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"Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs"

Thank you Chairman Cardin, Ranking Member Daines, and distinguished members of the United States Senate Committee on Finance Subcommittee on Health Care for holding a hearing today about the important and critical need to improve the care continuum for the millions of individuals with substance use disorders.

My name is Dr. Sarah Bagley. I am a pediatrician and addiction provider at Boston Medical Center (BMC) and board certified in Internal Medicine, Pediatrics, and Addiction Medicine. I am an Associate Program Director for the Grayken Fellowship in Addiction Medicine at BMC, where I trained in Addiction Medicine. I founded the BMC CATALYST program, whose multidisciplinary primary care team provides clinical care to adolescents and young adults who have substance use disorders.[1] I also provide inpatient consultation for patients admitted to BMC who have complications related to their substance use. I hold a joint appointment at the Boston University Chobanian & Avedisian School of Medicine as an Associate Professor of Medicine and Pediatrics. I am part of teams conducting research focused on minimizing the harms of substance use on youth and improving engagement of people in care after they have experienced an overdose.

Boston Medical Center (BMC) is a private, not-for-profit academic medical center and the largest safety-net hospital in New England. The Grayken Center for Addiction at BMC is a national hub for substance use disorder resources, encompassing a comprehensive continuum of addiction treatment and support programs for patients, and a leading center for addiction research, education, and prevention. The patients we serve at BMC are predominantly low-income, with approximately half of our patients covered by Medicaid or the Children's Health Insurance Program (CHIP). Among all BMC patients, roughly 70% identify as Black or Hispanic, approximately one-third have limited English proficiency, and roughly 1 in 4 screened positive for at least one health-related social need, including housing and food insecurity.

I am grateful to be here today to offer this testimony. Often when I share what I do professionally,

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[1] Bagley SM, Hadland SE, Schoenberger SF, Gai MJ, Topp D, Hallett E, Ashe E, Samet JH, Walley AY. Integrating substance use care into primary care for adolescents and young adults: Lessons learned. J Subst Abuse Treat. 2021 Oct;129:108376. doi: 10.1016/j.jsat.2021.108376. Epub 2021 Mar 23. PMID: 34080547; PMCID: PMC8380663.

people respond saying “that must be very challenging”. In my opinion, it’s no more challenging than what people with substance use disorders face in order to receive accessible, high-quality care. Historically, the youth substance use disorder treatment system has been dominated by expensive, non-evidence based models. Even today, the clinical team I am part of spends an inordinate amount of time on behalf of our patients locating high quality care along the continuum from inpatient to more intensive outpatient programs.

It is the stories and experiences I hear from my patients and their families that motivate and guide the work that I do. As a provider, I have the great privilege to be entrusted with promoting health and treating illness, educating future medical providers, and conducting research to advance medical science. With that privilege comes a deep responsibility to ensure that the care, education, and research is based on evidence and guided by compassion. As we continue the discussion of closing the gaps in the continuum of substance use disorder care, I am thinking of the patients who I have cared for over the years – the teen patients who have lost multiple friends to overdose and minimize the impact that their losses have had on them, the children who have lost their parents and other family members, and the parents who have lost their children. Finally, I am bolstered by my colleagues in community, academic, and other settings who work tirelessly to care for people with substance use disorders.

The rate of substance use among teens has decreased in recent years.[2] That decrease reflects a commitment to implementing evidence-based prevention programs in schools and effective public health campaigns educating youth and families. We should certainly celebrate that success and continue to sustain a commitment to primary prevention.

However, there are many teens who will initiate substance use and some who will develop a substance use disorder during adolescence. Furthermore, in recent years, overdose among youth has risen to the third leading cause of death among children and adolescents in the United States (behind firearm injuries and motor vehicle crashes).[3] Youth who use substances and those who develop a substance use disorder deserve access to high quality, evidence-based care that optimizes their safety and well-being, addresses underlying mental health conditions, allows them to reach their individual potential and achieve their goals. We often talk about how substance use affects all communities, and that is true, however we must ensure all patients who need treatment have equitable access. In particular, for youth, this care must recognize the ways that youth substance use has changed over the last decade:

1. The drug supply has become increasingly dangerous so that any use may lead to inadvertent exposure to fentanyl and overdose.

2. Youth are obtaining substances through social media and apps in addition to from friends or family members.

3. The ways that youth use substances have changed. For example, electronic cigarettes or vapes are prevalent and present us with new challenges.

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[2] Miech, R. A., Johnston, L. D., Patrick, M. E., O’Malley, P. M., & Bachman, J. G. (2023). Monitoring the Future national survey results on drug use, 1975–2023: Secondary school students. Monitoring the Future Monograph Series. Ann Arbor, MI: Institute for Social Research, University of Michigan. Available at https://monitoringthefuture.org/results/annual-reports/

[3] Goldstick JE, Cunningham RM, Carter PM. Current Causes of Death in Children and Adolescents in the United States. N Engl J Med. 2022 May 19;386(20):1955-1956. doi: 10.1056/NEJMc2201761. Epub 2022 Apr 20. PMID: 35443104; PMCID: PMC10042524.

