Written Testimony of

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Hearing on:

Front Lines of the Fentanyl Crisis:
Supporting Communities and Combating Addiction
through Prevention and Treatment

before the United State Senate Committee on
Finance

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Good morning, Chairman Wyden and Ranking Member Crapo. Thank you for the opportunity to speak to you about this critical topic. Thank you to Senator Cantwell, my Senator, for your consistent and impactful leadership on addiction. It is heartening to see the leadership from the Pacific Northwest, Oregon, Idaho and Washington, demonstrate their leadership on the fentanyl crisis by holding this important hearing. As a health services and public health researcher, it is an honor to participate.

My name is Caleb Banta-Green and I have worked to support individuals and communities impacted by opioid use disorder for nearly 30 years. Over this time the predominate opioid has changed multiple times and the models of care and treatment medications have evolved. We have made a dent in the treatment gap, the gap between those with active opioid use disorder and those on the medications methadone and buprenorphine[i]. These medications are the most evidence-based treatments for opioid use disorder—they support ongoing recovery and reduce

mortality by at least 50%[ii] [iii]. Unfortunately, the treatment gap persists, with approximately three-quarters of those with opioid use disorder not on medications.

Opioid treatment programs, primarily using methadone, and medical office based opioid treatment using buprenorphine are excellent models of care[iv]. Yet despite our work for decades, they continue to serve a minority of people with opioid use disorder. Policy makers and health care systems continue to improve these two models of care and expand access, but it is clear we also need a new third model of care as well.

Non-pharmaceutical fentanyl has exacerbated this need for a new model of care[v]. Fentanyl is a very potent and inexpensive drug that presents substantial risk for rapid development of opioid use disorder and fatal overdose. Fundamentally, we need to make it easier to access treatment medications than non-pharmaceutical fentanyl.

As part of our ongoing research, we regularly interview people who use drugs and are accessing overdose and infectious disease prevention services. Our published research shows that 80% of people with opioid use disorder ***do*** want to stop or reduce their use, the majority ***do*** want to be on medications, yet most are ***not*** able to access the traditional health care system[vi]. Further, three-quarters want to obtain health care at the community-based services program, at a place they know and with people they trust[vii].

Over the last 10 years we and others have been developing and testing new models of care based on clients stated needs, health services and public health data, and research supported interventions [viii] [ix] [x]. We are combining a low barrier clinical model, with community-based access points, and a team-based model of care. To support the treatment medication prescriber, we have added vital staff including nurse care managers, mental health care managers, and care

navigators. These care team members provide the majority of face time with clients and provide vital care and supports so that people start and stay engaged. We have been fortunate to have people in recovery from opioid use disorder in these medical and care navigator roles and their insights and ability to quickly build trust with clients have been invaluable. This new care model has positively influenced the care continuum; we are finding that jails and emergency departments that were once hesitant to start people on medications because they thought patients would never be able to navigate the health care system for follow up care, are now starting people on buprenorphine because they know there is a place in the community providing drop in access to medications and other supports.

Community-based health hubs for people who use drugs are showing positive outcomes, including in our research with six rural and urban communities across Washington State where we found significant increases in buprenorphine use and significant declines in deaths [xi]. To date these programs have been funded with one time funds including grant dollars. What we need is a bundled care model with adequate funding to pay for the complete care team in these community-based settings. While there has been some movement that allows for paying for nurse care managers and care navigators or peers in certain circumstances, we need a comprehensive approach inclusive of the low barrier community-based health hub treatment care model, flexibility in community care settings, and adequate funding for the entire care team to manage this complex, chronic, relapsing medical condition.

As one of our clients, an older unhoused women with long time opioid use disorder, told our community staff: *I've been in and out of treatment throughout my life and you are the first people to treat me well. So, I keep coming back and I've brought my friends.*

Opioid use disorder with fentanyl is tough. But we have a third model of care that can help us dramatically close the treatment gap, support recovery, keep people alive, and help restore the health of individuals and communities.

Thank you very much for your time. Please contact me with any questions.

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