Dr. Tom McLellan

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Female Speaker: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping the health care of the future. This week Mark and Margaret speak with Tom McLellan founder of the Treatment Research Institute, it's a non-profit organization dedicated to science driven reform of treatment and policy in substance use disorders.

Lori Robertson also checks in the Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain separating the fake from the facts. And we end with a bright idea that's improving health and well-being in everyday lives.

If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter, iTunes or wherever you listen to Podcasts and you can also hear us by asking Alexa to play the program Conversations on Health Care. Now stay tuned for our interview with Tom McLellan on Conversations on Health Care.

Mark Masselli: We're speaking today with Thomas McLellan PhD founder of the Treatment Research Institute an independent non-profit organization dedicated to science driven reform of treatment and policy in substance abuse. Recently a retired professor of psychiatry at the University of Pennsylvania, Dr. McLellan served as senior editor for the U.S. Surgeon General's 2016 report Facing Addiction. He previously served as senior scientist and deputy director of the White House Office of National Drug Control Policy. Dr. McLellan holds his PhD from Bryn Mawr College and did his post graduate training in psychology at Oxford University in England. Tom, welcome to Conversations on Health Care.

Tom McLellan: Well thank you for having me.

Mark Masselli: You know it's been 25 years since you founded the Treatment Research Institute and since then we've seen just this devastating impact of the growing epidemic of opioids in the United States. And still it seems we lack this consensus on both treatment of substance use disorder and the best policies to address the public health crisis. I wonder if you could share with our listeners some insight into why this is still so difficult to do.

Tom McLellan: Yeah. I think the way most of the world has understood addiction for centuries as weak character, poor upbringing, things like that. And now here's a fact, addiction is a chronic illness that affects the brain, specifically the motivation, inhibition, reward and stress circuitry and the brain. And what has happened is we have institutionalized prevention, treatment, all kinds of other policies based on this

understanding that addiction is something that bad boys do and should be punished for. We've flatly got it wrong, and we're just making that transition now, the science is finally leading the way. But it's going to be tough the institute, the proper policies and the most effective and efficient forms of prevention and treatment, but it's going to be made even more difficult because we have to displace centuries of thinking and institutions that are based on antiquated models.

Margaret Flinter: Well Tom, you've written so extensively on this topic of addiction and evidence based treatment, and I think that one of the most seminal documents you played a role in producing was US Surgeon General Vivek Murthy's very powerful call to action Facing Addiction. Can you share with our listeners what you and the Surgeon General saw to set in motion?

Tom McLellan: I think two things have to be communicated and these are facts backed by the 30 years of research; the first is, addiction is not an intractable social problem that we simply have to live with. This is a medical condition and we can prevent most cases, when we can't prevent those cases, we can intervene effectively and arrest the devastating effects. It is possible to treat even very serious cases of addiction and with full recovery now being an expectable outcome of the right kind of care, so this is a solvable problem. We know an awful lot about what to do and that is both the promise and the pity of this; the pity is it's just simply not been implemented. There's a second point that it is in the interests of mainstream medicine to finally embrace the study, management, understanding of substance use disorders. Not only because these are treatable medical conditions in their own right, but even more important in the context of the rest of medicine where there are desperate efforts going on to contain costs and improve quality. Undiagnosed, unmanaged substance use disorders are costing mainstream health care over a $120 billion a year, and that's from misdiagnoses, way too frequent, unnecessary emergency room and other high cost procedures. Medicine has been a reluctant participant in this, and it is time, and it is in the direct self-interests of every physician, but particularly primary care to learn how to recognize it and manage it because they can and because it will not be possible to deliver high quality mainstream health care for most other illnesses unless they do.

Mark Masselli: Speaking of that, you've been an advocate of something that we've practiced at our health facility, Medication Assisted Treatment or MAT which uses a drug regimen to help manage addiction in the ambulatory care setting. Your research has yielded powerful evidence of the effectiveness of this approach, especially in reducing incidents of relapse. There's a lack of uptake by primary care providers on medication assisted treatment, so tell us more about the research on

it, but also why you see reluctance to start to providing this very needed service.

Tom McLellan: Yeah. This is where politics, ideology and science, all meet. If I said Type 2 Diabetes is a chronic medical illness and it is a good idea to have FDA approved medications in addition to changing your lifestyle, that would cause exactly no stir at all. And the reason is diabetes has been accepted as a real medical condition, physicians are trained to diagnose it, to understand it, to manage it. Three, as a chronic illness, we know that it's basically not possible to cure it, but it can be managed. Finally, every insurer and every payer for health care understands all that and will reimburse treatment teams to do it. When I say the same things about opioid and alcohol dependence, we still as a country haven't fully accepted that this is a medical condition, physicians haven't fully accepted this, but these are medical facts.