4. Youth who enter substance use disorder treatment commonly cite relief from mental health symptoms and boredom as reasons for using substances. More youth with a substance use disorder are reporting using substances alone – which is a known risk factor for fatal overdose because there is no one there to respond.[4]

When I think about ways we can effectively address youth substance use disorder, there are a few key points that are important to highlight.

First, we have significant gaps in access to care for youth with substance use disorders.

According to national data from 2022, there are 1.8 million 12-17 year olds with a substance use disorder.[5] Of those, 1.7 million or 97.5% did not seek treatment or think that they need treatment. Only 8,000 youth sought treatment. A recent study that used a "secret shopper" approach, which mimics the experience of a family member calling to find treatment, found that only 57% of programs located in the SAMHSA treatment locator provided treatment for youth with Medicaid, and of those only 7 states had residential treatment programs that accepted Medicaid and offered buprenorphine, the gold standard for opioid use disorder.[6] There was no youth residential treatment in 10 states and that increases to 23 states for patients with Medicaid. On the other end of the continuum, the news is not more encouraging. A recent study of pediatricians found that most agree that they should identify substance use disorders and refer youth to treatment. However, when asked if they should treat substance use disorders in primary care, only 20% said yes and only 12% think it's their responsibility to prescribe medication treatment for addiction.[7] As a pediatrician working in a primary care setting that serves youth with Medicaid, I understand the tremendous pressure that our providers are under. Solutions to address the continuum must focus on the systems, not the individuals who are already stretched to their limits.

We need to have a different approach when working with youth who have a substance use disorder or at risk for overdose.

As we consider the ways to improve access to high quality, evidence-based care, there is a crucial first step that we must take. We can have the best treatment and the best providers but if the settings where we provide the care is not appealing to youth, they are not going to show up. I often think about a theme I've heard from patients over the years – "I am not hard to reach, you just don't know how to find me". Well, it's our job to figure out how to find them and invite them in.

An effective patient-provider relationship is founded on trust. For my patients, they want to know that I

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[4] Connolly S, Govoni TD, Jiang X, Terranella A, Guy GP Jr, Green JL, Mikosz C. Characteristics of Alcohol, Marijuana, and Other Drug Use Among Persons Aged 13-18 Years Being Assessed for Substance Use Disorder Treatment - United States, 2014-2022. MMWR Morb Mortal Wkly Rep. 2024 Feb 8;73(5):93-98. doi: 10.15585/mmwr.mm7305a1. PMID: 38329914; PMCID: PMC10861205.

[5] Substance Abuse and Mental Health Services Administration. (2023). Results from the 2022 National Survey on Drug Use and Health: A companion infographic (SAMHSA Publication No. PEP23-07-01-007). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

[6] King CA, Beetham T, Smith N, Englander H, Button D, Brown PCM, Hadland SE, Bagley SM, Wright OR, Korthuis PT, Cook R. Adolescent Residential Addiction Treatment In The US: Uneven Access, Waitlists, And High Costs. Health Aff (Millwood). 2024 Jan;43(1):64-71. doi: 10.1377/hlthaff.2023.00777. PMID: 38190597.

[7] Hadland, S. E., Burr, W. H., Zoucha, K., Somberg, C. A., & Camenga, D. R. (2024). Treating Adolescent Opioid Use Disorder in Primary Care. JAMA Pediatrics., 178(4), 414–416. https://doi.org/10.1001/jamapediatrics.2023.6493

have their best interest at heart. For my young patients who have lost friends or loved ones to drug overdose, many distrust authority figures in their lives, which I understand. The system as it's currently designed sends the message that their lives are not valued. So when I speak about engagement – what I mean is there's work required to change that narrative, to let patients know their lives do matter, and that as a provider I'm here to help them navigate decisions impacting their safety and well-being.

How can we do that?

1) **Shift from the paradigm of low barrier care to instead aspire to <u>no barrier</u> care.** We can identify and invest in alternative settings where youth could be receiving care such as school-based health centers and community drop-in centers. For example, at BMC we have a mobile, community-based program for youth with substance use and signs of psychosis called WRAP Without Walls.[8] Other concrete steps can include facilitating access to telehealth services in school settings, allowing for engagement through texting, supporting transportation to help patients come to appointments, and supporting models of team-based collaborative care.

