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Female: 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 Dr. Anand Parekh, Chief Medical Advisor for the Bipartisan Policy Center, a think tank dedicated to finding bipartisan solutions to America's biggest policy challenges including health care. He discusses their first of its kind reports on how different states are utilizing federal dollars to battle the opioid crisis and what's working in their states.

Lori Robertson also checks in the Managing Editor of FactCheck.org looks at misstatement spoken about health policy in the public domain separating the faith from the facts. We end with a bright idea that's improving health and wellbeing and everyday lives. If you have comments, please email us at chcradio@chc1.com or find us on Facebook, Twitter, iTunes, or wherever you listen to podcasts. You can also hear us by asking Alexa to play the program Conversations on Health Care. Now stay tuned for our interview with Dr. Anand Parekh, Chief Medical Advisor to the Bipartisan Policy Center on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Anand Parekh a Chief Medical Advisor to the Bipartisan Policy Center, a Washington based think tank committed to promoting bipartisanship and policy decisions that affect all Americans. Dr. Parekh previously served as Deputy Assistant Secretary for Health at the US Department of Health and Human Services. He's a board certified in internal medicine and is a fellow of the American College of Physicians. Dr. Parekh is an adjunct professor at Johns Hopkins University, as well as the University of Michigan School of Public Health. He received a BA in political science and MD and an MPH in health management and policy from the University of Michigan. Dr. Parekh welcome to Conversations on Health Care.

Dr. Anand Parekh: Thank you, glad to be on with you.

Mark Masselli: Yeah, I think we're excited, Margaret, when we hear the word bipartisanship in terms of public health policy, it's so important and probably no greater crisis facing Americans where we need bipartisanship is the opioid crisis. Really one of the great public health crisis is the country is faced with more than 70,000 people dying from overdose over last year. The federal government is responding by deploying billions of dollars to help states address the problem. Your team at the Bipartisan Policy Center has really focused in on creating a comprehensive, transparent study analyzing how these federal dollars are being spent at the state level. I'm wondering if you could just talk to our listeners a little bit about this, first of its kind report

and why this information is so important.

Dr. Anand Parekh: You know, our purpose for this report is really to identify how federal dollars are being spent on the opioid epidemic. One would think that this ought to be a government function, but it hadn't been done before to our knowledge, and so we thought that it was important. Certainly a critical public health issue, it's a bipartisan issue as well. It is the first comprehensive transparent study tracking federal funding streams to help states and localities tackle the opioid epidemic. Through our study, we identified 67 different funding streams, areas such as prevention, treatment, recovery, research, law enforcement, interdiction, criminal justice, so a broad range of areas. These programs accounted for about $11 billion in federal funding. A notable finding was between 2017 and 2018 there was a significant increase in the amount of funding for treatment and recovery specifically, and that's appropriate given the high numbers of Americans who have opioid use disorder.

Margaret Flinter: Well, I understand that your study looked at five geographically diverse states and looked at the kind of infrastructure that each one was building to address the opioid crisis in their communities and how they were really thinking about and allocating their federal dollars to do so. Can you share with us some of the more notable findings and what worked well, what didn't or still in process.

Dr. Anand Parekh: We look specifically at five states, we looked at Arizona, Louisiana, Tennessee, Ohio, and New Hampshire. We wanted to make sure that these were five different states. They are also politically diverse [inaudible 00:04:32] expanded Medicaid, which I'm sure we'll get into others have not. But as a whole, they have a significantly higher opioid overdose death rate. There are really two critical findings, and the first finding, federal opioid funding in the states is flowing the counties with the highest number of drug overdose deaths, and that's a positive finding.

The second finding was that many rural counties seem to receive lower levels of per capita funding in spite of some of these actually having pretty high drug overdose death rates. That really points to this issue that we need to continue focusing on vulnerable communities, particularly in rural America where there is limited treatment infrastructure and workforce capacity. Now, we saw a lot of best practices, for example, in New Hampshire, where they have a significant area that is quite rural. They are integrating a hub-and-spoke model, which is essentially a way to ensure that there are a few hubs in the state where complex cases individuals who have opioid use sort of can go. But then there are many spokes that allow any individual in state within one hour, they would be able to reach a treatment facility, so it's one way of increasing access to treatment.

