Maple Leaf Treatment Center

**MEMORANDUM**

**TO:** Senate Committee on Health and Welfare
**FROM:** Catey Iacuzzi, PsyD, LADC, CCS, Executive Director, Maple Leaf Treatment Center
**SUBJECT:** S. 243 An act relating to combating opioid abuse in Vermont
**DATE:** February 25, 2016

Chairwoman Ayer & Committee Members,

I write to you today regarding Senate Bill 243, an act relating to combating opioid abuse in Vermont. Maple Leaf is grateful for the committee's work to address opioid abuse in Vermont and supports the goals of this bill. We believe that many of the provisions in the bill will be beneficial in addressing opioid abuse. We also offer the following recommendations to strengthen this bill, achieve the goals the committee seeks, and reduce the risk of unintended consequences.

18 V. S.A. § 4771. Care Coordination

This provision references "high quality addiction treatment with buprenorphine or a drug containing buprenorphine." This language perpetuates a common misconception within the population of individuals seeking recovery that medication (buprenorphine) is *the* treatment. It is important to note that medication is only one component of treatment. This misconception creates real barriers to engagement in comprehensive treatment and lasting recovery.

> We would propose the following language: "…provide to the maximum number of patients that can receive buprenorphine-containing drugs, as one component of a high quality, medication-assisted opioid treatment program."

Vermont Prescription Monitoring System

S. 243 mandates that prescribers check the Vermont Prescription Monitoring System with every prescription renewal. While the intent of this provision is excellent, it poses the risk of unintended consequences. In particular, it incentivizes prescribers to write longer prescriptions than may be clinically indicated. For example, a provider may determine that they are willing to prescribe a controlled substance, but are only willing to write the prescription for a week at a time. This provision could result in the provider deciding to write a month long prescription to minimize the administrative work.

> We would recommend choosing a frequency, perhaps monthly, when VPMS should be checked.

Requirements for a "Qualified Addiction Medicine Physician"

While we do not want to open the door for care to be provided by physicians without appropriate training, it is important that this legislation does not limit the pool of potential qualified physicians.

We recommend that the requirements for a "qualified addiction medicine physician" be expanded to include physicians who have specialized training and experience, but do not yet hold the addiction medicine credential.

In addition, S. 243 outlines training and experience conditions for Nurse Practitioners and we would request similar provisions for physicians.

Complementary and Alternative Therapies

We support the use of complementary and alternative therapies instead of opioid control substances.

We believe this should be expanded to include:

a. Medical education their use for both acute and chronic pain;
b. All controlled medications and education on alternative/complimentary treatments to those medications. For example, mindfulness based stress reduction in lieu of benzodiazepines in the treatment of anxiety; and
c. A statement on the intent to fairly compensate providers of alternative and complimentary therapies – particularly when used in place of controlled meds. This would incentivize away from the use of controlled medications and toward healthier solutions

Abuse Deterrent Opioids

We strongly encourage the committee to include language requiring insurers to provide coverage for abuse deterrent opioids in order to encourage providers to utilize these in lieu of abusable controlled substances. ***Abuse-deterrent opioids have been shown to be very effective.*** In fact, data from the Research Abuse, Diversion, and Addiction-Related Surveillance System, call RADARS, published in September 2015 (Iwanicki JL, et al. Pain Week. Las Vegas, Sept. 2015 (RADARS™ System)) showed that the re-introduction of OxyContin™ with abuse-deterrent properties was associated with:

- A 72.6% decrease in abuse rates through both oral and non-oral routes between 1 year before introduction and the end of 2014, and
- An 85.7% decrease in diversion during the same time frame.