Written Statement for the Record

United States Senate Subcommittee of the
Committee on Homeland Security and Governmental Affairs

May 25, 2017

Terry L. Horton, MD, FACP, FASAM

Good morning, Mr. Chairman, Senator Carper, and distinguished Members of the Committee. Thank you for the opportunity to appear today. I am Dr. Terry Horton, Chief of the Division of Addiction Medicine, and Associate Physician Lead of the Behavioral Health Service Line at Christiana Care Health System in Wilmington, Delaware. I am also the founder and Medical Director of Project Engage, a nationally recognized and award winning treatment program using peer counselors integrated into health systems to help identify and transition substance use disordered patients into ongoing drug and alcohol treatment. I was appointed by former Delaware Governor Jack Markell to chair the State's recently enacted Drug Overdose Fatality Review Commission, which our State legislature tasked with reviewing all overdose fatalities in Delaware that involve prescriptions, opiates, heroin, fentanyl and other illicit drugs—and with providing elected officials with data-driven recommendations to prevent future overdoses.

Executive Summary

My prepared remarks today address four primary points, which I will address briefly in these remarks and have covered in more detail in my written statement:

(1) First, opioid addiction is a chronic brain disease that needs to be treated like other chronic diseases with evidence-based methods and medications. Without these treatments, opioid addiction is potentially lethal as witnessed by the epidemic spread of fatal overdoses across the United States. The problem is critical, urgent, and getting worse.

(2) Second, we know how to treat this epidemic. We are learning what works and we are being successful in treatment. That means we have hope, but only if our policy decisions continue to support evidence-based treatment. Not all treatment is created equally, and data overwhelmingly supports the use of long-term treatment, including the use of medication assisted therapies, which is far more effective than other methods of treatment, including detoxification alone.

(3) Third, we need to take advantage of reachable moments to connect people to treatment—including hospital admissions, law enforcement encounters, and ideally, interventions before either of those things happen. We are making great strides on that front in Delaware, including my work at Christiana Care with our Project Engage program, but we have a great deal more to accomplish.

(4) Fourth, none of the progress that we are making matters or will save lives without maintaining access to treatment—including maintaining coverage for treatment through

Medicaid, commercial insurance, and Medicare. The Medicaid rollbacks and caps as called for under the American Health Care Act recently passed by the House will mean fewer dollars for mental health services, including opioid and drug addiction treatment. Without treatment access and coverage, we have no hope of stemming the record-setting number of overdose deaths affecting all of our communities.

I. The Addiction Epidemic—Treating Addiction as a Chronic Brain Disease

I want to speak today to the human element of the opioid crisis – far more than a crisis – a new breed of health epidemic that has swept our great nation and for the first time in our country's history has resulted in a shorter average life expectancy for a significant segment of the U.S. population. In 2015, we lost 50,000 American lives to drug overdoses, surpassing the total number of deaths from AIDS at its peak in 1995.

Why is this epidemic so acute? Opioid misuse results in an acquired brain disease called addiction—a disease of your brain circuits that affects judgment, motivation, self-regulation, and decision-making. This is not about "just saying no" – as any family member of an opiate user will tell you. Opioid addiction is remarkably powerful.

I spend most of my days as a doctor providing direct treatment to members of our community who are addicted to opioids. I can assure you that this disease plays no favorites. Opioid addiction affects everyone: young and old, men and women, urban and rural populations. I have treated hundreds of patients, including a champion high school pole vaulter, a retired executive, a new mom attending college, an urban couple who have no transportation but who cobble together rides to get to their appointments. They are desperately seeking treatment and are desperate to be cured – they want out of their nightmare that is opioid addiction. At the same time they are terrified of the "primal misery" of withdrawal. I recently treated a 64-year-old grandmother with chest pain who had delayed seeking treatment because she was ashamed of her addiction and terrified of withdrawal. We were able to address her fear and treat her for both conditions. Her hospital visit for her unrelated medical need opened the door to allow us to address her addiction. She is doing well eight months later, adherent with her counseling and buprenorphine, safe from overdose, safely taking her heart medications and reconnecting with her grandchildren.

II. Effective Treatment

What I am here to tell you today is that we are learning how to address opioid addiction, critical lessons to impact this epidemic. When people are addicted to opiates, we need to keep them alive for long enough to engage with them, prevent them from overdosing, and ultimately get them into - and keep them in - the treatment that they need.

