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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we welcome Beth Macy, award-winning journalist, and author of Dopesick, and the follow up Raising Lazarus on America's deepening opioid crisis.

Beth Macy: We know that we have a 87% treatment gap in this country, and that means that only 13% of folks with SUD have managed to get care.

Marianne O'Hare: FactCheck.org's Managing Editor looks at misstatements about health policy in the public domain, and we end with a bright idea. Now here are your hosts Mark Masselli and Margaret Flinter.

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Mark Masselli: The opioid crisis, and the serious missteps that caused it, have been well documented by our guest. She painstakingly told the story from big farmers' office to the distressed Virginia mining town, and her acclaimed book Dopesick has been turned into an award-winning miniseries. 7 million Americans suffering right now from opioid addiction.

Margaret Flinter: And now journalist and author Beth Macy is here to tell us about the next part of the story. That's a new book. Raising Lazarus, is an account of what she calls the everyday heroes that are fighting on the frontlines of the overdose crisis. And as she says, patients cannot recover if they're dead.

Mark Masselli: Well Beth, let me welcome you to Conversations on Health Care.

Beth Macy: Thanks for having me.

Mark Masselli: You know, you really have dug into the subject of those you call 'treatment innovators for opioid addiction'. And I'm wondering what do we know about treatment and what's working best.

Beth Macy: Well, we know that we have a 87% treatment gap in this country. And that means that only 13% of folks with SUD have managed to get care in the last year. And that's, you know, if we are getting a 13% in school, we'd get failed out. We're failing. And another thing that I have noticed, having spent the better part of eight years working on two books about this, is that people die when they are facing barriers to care, when you have most rehabs in the nation still not allowing the gold standard of care, Buprenorphine and Methadone. That's a huge problem. And I have seen parents remortgage their houses and all manner of things to send their children to exactly the kind of care that isn't serving them the best. And it's just tragic.

What is working, there's this huge group, it's probably the largest group according to SAMHSA, 40% of people with opioid use disorder that say they don't want to stop using, they think they can't stop

using, and that's largely because they've been stigmatized, either by the criminal justice system, or by the health care system. So, this approach known as harm reduction, this idea of going to them where they are, even if they're still in chaotic use, and treating them like a human being with a treatable medical condition is basically the gateway into care. And that's what I learned from the last couple of years reporting on the new book.

Margaret Flinter: Well Beth, you have some compelling stories, and certainly you talk about resistance from law enforcement, but you also highlight a sheriff in Fairfax County, Virginia, who himself is organizing medication-assisted treatment. If we know that that works, what more can be done to provide such an approach on a broader scale?

Beth Macy: Yeah. So we need to be scaling up what people like Sheriff Stacey Kincaid are doing. She was willing to take a political risk. She's an elective sheriff. And she said, “Hey, let's work together with the Community Services Board,” which is the state-funded mental health and substance use disorder group, “and we're going to do things differently. So we're going to screen every person that comes in to our jail for addiction. And if they're willing, we're going to put them on Buprenorphine. We're going to partner with a harm reduction group to send peers into the jail and work with folks in their addiction on coming out with a reentry plan. And when they get out, we're going to physically literally meet them at the moment of discharge and help them go to their next step.”

So, a lot of new rules had to be written and rewritten. And a lot of the deputies didn't want to do it at first. “We're going to have Bupe in the jail when a lot of people here have been arrested for diverting Bupe?” And so train, train, train, bring in experts, give the stats, oh, and we're going to bring in peers, by the way all of whom are felons into the jail and let them -- give them badges. You know, they were very resistant. And then those who just simply couldn't get it were let go. That's risk. That's courage. That's really I think being a treatment innovator. And there are examples all throughout the book of people who are managing to bridge health care and law enforcement, and some of them are just having fantastic results.

Mark Masselli: You know, I was thinking about the tobacco settlement and what a disaster that was for many of us who lived through that time and how monies were diverted to everything but tobacco education for young people and intervention strategies. And beginning this spring, local government agencies started receiving funds from the $26 billion opioid settlement. I'm just wondering if we learned anything, and do you think they have good plans to utilize those dollars?

Beth Macy: I think some do. The week before the book came out in early August of this year, I met with all the county commissioners in North

Carolina. This is a state that hasn't passed the Medicaid expansion, is a conservative state, and my thinking was, if they can get harm reduction here, you can do it anywhere. Right? And how did they get over those cultural barriers. But I know from that meeting alone that about half of the 100 counties in North Carolina didn't really have a plan yet for what they were doing with the money. And you know, what are the chances it's going to go to either something unrelated altogether, which is not supposed to go the way of the tobacco settlement. We know that less than 3% of the money actually went to prevent smoking and smoking related diseases. I was hoping that this book could come out at this time when communities are making these really important decisions. And I'm really hopeful, but also a little cynical, that the money will be swiped by people in power for appearing tough on crime, what some people in the book call Hug a Thug, and that it'll go to incarceration first models, and abstinence only models, that we know don't work as well for OUD.

