

NEW YORK STATE JOINT TASK FORCE ON OPIOIDS

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My name is Debbian Fletcher-Blake. I am a family nurse practitioner and the CEO of VIP community Services, a community partner in the Bronx for 45 years. We provide, among other services, addiction services, housing and medical and mental health care to Bronx residents.

Thank you for the opportunity to testify on this extremely important topic that has ravaged the Bronx community. I also want to thank New York State for its boldness in leading the charge to reduce the impact of the opioid epidemic on its people. We still have tremendous work ahead, requiring us to address both the structural and social determinants of this disease.

While we continue to create access to treatment, we need to pause to evaluate the barriers to care that are responsible for the number of overdose deaths in our community.

- 1) **Regulations:** There must be harmonization of regulatory requirements to reduce the complexity of treatment. Treatments are complicated by conflicting regulations, such as the differing federal and state privacy standards. The regulations often set up structures that are prohibitive to care and limit access to medications and therapies that will save lives. For example, Medicaid laws prevent same day billing for patients that seek physical health treatments and behavioral health care. Often, physical health care is the gate way into behavioral health care. Requiring patients to come back another day leads to missed opportunities.
- 2) **Contagiousness:** Substance use shares similarities with HIV disease. Substance use is a chronic disease and is also contagious in nature. The contagiousness is evident in our community. People often use substances in groups, families are affected when family members are addicted to opioids, opioid use is sometimes associated with promiscuous behaviors -- the list goes on.
- 3) **Need for Compassion:**

The same level of compassionate care available for HIV is necessary for opioid use. I'll outline a few ideas:

- a. **More treatment options:** Research specific to how to rewind the brain chemistry is critically needed. Additionally, we cannot be satisfied with the current medications that are available to treat this disease. Similar to HIV, we need research to provide more individualized treatment options. The rapid pace at which HIV medications were ultimately developed needs to happen with opioid use. We need to remove stigma associated with opioid use and utilize a moral lens for the individual.
- b. **Wrap around services:** People with opioid use disorder (OUD) need wrap around services similar to those provided by VIP. These include, but are not limited to, care management, supportive housing, specific job placement and job support to keep them employed and engaged. Activities to prevent social isolation and services to keep people housed are critical. There must be special needs plans, money for innovating treatments and medications. Given the complex wiring of the brain and the effects of opioid use, simply providing former users of opioids with job training and sending them into the workforce is grossly inadequate and has the great risk of returning them to active use.
- c. **Prevention:** Prevention has played a significant role in the progress that has been made in reducing the number of new HIV cases. We need additional funding and research to determine prevention strategies that will work for OUD. We cannot continue to guess what will work and make decisions on the fly.
- d. **Better understanding of the disease:** We need to change antiquated laws to make medications accessible to people that need them. We need to remove the barriers people face in obtaining medications. Never in my clinical career was I required to have a treatment plan in

place to care for my diabetics or HIV patients in order to receive reimbursement. Never did I ask my patients when they were at the lowest point of functionality to meet pre-determined goals or risk be labelled non-compliant and a failure at treatment. But we do this with the disease of addiction all the time. We ask people whose brain chemistries are twisted to sit with us to develop treatment goals that we use to determine success or failure in treatment. We force them into psychological treatments, such as group therapies, when their brains are less than optimal, instead of waiting until the medication is beginning to work and they can make sound decisions. We ask people with OUD to pee in cups before we prescribe medications as a way to withhold life-saving treatment. We are exceptionalizing and stigmatizing an all too common disease. We should let brain science and compassion guide us.

Thank you.