Other states like Ohio, in some communities, law enforcement and public health teamed up. Right after there's an overdose, in the substance 24 or 48 hours, there's a team of health professionals who go to the home of the individual who's overdosed and try to see if they would welcome treatment. Some of these communities are reporting incredible rates of entry and then retention into opioid use disorder treatment with the gold standard treatment, which is Medicaid assisted treatment. Other states like Tennessee have seen a dramatic reduction in the rate of opioid prescribing some of which, as we know, is unnecessary. That's a trend that's going on nationally.

In Louisiana, for example, there's a focus on incarcerated populations, which is also vulnerable population. We know that if we can get treatment to individuals who are incarcerated who have opioid use disorder. Then we know that upon re entry their overdose rates are lower. We found quite a few examples of innovation in the states, four out of the five states that we explore did expand Medicaid, and you can see a difference, you know, the states that expanded are able to get treatment to greater numbers of individuals who have opioid use disorder.

Mark Masselli: Dr. Parekh I think you said it so eloquently this is the gold standard out there is medication assisted treatment, better known as MATs, such an effective tool in managing substance abuse disorder. I'm wondering if you could talk about what you learn from those communities that deployed an integrated approach to treatment, which included MAT.

Dr. Anand Parekh: The evidence is pretty clear now that medication assisted treatment, so it's the medication plus the behavioral counseling together, leads to the highest rates of recovery. I think this idea that addiction, we need to think of these as chronic diseases, what we learned in quite candidly, there are still communities across this country that are hesitant about medication assisted treatment. This may be due to the fact that even these medications are partial opioid, what we call agonist. If you take a medication like Suboxone, you can't become dependent or addicted on these medications. These are really proven evidence based treatments to treat opioid use disorder. I think just getting that information out, I think is critical.

Federal policies here are very helpful as well, and we were very pleased to see that the Substance Abuse and Mental Health Services Administration SAMHSA, in their key grant mandated that states have to use their treatment dollars toward medication assisted treatment, which is the gold standard. When we talk about MAT, that's the treatment piece, but I think what we're now increasingly understanding that it has to be treatment plus recovery, that it's MAT plus housing and employment and all of those elements to recovery

that help individuals stay in treatment that I think lead to the best long term outcomes.

Margaret Flinter: Within our health system, the full integration of primary care, and behavioral health and substance use disorder including MAT and trying to advance the ranks of providers who are trained, eligible and willing to engage in MAT treatment has really made a big difference. I also want to thank you for flagging this role that Medicaid expansion seems to have played in getting people into treatment. It raises the question, so what will we as a country do for those states that did not expand Medicaid coverage. In fact, Mark just today, one of our staff were telling me how high the copay is under somebody who has commercial insurance but can't afford the Suboxone because of it. I'm wondering what are we going to do for those folks living in the non-Medicaid expansion states?

Dr. Anand Parekh: I think that is a challenge that the non-Medicaid expansion states are grappling with right now, because they see these federal revenue streams coming in, these are discretionary dollars. But given that they have an expanded Medicaid to help pay for treatment, essentially these streams are going to pay for that treatment, when one would hope that it was actually a private payer or a public payer. Now you are seeing some states that have held out to date now partially expanding Medicaid. I think this is increasingly becoming less of a partisan issue, and you're seeing on both sides in red states and blue states 35 to 50% of the treatment dollars in some of the hardest hit states come from Medicaid. Strengthening Medicaid strengthen to respond to the opioid epidemic.

Beyond expansion, there are other critical issues such as how do you make sure that just because somebody has health insurance there aren't, for example, prior authorizations, making it difficult, for example, to get the medications that are needed, so I think that's an issue. But it's going to take public and private payer coverage of treatment. That will then allow a lot of the discretionary streams that BPC studied in its report that come in behind to help build what we need for the long term for this broader addiction crisis, which is to build the infrastructure.

Mark Masselli: We're speaking today with Dr. Anand Parekh, Chief Medical Advisor to the Bipartisan Policy Center, a Washington based think tank committed to promoting bipartisanship in American policy decision. Dr. Parekh we talk about this combination of treatment and recovery support being critical to the successful intervention. Clearly we see that concerns about the lack of access behavioral health services remains a huge stumbling block. You talked earlier about the role that SAMHSA, the Substance Abuse and Mental Health Administration is playing in. Connect the dots for us, if you will, about their integration

with the White House Office of Drug Policy, and to really improve the framework out of which local efforts can occur.