Margaret Flinter: Well Beth, it seems to me that one really important system in the United States is the Federally Qualified Health Center system that cares for about 30 million people with about 14,000 sites. And I think what's unique about them is not just the access piece, but removing the stigma. Because you can be going for your regular primary care, your dental visit, or your visit to get medication-assisted treatment. I think the increase between 2016 and 2020 was over 300%. Is this an approach that you heard much about in doing your research and writing the book, or what more can the health centers be doing?

Beth Macy: Yeah, absolutely. I think FQHCs are -- I mean, I think a lot of the money should come through them, because they are not dependent on the whims of politics. I begin the book with a nurse practitioner. He's worked all day at an FQHC doing mostly addiction and HIV care, and at night he works for harm reduction group in a rural part of North Carolina. His name's Tim Nolan, and he's meeting people where they are. He starts out passing out needles. He quickly realizes that he's tapped into this population. He calls them the ‘unseen’. And he begins with Hepatitis C, treats them, starts reaching more people, and then they come to the conclusion that they really need to offer low barrier care.

And so he's going to them where they are, whether it's in a McDonald's parking lot that they've pre-arranged to meet, and he's getting them on Buprenorphine. And through his FQHC he has arranged discount pricing at one particular drugstore. And he wants them to know two things. I think this is really the approach to getting that 40% back into systems of care. One is you can get better. Most Americans have given up on this population. And a lot of folks with OUD themselves, don't think they can get better. So first, we got to have hope. Medications are actually pretty efficacious. There are a lot

of studies going back to the late ‘80s on how well they work. And two, just don’t disappear. And that's this idea that we're not going to kick you out if you have a relapse. We're going to increase your treatment, your counseling, your social support. But we're not just going to shun you and kick you out because addiction is a chronic relapsing disease. We wouldn't do that for somebody with diabetes.

Mark Masselli: Not at all. You know, Beth, you said that your book was hopefully a primer for people to start thinking about plans for how they might utilize this money. But your book is also a clarion call to examine the laws and health policies that need to change. What policy changes do lawmakers and regulators need to look at and what are you focused in on?

Beth Macy: Well, you know, at the beginning of writing about this, I was kind of naive about how health care worked. I kept asking people, “What should the Federal magic wand be?” But finally somebody said, “Beth, medicine doesn't really run at the Federal level.” I mean, there can be -- certainly powers of the purse can be employed to incentivize people to treat this population differently, and I think the Biden Administration is trying to do that. First President on record who's used the phrase ‘harm reduction’, you know, and is putting money behind it.

Somebody pointed out in my research in rural North Carolina, he pointed out that the county sheriff is the highest elected law enforcement official so they hold huge sway over the way folks with addiction are treated in the court system. And so I'm going to show you innovators that I think are figuring out how to do it. So I think immediately of Judge Duane Slone, who’s in Eastern Tennessee, an elected judge, and he's a former tough on crime prosecutor. And he doesn't believe in letting his probationers beyond MAT at the beginning. And then something happens. He and his wife adopt a baby that has NAS. They get to know the biological mother. And they really get to know her story. And they realize she just can't do it without this. And so he does a deep dive, and he looks into the data and he says, “How can we not be allowing this?”

So, he partners with this physician named Dr. Steve Lloyd. Now, Dr. Steve is the doctor that the Michael Keaton character is based on in the Dopesick show. He really got addicted himself to Oxycontin, eventually got into recovery, and became a leader. And so Dr. Steve meets this judge, and he volunteers to serve on his drug recovery court, because simply he wants the voice of the medical professional there to start to change the thinking among the whole recovery court team. And so, in a couple of years, they start wrapping services around these folks. And they have reduced overdose deaths by 80% in the four counties that Judge Slone serves. But they had to really work

against some negative thinking about it.

And if you go to the drug court, which I have, it's not like a courtroom you've ever seen. Judge Slone knows these patients. Dr. Steve is sitting there. He's weighing in on whether he thinks they're using the appropriate prescription dosage. And at the end of every person reporting how they're doing this week, Judge Slone comes out in the front and gives them a hug and tells them he's proud of them. And, you know, they've had a reduction in NAS cases, a huge reduction in property crime. And you know, then he can go back to his voters and say, “Look, we're really dealing with the problems here.”

Margaret Flinter: Well Beth, this is one problem that's a national problem. But at the heart of it, you have to have somebody who's going to be willing to prescribe the treatment, the medication-assisted treatment. I was surprised by a statistic that only 8% of physicians have done what is necessary to get the DEA license or the waiver to prescribe opioid use disorder treatment. Is it a reluctance on the part of medicine, and certainly nurse practitioners and physician assistants can also get the license as you refer to, or is it that kind of unrealistic maybe for a single person to be treating it versus needing a team to make sure that they really can do it safely and effectively? What did you hear in your interviews?