So Medication Assisted Treatment has been a big philosophical point because for decades it was thought that drugs are drugs and a person who is drug dependent, they should be abstinent of all drugs. It's been the prevailing and often very effective way to treat lots of patients, but the opioid addiction, that kind of view has to be reconsidered. Now overdose deaths are the largest cause of death in people under 50, so let's just accept that the addiction is a chronic illness. Okay, well, what would you want from an effective treatment? One, you want to reduce the cardinal symptom of the problem. Again, if it's diabetes, you want to reduce hemoglobin A1C. If it's hypertension, you want to reduce blood pressure. First and foremost, thing you want any treatment to do is to protect the patient and reduce the cardinal presenting symptom of the illness, in this case drug use. That's not enough, you also want generally improved health and function. And finally, because it's a chronic illness, you're going to have to convert the patient and their family to be actively monitoring and managing their own disease, and that's effective care for any chronic illness. In the addiction field, if you put those three things together, that is called recovery, so in my mind we want Medication Assisted Recovery because that's what patients' want, that's what payers want and it is entirely possible.

Now, especially for opioids, especially for alcohol, where there's a risk of overdose and a risk for relapse, it is a fact that medications are the safest way and the most reliable way to protect the patient and reduce the presenting symptom, the substance use. Even when medications are necessary, usually they are not adequate in and of themselves. Just in the case of diabetes, nobody would advocate driving up, getting insulin, driving off as a treatment for diabetes. You need to change your lifestyle, you need to change your diet, you need to change your exercise and you need to self-monitor and get the help

of your family. That's what good addiction treatment does too, it helps you change your lifestyle, recognize triggers for relapse and be protected with the medication while you're doing that.

Margaret Flinter: Tom, I want to just focus for a moment on another element of the important work that you've done on addiction, and that's developing tools for those clinicians who are engaged in working with patients on treating addiction. Two of them that come to mind are the Addiction Severity Index or the ASI and the Treatment Services Review, the TSR, which I understand are really quite widely used now in clinical settings. So maybe if you could expand upon that a little, is that for in the substance abuse specialty treatment domain? And if it is, what would you recommend in the primary care domain?

Dr. McLellan: So these instruments have a purpose, they are not to screen to see if there's presumptive evidence of a problem. In fact, it's now clear that you can get a presumptive idea of whether an individual, adolescent or an adult may have a substance use problem with a few [inaudible 00:11:47] questions and it's still not widely enough used. The next thing you want to do is diagnose it whether there is loss of control over their substance use that can be done with a diagnostic interview.

Okay, now you've got a diagnosis. Next question is, what are we going to do to treat that patient and how you are going to prepare yourself as a clinician and how you're going to prepare the patient to understand the problem? That's where the ASI was designed. We [Inaudible 00:12:18] the premise that addiction is best understood in the context of the problems that may have preceded, may have resulted from the substance use, typical life scenarios, medical conditions, employment, legal, family and psychiatric problems.

At the end of the 40-minute interview, a clinician and the patient ought to better understand how they got into this substance use problem and what other problems have to be addressed. I foolishly thought that the person with the worst substance use problem would also have the worst financial, the worst legal as well, and the first sort of surprising finding is that that isn't true at all. Think about it, you know celebrities who have no problem with their employment and they've got an enormous substance use problem because of ready availabilities, where another group addicted physicians who have often very serious rates of substance abuse, but no other problems. Meanwhile, you can have an unemployed, pregnant teenage girl who has a rather modest cocaine problem, but is going to be an awful lot more difficult to treat than a very seriously addicted physician. The Addiction Severity Index was designed to prepare treatment providers to address the often complex interrelated problems that occur.

The second thing that’s designed to do was to establish a baseline to

what do these patients look like when they walk through the door to your treatment facility? How bad are things recently in the last month so that later you could reassess the patient and you could compare to see whether there's been improvement? Most patients enter substance abuse treatment have many problems, so you're not just dealing with drug use, you're dealing with a combination. Good news is patients who undergo treatment do better, they improve relative to where they were when they come in the door, patients who get tailored treatments do better. And again, these are things that have been found with the research, so it is guided the thinking I suppose to take it off simply focusing on substance use and begin to think about the whole package. And it has led away from programmatic care to more individualized, tailored, personalized treatments as are now typical for other chronic illnesses.

Mark Masselli: We are speaking today with Thomas McLellan, Founder of the Treatment Research Institute, dedicated to science driven reform of treatment and policy and substance abuse. Tom, I was listening to you sort of walkthrough those numbers about the size of the opioid crisis in America. We always keep our eye on what's happening in Washington in terms of how they're allocating money for this and also the policies that they're implementing. President Obama and his former drugs are adopted a pretty aggressive approach, it seems since 2017 things have slowed down. Tell us what's happening in there and your prescription for what policy should be implemented.

Dr. McLellan: I'm dismayed by federal policy towards addiction and in fairness, I don't think the Obama Administration guide right either. I think we moved further towards a view that addiction is a public health problem that is best addressed with prevention, early intervention and treatment, and moved away from addiction is a criminal problem and needs to be punished, and now I see it going the other way. I'm trying to take a cold-blooded what's going to work approach, and the truth is that top national policies that punish but offer no treatment or national policies that simply say everybody needs treatment and there's no punishment and no sanctions for use are wrongheaded. The best policies that I know of are those that combine them, and it's an artificial separation between police and treatment professionals. You can't treat any addiction when there's ready availability of the substance in the street, it's just not, it's like treating diphtheria with a place where there's polluted water. Further, you can punish an addicted person all you want but if they don't get the right kind of monitoring and supervision, they're simply going to go back to it.