Dr. Anand Parekh: I think there are several critical points when we think about how do you improve access to behavioral health services, certainly access to health insurance is critical parity, ensuring that insurance companies are providing the same level of coverage for mental health services as they do as physical health services. Addressing stigma, I think is critical having the workforce to provide the care. If you think about the federal response, there are multiple agencies involved, so SAMSHA is one, HRSA which is the Health Resource Services Administration oversees workforce programs, community health centers, the Veterans Affairs Department, CMS Center for Medicare and Medicaid Services. All of these federal agencies play a critical role in improving access to behavioral health services.

I think a critical point of BPC's report was that to coordinate the efforts of all of these entities you need a robust empowered White House Office of Drug Control policy. You can imagine if you're a state official, and you're seeing 57 different programs from the federal government coming your way, unless there's coordination at the federal level, how can we expect coordination at the state level? I think that's why one of our key recommendations is that, again, that White House Office, be empowered to provide the coordination across all of these federal agencies.

Margaret Flinter: Well, let me ask if you could comment on a very compelling piece that you wrote last year, titled, how can we fix the opioid crisis. Just kind of lay out a couple of the key recommendations, one seems so obvious, but get clinicians to prescribe fewer opioids. Honestly, there are some pretty good evidence that is happening, certainly reducing barriers to treatment. We encounter many places that have kind of zero tolerance for any complicating factors as opposed to a sort of harm reduction model and treatment. Certainly the push to hold the makers of these addictive drugs accountable may play a role. Last, how do we stop the flow of illegal substances like black market Fentanyl. This is a very broad range of strategic interventions, but they all seem to play an important role. I'd wonder if you'd like to elaborate on any of them.

Dr. Anand Parekh: You know, in this country we have made it much easier to prescribe opioids than to prescribe the medications to treat opioid use disorder. For example, to prescribe opioids, all I need to do is every three years renew my DEA license, and that form takes about five minutes, and you send in a check. Then you essentially have a carte blanche, the federal level to prescribe opioids. To prescribed the treatment for opioid use disorder, you actually have to go through an eight hour training to prescribe Buprenorphine, and then you have taps on the

number of individuals you can treat. Imagine if somebody told me, well, you can only see 100 patients with diabetes, or 50 patients with heart failure, and they make it much more difficult to prescribe treatment, and they make it quite easy to prescribe unnecessary opioids.

Now, Margaret, you're absolutely right, we have made some progress in reducing unnecessary prescriptions in this country. Back in 2012, about 250 million opioid prescriptions annually, and now we've got that down to below 200 million, closer to about 190 million prescriptions. Still, there has been a significant over 20% reduction, so that's good. We need to be mindful of the fact that there are individuals in this country suffering from pain syndromes who have chronic pain and individuals who for whom opioids are the correct treatment. But we know that there's tremendous prescribing of unnecessary opioids and that's what we're trying to get under control. But I think tying in some sort of requirement or training, every time a provider renews their DEA license where they get some kind of continuing education on addiction, or opioid prescribing or opioid use disorder and treatment, I think would be really helpful.

Reducing some of these regulations that make it just that much more difficult to prescribe medication assisted treatment for opioid use disorder, I think really ought to be looked at. But then, as you said, that’s just one piece of the puzzle, but we also need to curb the illicit flow. You're absolutely right, Fentanyl is what is driving overdose deaths now in this country. We need to get people in a treatment, we need to support harm reduction strategies, like ensuring that Naloxone is distributed widely. They're all critical, it has to be across the board prevention, of course, is critical -- a critical ways to tackle the epidemic.

Mark Masselli: Dr. Parekh I want to end where we began, which is the word bipartisanship. I wonder if you could just share with our listeners, not all of them may know about the incredible forming of the Bipartisan Policy Center, where it came from, and maybe some of its broader work that bring you to the tables with a thinkers from both sides of the aisle.

Dr. Anand Parekh: I, like many of my colleagues here are driven towards the Bipartisan Policy Center because we believe in the mission. Frankly, we think there are ought to be more bipartisanship in this country. We're thankful to the founders, Senator Tom Daschle, Senator George Mitchell, Senator Howard Baker and Senator Bob Dole for helping create the center, which essentially allows us to take the best ideas from both political parties to promote health, to promote security and to promote opportunity. The opioid epidemic is a bipartisan issue, and God knows we need more bipartisanship in this country.

