Testimony of:

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Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
for hearing on "Examining Advertising & Marketing Practices within the Substance Use Treatment Industry"

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Main points

- Substance Use Disorders (SUD) can be effectively managed when treatment is accessible and of high quality.
- There are three primary steps necessary to provide impactful treatment:
    1. Begin engagement in treatment during times and in settings of opportunity.
    2. Complete a comprehensive assessment of the individual to determine the best type, intensity and setting of initial treatment, and based on that, admit or make appropriate referral.
    3. Provide treatment that:
        - uses medications for addiction treatment (MAT) when medically indicated;
        - uses verbal therapies delivered by skilled professionals;
        - uses behavioral therapies to facilitate change and reinforce treatment engagement
        - uses adaptive models, that adjust treatment type and intensity based on ongoing indicators of patient response
        - incorporates wrap-around services that are embedded when possible, and otherwise through solid linkages with community resources.
- By facilitating treatment that is both accessible and of high quality, gains can be made over time that reduce the devastation of SUD on the individuals, families, and communities.
- This can also lessen the extraordinary health care and other societal costs related to SUD.

Testimony

Chairman Harper, Ranking Member DeGette, Committee Chairman Walden, Committee Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to speak with you today about the treatment of substance use disorder (SUD), in the context of this national health crisis.

I am an addiction psychiatrist, and direct the outpatient SUD treatment program at Johns Hopkins Hospital, the Broadway Center for Addiction. I am also the medical director of a similar program at a Johns Hopkins affiliate hospital, and am an inpatient attending psychiatrist on hospital unit that focuses on SUDs.

With an estimate of approximately 64,000 individuals dying from overdose in 2016,[1] most of which were related to opioids, we are fortunate to have at our disposal effective, evidence-based approaches to treating SUD. I feel privileged to be part of a system that treats patients with SUD, and as a member of local and national associations that endeavor to shape treatment systems to optimize care.

3 Steps Enabling Impactful Treatment

In my experience, the impact of treatment is optimized when we ensure that three sequential actions are taken: 1) Engage potential patients during opportunistic times and in opportunistic settings; 2) Complete a comprehensive initial assessment to determine the best setting and type of treatment for each individual, and 3) Offer treatments that are evidence-based, high quality, and dynamically adjusted. I will be focusing on these three actions for the next few minutes.

Action #1: Referral and Engagement

[1] Centers for Disease Control and Prevention. National Center for Health Statistics. Available online at: https://www.cdc.gov/nchs/products/databriefs/db294.htm

Addressing the first step, where do I seek out patients for my treatment programs? I focus on locations where the individual is most in need of treatment and is experiencing a "teachable moment" when their likelihood of considering treatment entry is high. Accepting patients from settings where others have already engaged the individual, and are now seeking facilities to which to link them, helps to avoid the all-too-common experience of having the person drawn back into continued use, and missing an important and perhaps life-saving opportunity for treatment entry. Sadly, there is no shortage of potential patients in Baltimore, and many require immediate engagement. They are found in hospital emergency rooms and inpatient units - having survived an overdose, being treated for medical problems resulting from injection drug use, or contemplating suicide due to being demoralized by the devastation of ongoing SUD. Hospitals are aware of our program and refer those individuals to us. Other sources of referral that I have cultivated include Baltimore-area primary care practices. Through that work, I established CoOP, a hub and spoke model of collaborative buprenorphine treatment that is gaining national recognition.[2] Two other common sources of referral include other treatment programs who may decide that one of their patients would be best served in our program. And of course, we accept citizens walking in from the community. Johns Hopkins considers improving the health and well-being of the community surrounding our hospitals to be a critical mission. By focusing on these and related sources of referral, we serve patients who find themselves on the cusp of tragic consequences from their SUD, to themselves and their family. It also can avoid what would otherwise be tremendous costs to the health care system if active substance use continued to result in frequent avoidable emergency room visits and repeated costly hospital admissions, for people with the most severe substance use, other medical and social problems.

For example, I examined the emergency room utilization of a patient of mine whose managed care organization informed me that he had high volumes of ER visits. I was given data from the prior 17 months, which included 1 year when he was not in our program, and 5 months when he was. He

[2] Stoller, K.B. *A collaborative opioid prescribing (CoOP) model linking opioid treatment programs with office-based buprenorphine providers.* In Addiction Science & Clinical Practice. 2015; 10(Suppl 1):A63.

had an astounding 81 visits to the emergency room, but only 4 of them were during the time that he was in our program. The others were from prior to his admission, and during a brief period that he dropped out of care. For the MCO, this translated into a 10-fold reduction in monthly spending on ER visits alone.

Finally, by focusing on treating people primarily in their own community, it is easier to leverage potential community supports such as family, friends, and local agencies who can help increase the strength of our patients' recovery foundation over the long term.