Not all treatments are created equally. We need access to effective drug treatment as an essential element of addressing the opioid epidemic and reducing associated deaths. But not just any drug treatment. Long term treatment is considered the standard of care to address addiction. Several decades of medical research has taught us that effective opioid drug treatment requires a long term approach with medication assisted therapies (MAT) such as methadone and buprenorphine,

counseling support and similar means to assist with psycho-social challenges. Medication-assisted therapy, or MAT, is considered an essential medication by the World Health Organization. Detoxification or other tapering methods are inferior and place patients in harm's way. Tapering MAT is associated with a 50% increase in drug use, 3 fold reduction in treatment retention and over 4 fold increased mortality compared to not tapering.[1] As the United States Surgeon General's 2016 report on the addiction epidemic noted:

> One of the most serious consequences when individuals do not begin continuing care after withdrawal management is overdose. Because withdrawal management reduces much of an individual's acquired tolerance, those who attempt to re-use their former substance in the same amount or frequency can experience physical problems. Individuals with opioid use disorders may be left particularly vulnerable to overdose and even death. It is critically important for health care providers to be prepared to properly assess the nature and severity of their patients' clinical problems following withdrawal so that they can facilitate engagement into the appropriate intensity of treatment.[2]

Compared to counseling alone, participation in MAT resulted in approximately a 50% reduction in overdose fatalities.[3] In a recent meta-analysis involving a review of studies of 122,885 patients, retention in MAT, including methadone and buprenorphine treatment, was associated with significant reduced risk of all-cause mortality and overdose mortality.[4]

When we provide the right treatment we can reduce drug overdose deaths. When we can lengthen a patient's time in treatment, we know we will get better outcomes. When we combine medication assisted treatment and therapy, we can win this battle that is being fought in nearly every family in our country. I know this because I am on the front line of this battle every single day, encouraging my patients, making sure that every person I am treating gets their medication every day. These are the words I say to them: "Each morning you take your buprenorphine is a day you are safe, a day you will not overdose and die". As days become weeks, our focus evolves and grows, from simple safety to learning how to negotiate the tribulations of life, to re-experiencing the simple joys of living. We can break this disease pattern, we can pull them back

---

[1] Nielsen S, Larance B, Lintzeris N. *Opioid Agonist Treatment for Patients With Dependence on Prescription Opioids.* JAMA. March 2017, 317(9):967-968. DOI:10.1001/jama.2017.0001, *available at http://jamanetwork.com/journals/jama/fullarticle/2608202.*

[2] United States Department of Health and Social Services, *Facing Addiction in* America, *the Surgeon General's Report on Alcohol, Drugs and Health*, 2016, p. 4-13, *available at* https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf.

[3] Nora D. Volkow, M.D., Thomas R. Frieden, M.D., M.P.H., Pamela S. Hyde, J.D., and Stephen S. Cha, M.D. *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic,*
N ENGL J MED, May 29, 2014; 370:2063-2066. DOI: 10.1056/NEJMp1402780, *available at http://www.nejm.org/doi/full/10.1056/NEJMp1402780#t=article.*

[4] Luis Sordo, Ph.D., *Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies*, BMJ, April 26, 2017; 357. DOI: https://doi.org/10.1136/bmj.j1550, *available at http://www.bmj.com/content/357/bmj.j1550.*

into society, we can get great outcomes – but only if we can get them into treatment and keep them in treatment.

III. Engaging at the Reachable Moment

In 2010, Dr Christopher Shanahan coined the phrase, "reachable moment" to describe that critical opportunity that hospitalization affords patients to be engaged and transitioned into addiction care.[5] At Christiana Care Health System, we are learning to rapidly identify and treat opioid withdrawal helping our patients experience reachable moments instead of leaving against medical advice only to be readmitted when they are much more ill. We have developed and implemented screening and treatment pathways and utilize embedded peer counselors, Project Engage staff who are in stable recovery and help us reach patients who are so often unreachable. It has proven a powerful combination—and our patients respond, like the 64-year-old grandmother whose hand we were able to find and grasp, helping her into recovery.

My preliminary data shows that more than two-thirds (2/3) of my patients expressed interest in, and motivation, to begin drug treatment. Of those patients, more than three-fourths (3/4) showed up for their first appointment after hospital discharge, and more than seventy (70) percent remained in community-based treatment one month later. The longer we keep them in treatment, the better outcomes we will get.

We know that many overdoses occur in the community, behind closed doors out of the reach of health providers. One effective tool to prevent overdose deaths has been the use of Narcan. In Delaware, and as I imagine is true in other states, without Narcan we may have had as much as four to five times the number of overdose deaths last year—and possibly even more. The United States Drug Enforcement Administration's data reflects 2,214 Narcan saves in Delaware from 2014-2015.[6]

But averting an overdose is not enough—especially when overdose events increasingly involve fentanyl, a synthetic painkiller that is up to 50 times more potent than heroin. In Delaware, the number of fentanyl-related deaths increased 180 percent from 2012 to 2015. In 2016, fentanyl-related deaths in Delaware increased 115 percent over 2015. Narcan has kept them alive – the next step is for us to actively partner with the law enforcement community in Delaware to determine how we can better engage with people who do not seek medical care following a Narcan episode.

