Testimony LD 1108

4/13/2017

I am a Family Physician who has been treating patients in Maine for over 36 years, the last 27 as a faculty physician at the EMMC Family Medicine Residency Program. In the process of training new doctors for Maine communities, I get to work with a lot of high risk pregnant patients in high risk families: for example, families experiencing substance abuse, domestic violence, and child abuse. We treat the largest percentage of pregnant moms addicted to opioids in the state with medically assisted treatment with Buprenorphine. To do this well, we need to collaborate as a team with other community intervention and prevention partner resources for the best outcomes for our infants as well as adults.

What we are seeing each day is alarming. Maine's system of care for our most vulnerable babies used to be a model in the country. However, after years of successful intervention as a community team with markedly decreased fetal/neonatal deaths Maine, statistics are revealing that while other states continue to improve prenatal and infant death rates, Maine's babies are now dying at an increased rate (BDN August 17, 2016). The deaths, however, are just the tip of the iceberg. Many more kids will be experiencing trouble both medically and socially. Well-documented research on the effects of Adverse Childhood Experiences (ACEs) has demonstrated that when we ignore children's well-being they are prone to chronic illness, mental illness, substance abuse, higher rates of cancer, and, more likely to live in poverty. The cycle perpetuates because the safety net is full of very large holes. The result, notwithstanding the human costs and lost potential, makes no sense for our state's economy. A large portion of the kids from whom we are taking services, grow up to be less likely to graduate from school, more likely to be in trouble with the law, less likely to reach their earning potential and can land up in the least therapeutic repository for so many suffering from mental illness and addiction, our jails, at a cost of $45,000 a year. Just ask any sheriff or chief of police.

Sadly the one difference between our state and others is that our state DHHS administration has intentionally decimated Public Health Nurse (PHN) roles by over 2/3. They have cut positions and refused to fill the others when turnover occurs. Thus, our PHN prevention visits are drastically reduced, if not nonexistent in most of the state outside a few cities. When concerned about their at risk situation, I have asked many of my pregnant, or recently delivered patients, directly whether or not a PHN has contacted them. Most didn't know whether a visiting PHN was even being considered. When I try to communicate with the PHNs for the patients' region (we treat patients from 2 and 3 hours away), I find out they don't exist. Because of decisions being made by the Department of Health and Human Services to cut proactive and preventive resources, i.e. not refilling the vacancies of over 40 public health nursing positions, we are flying blind and I feel adult patients, mothers, and especially children are suffering and are at more risk. I feel this misguided policy will have terrible consequences and thus costs: higher and higher rates of our mothers, fetuses and babies will be in trouble with delayed interventions leading to worse care and worse outcomes. One example recently was a baby that had failure to thrive(severely malnourished): The baby was losing weight. Since usual doctor's visits were every 2 months for the first six months, without the PHN visit, the failure to thrive went on and on until, at the next 2 months visit, the physician was aghast at the situation which required the baby to get immediate hospitalization when it could have been resolved at home 5-6 weeks earlier. Permanent damage to brain development may have occurred. Pediatric ICU days cost a lot more than a few nurse visits.

Over the years, I and many other doctors have worked very closely with Bangor and county-based PHNs. Alarmingly, since these nurses' ranks have virtually disappeared, accurate and timely assessment of babies' safety has suffered. In the past, before our patients left the EMMC post-partum unit with their

babies, we were able to refer all babies to PHNs who had great success at mitigating high risk issues. These nurses were outstanding at physical assessment and really knew the communities and resources and how to mobilize them to make them work for such patients. Now signs of complications or assessment of risks for those babies mentioned above are not even recognized because nurses are not on the case. While the frequently restructured replacement programs staff i.e. Cradle Me, Maine Families, and Navigators staff has their hearts in the right place and do have a place in evaluating and mobilizing needs for social stressors, they do not have the needed assessment skills, nor do they know the very stressed and vulnerable families in the area. They become surprised and overwhelmed when, for example, it is discovered that a peripheral couch surfing family member who is a serial perpetrator active in their addiction using cocaine and heroin, but is not the biological father and is a known multiple violent offender of multiple females and their infants is discovered as part of the relevant "household". They don't recognize early asthma, can't assess for physical environmental risk factors (lead), nor can they recognize initially subtle signs of severe malnourishment in babies. It is only very late, often sadly too late, that such problems finally come to light at 2-3 month pediatrician/family physician visits. By this time, these conditions can lead to major consequences, even death, especially with our epidemic of opioid addiction.

Proactive public health and prevention planning is critical for Maine but now is virtually gone. I urge you to ask the DHHS public health department about exactly who is available on site to help with community infectious disease outbreak emergencies: meningitis, Tb, measles outbreaks at schools (U Maine in past) etc. New Tb outbreaks have been occurring all over the world with very resistant Tb types. PHNs know how to assure home treatment is efficacious. There is no one who can assure treatment at home any more.

The public health infrastructure that took 30 years to develop has been lost and even with a total turn around will take years to rebuild the institutional and community knowledge base, thus effectiveness. Note: we WILL have a pandemic outbreak of some terrible influenza in the future. Not if, but when it does occur, Maine is in trouble. There is no structure to help expedite community response. The rapid action programs set up by the PHNs in the past to prevent the H1N1 outbreak with massive school vaccinations took staff and lots of overtime with a full contingent of nurses. That nursing staff, in fact, even the desks, secretarial supplies, and support staff for the current few nurses as well as the greater organization is just gone.

If we really care about having healthy babies who turn into healthy adults, we need the whole contingent of Public Health Nurses to maintain a strong, proactive safety net for families at risk as well as the rebuilding the decimated more traditional public health duties and infrastructure. I strongly urge you to vote for LD 1108.

Eric R Brown MD
Eastern Maine Medical Center Family Medicine Residency
Clinical Faculty:
University of New England College of Osteopathic Medicine
University of Vermont School of Medicine