Comments of Dr. Kristen Silvia before the Joint Standing Committee on Health and Human Services

Regarding Outpatient Treatment of Individuals with Opioid Use Disorder

April 11, 2017

Good morning. I have been working with patients with opioid use disorder for the past 11 years. I obtained my buprenorphine waiver in 2006 and treated patients in my family medicine office in Scarborough with a fellow physician. Our office lacked the behavioral health supports that are so important to help patients sustain their recovery, but we did the best we could. We partnered with local community resources, encouraged 12 step meetings, and saw patients frequently in the office when they were struggling. More recently, I have had the opportunity to begin to build an integrated medication assisted therapy program at MMC – and now, the entire MaineHealth System - that uses addiction specialists and behavioral health clinicians to support treatment for OUD in our primary care offices.

As you have heard from Dr. Fellers, addiction is a chronic disease of the brain. I truly believe this from my own clinical experience as a family physician. When I see a patient with OUD, I regard their illness no differently from my patients who have chronic illnesses like diabetes, high blood pressure or asthma. All of these patients have times when everything seems to be going right- they are engaged in managing their own health; they take their medications, monitor their diet, exercise regularly and come to their appointments. But there are other times when they are less engaged. Their blood sugar, their blood pressures, lung function are seriously abnormal; they miss appointments, they don't take their medications as prescribed and their health suffers for it. But I don't stop working with them when this happens. I try to figure out what is going on in their lives that is getting in the way of them being well. I see them more frequently to try to get them on the right path. I involve more team members to surround them with more support.

The same is true for patients with OUD. Because this is a chronic, relapsing, remitting illness, they stumble and fall like the rest of my patients. There are times when they need a lot of support and treatment, and other times when all is going well

and they need less intensive efforts. Our health care systems need to be able to meet people where they are and offer them an evidence-based continuum of care based on their level of illness.

You have heard about the benefits of methadone maintenance for patients who have severe symptoms from their disease. For those whose use is very high, who have ongoing use of other substances, who need very close monitoring, this may be the best option.

Some patients who either refuse methadone treatment, or whose disease is not as severe, are best served in an IOP, or Intensive Outpatient Program. An IOP provides behavioral therapies several days per week (typically 3 to 5 days or evenings). Focus is on building the skills needed to support early recovery. Patients are monitored with drug screens, and some programs provide buprenorphine (Suboxone). Other programs do not prescribe buprenorphine but can partner with area physicians who are willing to prescribe the medication. An IOP typically lasts 3 to 6 weeks. Some programs with IOPs offer ongoing support for several weeks or months after the initial treatment for patients who need those services.

IOPs can serve as "hubs" in a hub-and-spoke system such as the Vermont model where patients can start receiving care in the hub, and as the acuity of their illness lessens and they can achieve abstinence and stability, transition to "spokes". In your handouts, we detail the hub-and-spoke model being developed throughout the MaineHealth system. In this type of model, patients are able to move through the continuum of care based on the severity of their illness. Again, like any other disease I see in my office as a primary care doctor, sometimes they fall and need more help, and other times they are doing quite well. We need to be able to match the right level of care to where the patient is at that point in their illness. We expect that, because relapse is part of this disease, a patient may use different parts of the continuum of care at different times in his or her life.

The only way the system can work is if we have an adequate number of "spokes" to meet the demands of patient need. We can do this only in primary care. This is the best place to provide this care. In a patient's medical home, all of their health needs can be addressed. They have strong, on-going relationships with their providers and care teams. Bringing addiction care into primary care is a powerful tool for reducing

the stigma of this illness and treating the patient's needs holistically. My patients with OUD sit in the waiting room next to those with diabetes, high blood pressure and asthma. They are treated the same by staff, with respect and compassion. Indeed, they are in our office one day for OUD treatment and another to get their annual physicals. This is a powerful message to send to a person who has felt less than or dismissed by society because of their illness.

I won't lie to you. Sometimes working with patients who have OUD can be frustrating. The behaviors that are the symptoms of the illness can be challenging. Patients relapse sometimes and are resistant to more support. But they are also my favorite patients. There is no other treatment that I have provided as a primary care doctor that has made a greater impact on an individual's life, and that of their family and community. It is incredibly rewarding work.

