RECOVERY WORKS NORTHWEST
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House Committee on Health Care

Oregon State Legislature

900 Court Street NE

Salem, OR 97301

RE: Support for HB 4143 directing DCBS to study barriers to medication assisted treatment for substance abuse disorders

Dear Chair Greenlick, Vice-Chair Hayden, Vice-Chair Nosse, and members of the committee,

Recovery Works Northwest is a medical assisted treatment facility that provides affordable, sustainable addiction treatment for opioid-addicted patients. Our providers have 35 years of combined experience in drug addiction treatment, our effective, unique model develops personalized plans to treat opioid addiction.

As medical assisted treatment providers, we appreciate and support Governor Brown's desire to address the opioid crisis, starting with House Bill 4143. This bill has three main goals: (1) study the barriers to medically assisted treatment for substance abuse disorders; (2) pilot a peer recovery support specialist program in emergency departments; and (3) require opioid prescribing practitioners to register with the prescription monitoring system (PDMP).

We support the Department of Consumer and Business Services (DCBS) studying the existing barriers to MAT. We believe those barriers include a lack of providers, especially those who treat patients on the Oregon Health Plan (OHP), and a lack of training. We believe that the review of reimbursement rates for Medicaid providers will help address this issue. Additionally, restrictions (DATA2000) around buprenorphine prescribing makes it more difficult to site(?) MAT clinics than methadone clinics. We

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encourage DCBS to review and improve the current regulatory framework, with the goal of including and promoting the next generation of opioid treatment centers.

We are concerned by the current treatment of substance use disorders as acute illness rather than a chronic one. This goes against the current disease model of addiction, as even the Diagnostic and Statistical Manual of Mental Disorders (DSM) has it listed as a chronic illness. By categorizing these disorders as chronic illnesses, the distribution of resources would focus more on disease maintenance to prevent frequent ER visits and overdoses which are much more expensive. At current time it does not seem as though hospitals are being held accountable. In other chronic disease states such as Congestive Heart Failure, hospitals get dinged for any readmission to the hospital within 30 days of discharge. This motivates them to be a more active member of the treatment continuum.

We believe that placing peer recovery support specialists in emergency rooms is a great idea and a good first step. But in order to adequately address the opioid epidemic, there needs to be treatment centers for peer specialists to refer patients to. If there is not an simultaneous effort to expand outpatient treatment this legislation will not be as effective as it could be. Furthermore, in our opinion, the peers need to be well educated in MAT. Studies have shown that starting MAT treatments in the emergency rooms can lead to significantly better follow up rates compared to current practices. Many peer specialists are abstinence based and would not be a good fit for reaching this opioid population as the evidence shows MAT has the highest success rates.

To that end, it may be beneficial to encourage the Oregon Health Authority to contract with MAT facilities for this work. Emergency rooms need to have somewhere to send patients once they have recovered and outpatient MAT facilitates with higher success rates make the most sense over expensive residential facilities that have a 6-8 week waiting list in the metro area.

Additionally, for reporting to authorities on the progress of the peer recovery support program, there should be metrics that can back up the impact peer mentors are having in reducing the rate of overdosing and returns to the ERs. Early intervention with peer mentoring will hopefully prevent overdoses.

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Requiring opioid prescribing practitioners to register with the PDMP is also an important step. It is very helpful as a facility to know that the PDMP is a reliable source for checking a patient's history of prescriptions. Unregistered physicians can be detrimental to recovery. This can include increasing the potential for overdose and precipitating withdrawal, as people who suffer from the disease of addiction will not always want to admit who their prescribers are and how much they have been prescribed. If we could trust that everyone is on PDMP we can better serve patients in a safe manner.

We strongly believe that methadone clinics need to be on PDMP for prescribing methadone for the same reasons. Currently, methadone clinics are not required to report to the PDMP, creating a blind spot in the system and a way for patients to be enrolled in multiple programs at the same time. This can lead to diversion in the community as patients could not tell their suboxone provider that they are also getting methadone or suboxone from an Opioid Treatment Program (OTP) and could sell the suboxone on the street.

We encourage the legislature to pass House Bill 4143, and hope that you will consider our testimony as improvements to the legislation. Removing the barriers to medically assisted treatment for substance use disorders is key to fighting the overwhelming opioid epidemic in this state. As the legislature and Governor continue to pursue policies addressing the opioid crisis, Recovery Works NW stands ready to be a resource.

Sincerely,

Benjamin Schwartz, MD

Bryan Schwartz, MD

Recovery Works NW, LLC