2) **Provide education for health care providers who work with youth to address substance use in outpatient settings.** Given the changing drug supply, it is critical that we provide opportunities for youth in healthcare, school, and community settings to learn about substance use and strategies to stay safe. Just last week I published a paper with a pediatric colleague and a mother who lost her daughter to overdose that provides a guide for how pediatric providers can provide overdose prevention in primary care.[9] As the toxicity of the drug supply has changed, the way that we think about the risk of using drugs and the ways that we talk to adolescents about drug use should change too. With our patients and families, we can first say that no drug use is the safest *and* if you are going to use, or your friends are going to use, I would like to make sure that you know how to stay as safe as possible.

3) **Ensure patients have access to all medication treatment options for opioid use disorder.** Just recently, I had a heartfelt conversation with a patient who confided in me that they wished I could prescribe them methadone, to which I replied "me too." I start patients in the hospital setting on methadone and I completed four years of medical school, four years of residency, and three years of fellowship. Despite this intensive training, under current law I am not permitted to prescribe methadone – a life-saving medication – to my patients in the outpatient setting. I cannot possibly capture in words the frustration and sadness that brings me.

4) **For youth who require a higher level of care, such as inpatient treatment, we must guarantee that it is high quality, evidence-based, accessible, and includes addressing co-occurring behavioral health disorders.** As noted earlier, there has been a long history of poor quality and at times dangerous care for teens with substance use disorders. Pharmacologic and behavioral treatments are effective, but they need to be well implemented. Reimbursement should depend on quality metrics similar to expectations that we have for other conditions.

5) **Develop and support models of care that are responsive and youth centered**. This means reimbursement structures that incentivize providing care that integrates addiction, behavioral health, and primary care, has strong connections to community organizations that promote youth resilience, and provides family treatment. Teams who treat youth with substance use

[8] https://www.bmc.org/wellness-and-recovery-after-psychosis-wrap/wrap-without-walls

[9] Hadland SE, Schmill DM, Bagley SM. Anticipatory Guidance to Prevent Adolescent Overdoses. Pediatrics. 2024 Apr 2:e2023065217. doi: 10.1542/peds.2023-065217. Epub ahead of print. PMID: 38563066.

disorder are multidisciplinary and include non-physicians such as advanced practice providers, nurses, social workers, recovery coaches, community health workers, and psychologists. The collective treatment services must be adequately reimbursed to build sustainable models.

Creating a place in the substance use disorder care continuum for family and peer support

Youth are part of families who care about them. Parents and other family members are vulnerable, often times scared, and not sure where to turn when they recognize that their teen may have a substance use disorder. In those moments, we must have ways for families to know that there is hope and there are options. Families need access to information about treatment and where to go for care. This should also include receiving guidance when a teen is not yet ready to engage. There are evidence-based approaches such as Community Reinforcement and Family Training (CRAFT) and Invitation to Change that provide guidance for families that is not contingent on their loved one wanting to make changes in their substance use.[10,11] When a teen is engaged in care, family involvement should be incentivized and should also include teaching them about overdose prevention.

Part of being a teenager is learning how to navigate decision-making and even learning how to take risks. Teens rely on friends to help make decisions. Alternative Peer Groups are an example of an approach to provide youth with positive recovery support in the community in addition to peer support and prosocial activities. Further expansion of such programs that provide options for teens to continue to grow and develop into young adults and not be solely defined by their diagnoses is needed.

Twelve years ago, when I started my fellowship training in Addiction Medicine, Boston Medical Center was one of only ten institutions in the country to offer specialized training for physicians. Since that time, the field of Addiction Medicine has grown significantly and there are now 102 accredited programs across the US where physicians of all disciplines can learn about how to provide care for people with substance use disorders.[12] I regularly have high school students, college students, and medical trainees reach out to me wanting to participate in addiction-related work. I am heartened and inspired by this as it reflects an important evolution in how we think about substance use and substance use disorder.

Last week, when I was working in the hospital on our addiction consult service, I was struck by something a patient shared with me while we were making adjustments to their methadone dose. The patient, a middle-aged gentleman who had been in the hospital for a few days, said he had been reflecting on a saying he heard, and some of you may be familiar with, called the ”3 S’s” – to paraphrase, he told me we all need the following things: *something to do, someone to love,* and *something to look forward to*. There are a lot of things that can get in the way of such a simple approach and yet this really spoke to me. When I think about what my job is, in the plainest terms, it’s to ensure that the youth I care for have access to all the tools they may need to feel fulfilled, develop meaningful relationships, and have hope for their futures.

Thank you for the opportunity to testify. I look forward to your questions.

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[10] Meyers RJ, Miller WR, Hill DE, Tonigan JS. Community reinforcement and family training (CRAFT): engaging unmotivated drug users in treatment. J Subst Abuse. 1998;10(3):291-308. doi: 10.1016/s0899-3289(99)00003-6. PMID: 10689661.

[11] https://invitationtochange.com

[12] https://www.acaam.org/about