Action #2: Comprehensive Assessment

Moving on to the second of the three steps – the initial comprehensive assessment. When people ask me what causes SUD, my response of late always starts the same way – "It's complicated." In the field of medicine, complex problems require multipronged and prolonged treatment elements. To treat asthma effectively, treatment recommendations are based on patient needs and change over time – including environmental abatement, steroid inhalers, nebulizers, pills, rescue inhalers, allergy testing, immunotherapy, and other approaches. To most effectively treat each individual with SUD, my clinical and medical staff spend 2 or more hours to develop an initial clinical impression and treatment plan. Although SUD can be described by a common set of criteria such as those listed in the DSM-5 manual,[3] the number, combination, and severity of symptoms that individuals experience vary widely; and each person brings with them differing strengths, liabilities, and resources. Additionally, the person's past experience in treatment can determine next steps to try. You may have heard the saying "the definition of insanity is doing the same thing over and over and expecting different results." Past treatment episodes can inform what has worked and what has not been helpful. I have had patients report repeated inpatient or residential treatment episodes that have resulted in prompt relapse, and that medications have never been tried. For them, I was more likely to recommend a medication trial in the

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[3] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

setting of long-term treatment including counseling in an outpatient program. When other patients with opioid use disorder and co-occurring severe mental health and social problems report failing office-based buprenorphine treatment, I express that hope is present through participation in a comprehensive specialty SUD treatment program that has the resources to effectively address those problems alongside their SUD-specific treatment.

Action #3: Five elements of high quality treatment

This leads to the third key to impactful treatment – the treatment itself. I consider there to be 5 critical elements of high quality approaches.

1) They use medications as clinically appropriate. We are fortunate to have three FDA-approved medications for the treatment of opioid use disorder – methadone, buprenorphine and naltrexone;[4] and three for alcohol use disorder – naltrexone, disulfiram and acamprosate.[5] These medications should be chosen, started, discontinued, and restarted over time, according to scientific evidence, considering patient ongoing response and preference.

2) They combine it with psychosocial treatments. This includes counseling or psychotherapy, delivered in individual and group-based settings, by skilled, experienced staff who are well-trained to work with this population.

3) They use behavioral therapies, such as contingency management, that motivate positive change, discourage drug use, and increase adherence to medication and psychosocial treatments.[6]

4) They use adaptive stepped care models. This means that objective measures of treatment response, like toxicology results and treatment adherence, are measured continually over time and are used to adjust the intensity and types of treatment – while motivating a high level of

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[4] SAMHSA TIP 63: *Medications for Opioid Use Disorder*. Full Document available for download at: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

[5] SAMHSA. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*. Available for download at: https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907

[6] Petry NM, et al. *Contingency management treatment for substance use disorders: How far has it come, and where does it need to go?* Psychol Addict Behav. 2017 Dec;31(8):897-906.

engagement in those treatments. We have studied adaptive treatment approaches extensively at Johns Hopkins, and have demonstrated its powerful impact;[7] and our accreditation body, The Joint Commission, publicly recognized it as an exemplary treatment program.[8]

5) They incorporate wrap-around services, whether provided within the program or through linkages, to support a holistic approach to recovery. This can include resources such as mental health assessment and treatment, supportive housing, vocational rehabilitation, 12-step facilitation, connections with the spiritual community, primary medical care or health home services, hepatitis C and HIV testing and specialty services, and certified peer recovery specialists. I recognize that not every program or provider can become a "megamall" of embedded services, but when services cannot be integrated directly into the program, strong linkages through referral can also be powerful. And speaking of linkage, the most important linkage is to carefully-chosen treatment resources at the time of program discharge. Those linkages should be facilitated in a way that maximizes patient follow-through and continuation in recovery.

Conclusion

We are fortunate to have the ability to meet the challenge of the opioid epidemic head-on with effective treatment. The treatment workforce must be adequate in number, well-trained, well-paid and supported, and be hopeful and empathic. Comprehensive, highly-regulated, federally-approved opioid treatment programs are well-positioned to be hubs of expertise, resources, and care coordination.[9] They are an element of a treatment system that can be scaled up locally and nationally to close the treatment gap. I appreciate the recent work in congress to increase access to care, such as efforts to create a

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[7] Brooner, R.K., Kidorf, M.S., King, V.L., Stoller, K.B., Peirce, J.M., Bigelow, G.E., Kolodner, K. *Behavioral contingencies improve counseling attendance in an adaptive treatment model.* Journal of Substance Abuse Treatment. 2004; 27(3):223-232. PMID: 15501375.

[8] The Joint Commission Ernest Amory Codman Award. National Health Care Award for Performance Measurement. https://www.jointcommission.org/assets/1/6/Addiction_Treatment_Services_of_John_Hopkins.pdf

[9] Stoller, K.B., et al. *Integrated Service Delivery Models for Opioid Treatment Programs in an Era of Increasing Opioid Addiction, Health Reform, and Parity.* Substance Abuse and Mental Health Administration. http://www.aatod.org/policies/mat-hub-setting-whitepapers/ Published online July 13, 2016.

Medicare reimbursement model for our seniors in need of treatment. And I applaud your efforts to ensure that when encouraging increases in treatment access, we do not inadvertently sacrifice quality of care.

Sincerely,

Kenneth B. Stoller, M.D.

(Note: The statements above reflect the opinion of Dr. Stoller, and not necessarily that of Johns Hopkins Medicine.)