So I favor policies that reduce the availability of substances, I'm not for legalization of or even medicalization of marijuana just because it makes the availability increased the likelihood of more people using you're going to have more misuse and you're going to have more

addiction. I'm for policies that expand incentives for mainstream health care to embrace substance use disorder, it's in their interest for providing high quality general medical care to know something about addiction. Less than 30% of American medical schools have even a single course in it, that's what science tells us are the best ways to prevent, intervene early, and treat substance use disorders.

Margaret Flinter: We've been speaking today with Dr. Tom McClellan, founder and CEO of the Treatment Research Institute. You can learn more about his groundbreaking work by going to trisearch.org or follow them on Facebook @Treatment Research Institute. Tom, we want to thank you for your dedication to this incredibly important health issue, for your body of research and for joining us today on Conversations on Healthcare.

Tom McLellan: Well, thank you. It's been a pleasure.

Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about healthcare reform in policy. Lori Robertson is an award winning journalist and Managing Editor of Factcheck.org a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: President Donald Trump has repeatedly said that Obama Care is dead, but recently he has been making a misleading boast about low insurance premium growth for 2019 marketplace plans.

Trump claimed that the “rates are far lower than they would have been under the previous administration”. He added “because we're managing it very, very carefully”. One study disputes that, and experts say, most administration actions in the past two years have driven premiums up, the actions the administration has taken “by and large, have destabilized the market”, said Cynthia Cox, the Director of the Program for the Study of Health Reform and Private Insurance at the Kaiser Family Foundation. Experts also espoused a longer view at the trajectory of premiums for the individual market. The expected low average premium change for 2019 plans comes after a double digit increase last year which was also under the Trump administration and driven by the administration's elimination of cost sharing subsidies and uncertainty over the ACA’s future.

Kelly Turek, the Executive Director of Employer and Commercial Policy at America's Health Insurance Plans told us that insurers are also getting a better sense of the market. For plan year 2015, premiums for the second lowest cost Silver plan went up 3% on average for 27 year old according to the Department of Health and Human Services. Premiums went up 8% for 2016, 24% for 2017 and in the first year under Trump 2018, they went up 37%. Silver plans in particular were

affected for plan year 2018 by the administration ending cost sharing subsidies paid to insurers to lower the out pocket costs of low income policy holders. For plan year 2019 HHS said, it is projecting a 2% average decrease for benchmark silver plans in Healthcare.gov state. An analysis by the Associated Press and the consulting firm, Avalere Health upstate rate filings by insurers found a 2% average increase for 48 states and Washington DC for 2019 overall premium.

Avalere Health Founder Dan Mendelson told us the low growth for 2019 was due to an absence of political disruption this year and an expectation of slower growth in medical expenses. Next year the individual mandate penalty will be eliminated and the Trump administration has announced new regulations to expand the use of association and short term health plans. One study from the Brookings Institution found that the nationwide average premium and the individual market would decrease by 4.3% if such policies hadn't been enacted, and that's my Fact Check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, e-mail us at www.chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. Tinnitus is the vaccine condition that afflicts millions of Americans, a condition for which there is really no viable treatment to date, but a University of Michigan researcher may have found a solution. Lead researcher Dr. Susan Shore says tinnitus marked by a constant ringing in the ears is really the results of misfiring brain signals. Her team has developed a device aimed at getting to the root cause of Tinnitus. Neurons in the region of the brain stem, when those cells become hyperactive, they create a signal that is transmitted to the part of the brain where hearing perception occurs and the constant ringing can wreak havoc on sufferers' lives.

Dr. Susan Shore: What you're doing is you're tricking the brain into altering its circuitry to go back to normal.

Mark Masselli: The device is called a targeted bimodal Auditory somatosensory stimulation and works on two fronts. It uses both weak electrical impulses target to the brain region responsible for their problem, and also sends time sound to interrupt the auditory sensation caused by the tinnitus.

Dr. Susan Shore: We developed this treatment for a particular class of Tinnitus in which the person who has the Tinnitus is able to modulate either the pitch or the loudness of their tinnitus by pushing on their face or pushing on their forehead or clenching their jaw.

Mark Masselli: The study group has been relatively small so far, just a few dozen participants, but the results have been quite promising. Dr. Shore says that the severity of the tinnitus was greatly reduced in most of the participants and some got to the point where they no longer interfered with their daily lives.

Dr. Susan Shore: We need a good solution for Tinnitus as it's affecting millions of people.

Mark Masselli: A relatively simple targeted device that could potentially help millions of tinnitus sufferers from the worst effects of their condition, allowing them to diminish or even ignore what is often a debilitating condition for many to live with, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Peace and Health.

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