I have been pleased with the scientific leadership at Health and Human Service Agencies. I think Commissioner Gottlieb has done a great job at FDA has been zero it in on the opioid epidemic. There is good leadership across the scientific agencies. I do come back to the Office of National Drug Control Policy at the White House, because I do think there's an opportunity for this administration right now to really empower that office. Then I think, finally congress has and is playing a critical role in this response. What we heard from states while many of these funding streams, most of them are annual or one time appropriations. One of the key findings from our report was a sustainable funding is critical.

Another finding was that flexible funding is also important. We went to some of these states to talk about the opioid epidemic, and they started talking about methamphetamine abuse. States need to be equipped at times to be able to deal with multiple drug abuse epidemics at the same time. We need bipartisanship in congress and any administration coming in needs to keep their eye on the ball and stay committed to this issue.

Margaret Flinter: We've been speaking today with Dr. Anand Parekh, Chief Medical Advisor to the Bipartisan Policy Center, a Washington based think tank that's committed to promoting bipartisanship and American policy decisions. You can access Dr. Parekh's report by going to Bipartisan Policy.org. You can follow him on Twitter by going to @ A. Parekh BPC or follow the organization @BPC_Bipartisan. Dr. Parekh we wanted to thank you for your dedication to improving health policy, advancing public health to saving lives during this opioid crisis and for joining us on Conversations on Health Care today.

Dr. Anand Parekh: Thank you, Margaret. Thank you, Mark.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and 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: In the midst of a chicken pox outbreak in his state. Kentucky Governor Matt Bevin said in a radio interview that he had not vaccinated any of his children against the disease, choosing instead to purposely expose his kids to an infected person to get chickenpox. Public health officials say that practice is dangerous. According to his campaign website, Bevin has nine children between the ages of 5 and 16. His office did not reply to our request for additional comments. Eugene Shapiro, a Professor of Pediatrics and Epidemiology at the Yale School of Public

Health told us that in the past, some doctors recommended so called chickenpox parties with the idea of making sure a person gets chickenpox as a child and not as an adult when the disease is usually much worse. Now that there's a vaccine that protects against the disease, Shapiro said deliberate exposure is, quote, foolish to do. That's because while most kids who get chickenpox are fine after a few days of itching and scratching, there can be complications, including serious skin infections, brain inflammation and even death.

In the early 1990s before the first vaccine was licensed, around 12,000 people were hospitalized, and between 100 and 150 died every year according to the Centers for Disease Control and Prevention, which strongly recommends against chickenpox parties. Bevin made other false or misleading statements in his interview, he said that the people catching and spreading chicken box had been vaccinated calling this an example of irony, because vaccines don't work 100% of the time, and the vast majority of children are vaccinated in the United States. It's entirely possible for more vaccinated than unvaccinated people to get chickenpox. There's no irony involved, just math. Bevin also falsely claimed that people who are vaccinated against chickenpox, quote, need to keep getting boosters. There is no evidence that boosters are needed after a person receives the two recommended doses of the vaccine. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCeck.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'd like checked, email us at CHCradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversation.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. While more than 20 million Americans have gained coverage under the Affordable Care Act, some 30 million remain uninsured and many of these are either immigrants or without the resources to purchase coverage. While most cam access primary health care in the nation's community health centers and safety net hospitals, many more with complex conditions simply can't afford access to specialty care. Entrepreneur [inaudible 00:23:35] decided to create a virtual way to bypass the system and founded the human diagnosis project. A network of volunteer specialists around the country offering virtual consults for the neediest patients.

Male: The human diagnosis project is an online system built by the world's doctors to understand the best steps to help any patient. We realized

that there is an opportunity to develop a system that can ultimately help solve the problem for those people who won't have access to specialty care.

Margaret Flinter: Dr. Shantanu Nundy is Director of the Human Diagnosis Project. He's a frontline primary care provider in a safety net clinic who saw the opportunity to provide specialty care in a cost effective way through volunteer participation from specialist. A free online portal, linking safety net providers serving underserved populations to specialty care expertise. Now that's a bright idea.

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University streaming live at chcradio.com, iTunes or wherever you listen to podcast. If you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. The show is brought to you by the Community Health Center.