Improving access to treatment will require a more robust approach to this epidemic. We need more IOPs so that primary care providers have a place to refer patients who are not doing well in the spokes. And we need more primary care providers to step up and offer this treatment in their offices.

There are several reasons why PCPs are hesitant to offer medication assisted therapy. Most of us were not trained in addiction medicine in our medical schools or residencies. Primary care providers are worried about their offices being flooded with patients needing this treatment and not having the resources to provide it. A large number of patients in need of treatment are uninsured, so many primary care offices cannot afford to add additional unpaid work to their caseloads. Andthere is ongoing stigma even within our medical community that keeps some from participating. This to me is the most tragic part, given that we have helped create this epidemic by our prescribing opioids too freely in the first place.

Primary care providers need the support of specialists to do this work successfully. Whether it be in the ability to refer patients to IOPs or to call a specialist on the phone and get advice, they can't, and shouldn't do this alone.

Those of us providing this care see examples of a health care system that is not meeting the needs of our patients. In my own program, one-third of patients lack health insurance. This is typical for this population-often not fully employed, of lower

socioeconomic status and not meeting the current requirements for Mainecare. I am fortunate in that my hospital system provides uncompensated care to them and pays for their office visits and lab tests. Not all hospital systems are in a financial place to afford increasing their uncompensated care costs. Andthe costs are significant and are only expected to rise as the epidemic worsens. We estimate that it costs at least $6700 for the first year of treatment for the average patient. And for the patients, the cost of the medication can be a barrier to success in treatment. Even with discounts the hospital provides, or with my efforts to prescribe generic buprenorphine and find discount coupons on-line, some cannot afford this life-saving medicine.

I saw a patient just last week who had to make a tough decision because of his lack of insurance. Michael is 27 and has been injecting 3 to 5 grams of heroin every day for months. We accepted him into our program and I started him on buprenorphine. He will likely require a higher dose of medication due to his high tolerance. But when we discussed this, he told me he could only afford half of what I believe he needs. This will make avoiding relapse very difficult for him and he may not succeed in treatment.

Our patients face other challenges to their recovery. Without Mainecare to provide them with help with transportation to our offices, some struggle with getting to the treatment they need.

The lack of sober housing is another barrier. Most of the sober houses that exist in our communities do not allow people to be on medication assisted therapy. So those who use methadone or buprenorphine as part of their treatment have few options. Having a supportive, sober living situation is critical in providing a safe and stable environment for recovery. Many patients are living in places where they remain surrounded by drug use. Their chance of staying in recovery would be much better if they had access to sober housing.

And job opportunities are necessary for those patients who are not currently employed.

I have seen what effective and evidence-based treatment for OUD can do for patients and their families. I will leave you with an example of my patient Julia, age 26. I first met Julia 2 years ago when I was volunteering at the Portland Free Clinic. She came there because she lacked health insurance and was worried about medical

complications from her drug use. Julia at that time was injecting opioids. She was homeless and standing on street corners with a sign trying to make enough money to support her habit and buy food. She told me that she developed a dependence on opioids after having been sexually assaulted and developing post-traumatic stress disorder. Sadly, this is not an uncommon story from many of the women we treat. Julia is a mother, but lost custody of both of her daughters due to her drug use. She had been in treatment at an IOP, trying to get sober, but when she lost custody of her kids, she lost her Mainecare. She had to drop out of the IOP because she couldn't afford treatment. She went back to using drugs and that was the situation when I met her. She was in a terrible situation, but there was something about her, a desire to make a better life for herself, that motivated me to help her. At my urging, she applied for uncompensated care through MMC and began to see me in my office. We were able to secure for her one of only three slots I am allotted by the manufacturer of Suboxone to get her free medicine for a year. She started working intensively with a therapist. Within only a few months, Julia turned her life around. She found a part-time job and was able to get into an apartment. Her boyfriend, also without insurance, started treatment with me. He began working full time. Within 6 months, they were able to get custody of their children back and begin working on being a family again. Today, they are both in recovery, still on buprenorphine, but working and going to school and being parents.

Julia could have been one of the 378 Mainers who died last year from overdose. Instead, she has a good chance of staying in recovery and providing a stable life for her children. The investment we make in her, and others like her, is not an insignificant one. It requires a robust response to a terrible epidemic that is claiming more than one of us every day. Health providers need your support to do all we can to turn this around before it gets worse. Thank you.