opioids because of Rheumatoid Arthritis, eventually using a dose of Fentanyl 50 mcg patches and 120 mg of oxycontin daily.
For those of you who are unfamiliar with these medications, that's the equivalent 40 Percocet tablets that you or I would normally be given for acute pain management. You and I would take 4 a day, and David was taking 40.

Because of increased scrutiny of physicians, his doctor decided to stop prescribing these medications. Pain and withdrawal led him to desperation. The night before he came into my office, he was caught by police while trying to buy drugs off the street. He was put into a special program by the Scranton Police which delayed his charges so he can get help for his drug use.

When I saw him that day, his urine drug screen showed fentanyl. Fentanyl is linked to 70% of overdoses in Lackawanna County.

I immediately started this patient on buprenorphine. When I next saw him, the fentanyl was gone from his urine. He still had pain, but no withdrawal. Other than a little insomnia, he said he felt normal.

The buprenorphine helped. Counselling was a non-issue, because he wasn't able to get an appointment with a counsellor *one week.* One whole week. In my experience, this delay is not unusual. Unfortunately, in Northeastern PA, there are more patients than counselors.

If this patient hadn't been treated with buprenorphine, if he had been forced to go into withdrawal because of Bill 675, I'm sure he would have been back on the street buying fentanyl. He might even be dead.

These are just two examples, but the point I am trying to drive home is that even in different scenarios, the results of the patient encounter are the same—if buprenorphine is given when a patient is in crisis, it is likely to help them. If treatment is delayed by blanket mandates for counseling in facilities licensed by the state, physicians will be powerless to help these patients, and people will die.

Another point to consider is access to care for some of my patients. Because I accept medical assistance, I see patients not just Lackawanna County, but adjacent counties as well—Susquehanna, Wayne, Pike, Monroe, Luzerne and Wyoming counties. Many of these counties are rural, where patients don't have access to medical providers that prescribe buprenorphine. It is unlikely that they will have access to counselling providers, either.

I understand that there are problems with the current standards of care for patients with buprenorphine. Some doctors accept only cash for their services. Patients sell their medication. Some patients doctor shop and there is no continuity of care from one provider to the next.
But Senate Bill 675, as it is currently drafted, will not help these issues. I will only hurt patients.

POMA and other doctors like me are willing to work with the Committee to seek a solution to curbing problems with the current system, but as my testimony today explains, a blanket mandate tying the hands of physicians will only shut off access to care for many vulnerable members of society that desperately need help. And in the most extreme cases, that help really can mean the difference between life and death.

Thank you for the opportunity to be here today. I will be happy to answer any questions you may have of me.