IV. Preserving Treatment Access, Coverage and Funding is Critical

It is critical to keep in mind--when we discuss policy solutions to the opioid crisis-- that much of the treatment provided is covered by Medicaid. The Medicaid rollbacks and caps as called for

---

[5] Christopher W. Shanahan, MD, MPH, *et al.*, *A Transitional Opioid Program to Engage Hospitalized Drug Users*, J GEN INTERN MED. Aug. 25, 2010, p. 803–808. DOI: 10.1007/s11606-010-1311-3, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896583/.

[6] Brittany Horn, *Narcan Becomes a Safe, Common Tool for Delaware* Police, THE NEWS JOURNAL, May 22, 2016, *available at* http://www.delawareonline.com/story/news/2016/05/22/narcan-becomes-safe-common-tool-delaware-police/84488900/.

under the House AHCA bill will mean fewer dollars for mental health services, including opioid and drug addiction treatment. Fewer people will get treatment and those who do will likely get less effective and sustained treatment. If Medicaid is reduced as proposed, we will not be able to deliver the care and treatment that we know works – it will be like having a cure for cancer that we are not able to use or a vaccine for polio that was never deployed.

In Delaware, our largest substance use disorder treatment provider first began medication assisted treatment when Medicaid covered the cost of that care; they now provide thousands of outpatient treatment slots for patients with opioid addiction—slots that are at risk of being eliminated under the House proposal.

Treatment for opioid addiction also benefits from consumer protections in the private insurance market, such as the current prohibition of underwriting based on preexisting conditions and the requirement for plans to cover essential health benefits like addiction treatment. Returning to underwriting, making coverage inaccessible or unaffordable due to preexisting conditions, and removing essential health benefits mean that individuals fighting addiction will lose health insurance when they need it the most. Instead of treating people, we will likely see the opioid epidemic get worse and more individuals falling through the cracks just as the Medicaid safety net has been weakened. A 2014 survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that a lack of health insurance and/or high health insurance costs were the second-biggest reason people with substance use disorders went without treatment.[7]

I spend my days caring for patients addicted to opioids. I am witnessing this epidemic firsthand—and I suspect some of you are as well. We see how this epidemic is devastating lives and families and killing so many people in our communities. I also know that we have treatments that are effective and that help the people we care for return to their lives and return to society. I respectfully encourage this Committee to reject any attempts to remove the Medicaid funding and insurance coverage that support treatment for so many people in my community, and so many Americans.

Thank you again for the opportunity to present this information.

---

[7] "Not ready to stop using" was the most common reason (41.2%), with "no health coverage and could not afford cost" as the second reason (30.8 percent). United States Substance Abuse and Mental Health Services, *Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health Administration*, September 2015, *available at https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.htm. See also* Matthew Albright, *Tom Carper: Obamacare repeal could hurt drug* treatment, *The News* Journal, Mar. 16, 2017, *available at* http://www.delawareonline.com/story/news/politics/2017/03/16/drug-abuse-cuts/99257912/.

Terry L. Horton, MD, FACP, FASAM is a member of the teaching faculty of the Department of Medicine, Attending Physician, Chief of the Division of Addiction Medicine, and Associate Physician Lead of the Behavioral Health Service Line at Christiana Care Health Services in Wilmington, Delaware. In addition to teaching medical students and residents in inpatient and outpatient medicine, he has chaired the Alcohol Withdrawal Workgroup which developed and implemented alcohol screening, treatment and referral protocols into the institution's electronic health record, an effort recognized nationally by the AHRQ Innovation Exchange as a model effort. More recently, Dr Horton helped develop and launch the Opioid Withdrawal Pathway, a ground breaking effort to screen, identify and treat opioid addicted patients who are admitted into the hospital. He has similarly developed a new Substance Abuse Consultation Liaison role assisting with the care of hospitalized patients. Dr. Horton is the founder and Medical Director of Project Engage, a nationally recognized and award winning program using peer counselors integrated into health systems to help identify and transition substance use disordered patients into ongoing drug and alcohol treatment. Dr Horton currently chairs Delaware's new Drug Overdose Fatality Review Commission and has served on a number of similar efforts both in New York and Delaware. His interests include improving the care of hospitalized substance disordered patients as well as understanding their impact on health systems, innovating and researching methods to better integrate addiction medicine into inpatient and outpatient systems of care, and physician and student training. Dr Horton has published broadly and is a frequent speaker regionally and nationally on these topics.

Previously, Dr. Horton worked as the Medical Director and Vice President of Phoenix House Foundation in New York developing innovative models of on-site primary care and the use of buprenorphine within substance abuse treatment settings. He was a member of the Clinical Trials Network of the National Institute on Drug Abuse from 2000 to 2015 participating in a number of national research efforts.