Beth Macy: Well, I heard a lot of stigma among health care providers, and this idea that they're very, very busy and it's easier not to have the difficult patients. We don't want those kind of folks in our waiting room is something that really happens. Now I was talking to the drug czar, Dr. Gupta, not wanting to go, and of that 8% he said very few of them, even the 8%, prescribe. So even those that got -- not everybody that got the waiver, takes advantage of it. We are still turning out young doctors who don't know how to identify addiction and treat it. I have some good friends who just finished Harvard Med, then did the residency, just took a nine hour board exam. They're married couple, and they took a nine hour board exam. And there was exactly one question on addiction in that whole nine hours. So we're pouring a lot of tax dollar money into the GMEs in the Graduate Medical Education, to turn out new doctors, that can't help with the disease that took out 108,000 Americans.

So, the whole system really needs to be revamped. I'm hopeful that if this MAT Act, which is currently in the Senate, gets passed, that will axe the X-waiver, the so-called X-waiver, that will get rid of this which is another huge barrier. You don't have to have a special waiver to prescribe Oxycontin for instance, or Percocet, but you do to prescribe the addiction that you got from Oxycontin or Percocet. So, I think that will open it up. There are still these patient caps, people who've been prescribing, can prescribe, after they've done it for a year or two, up

to I think 275. And, you know, these are barriers. And I think we've got to make the treatments easier to access than the dope, because the dope is out there and it's very easy to access, and Fentanyl is in almost all of it now. I was in Baltimore last month, and a public health worker told me that Fentanyl was selling for a dollar a pill, and that's frightening.

Mark Masselli: You know, not to toot our own horn, but all of our providers are MAT providers in the national program that Margaret set up for training nurse practitioners. It's a prerequisite for anyone going through the program. So Margaret was saying earlier about, you know, it's a national problem. But there are some communities that are severely affected by this opioid crisis. And NIH reports that as many as 10% of newborns are affected by neonatal opioid withdrawal syndrome. What do we know about treatment for these babies?

Beth Macy: We know that, you know, people will say addicted babies. They're not addicted, they're dependent on the medicines. And I'm sorry, but I am not -- that is not top of mind for me right now. But we know it's a huge concern. And it has led to a 17 times increase in foster care. I write about Batesville, Indiana in the new book. And, you know, even the foster care parents are getting their foster kids taken away from them. So we're going to be looking at just a tsunami if we don't go upstream from this.

Margaret Flinter: Well, that is heartbreaking, and certainly warrants all of our attention. And medication-assisted treatment is our best hope right now. But you've noted, I think, that there may be some room for more breakthroughs on the horizon. We've heard about FDA-cleared drug-free non-surgical device that uses neuromodulation to help in the reduction of symptoms associated with opioid withdrawal. Anything else coming down the research pathways that you think is promising?

Beth Macy: You know, my real goal with this book was really to show people out in the communities that are scaling these barriers of getting treatment access. I am not as up-to-date on the new scientific drugs and research as I probably should be for this conversation. But you know, we have these low-hanging fruits of axing the X-Waiver, and then reaching this really hard to reach population of folks that simply aren't captured. And so I think harm reduction, this idea of going out and going to people where they are, and really enveloping them in systems of care is where we've got to start. I'm also a fan of safe consumption, which is very controversial. But again, it's anything that gets people into systems of care, whether it's a needle exchange, passing out Fentanyl test strips, or even safe consumption, which you know New York City right now is the only location, has two sites, and I think plans for a few more, because that's a big political lift these days, so.

Mark Masselli: You know, we think about health care providers legally prescribing opioids to treat pain. And you hear all kinds of anecdotal stories about doctors holding back on prescribing opioids, even when they might be helpful, and certainly the DEA always looming large over practices. Are we headed in the opposite direction, too much of an overreaction?

Beth Macy: Yeah, a lot of folks think so, and there has been some recent research showing that people are being forced taper, people who are not misusing their medicines, and there's a lot of anger among chronic pain patients at the CDC guideline that came out in 2016. I think they walked a little bit of that back. I mean, opioids shouldn't be the first line of defense for somebody with a moderate injury. But there is this large group of folks that are already out there on stable dosages, and I hear from them a lot. They're really angry, they're really hurting. And I tried to address that in the new book, just because I knew they felt so unheard.

And there's example in the book of a doctor getting arrested for overprescribing, and we know the DEA has really cracked down on that. Some doctors have gone to jail. But what about the other patients that are the chronic, legitimate chronic pain patients? And so I try to parse out like what's the best way to treat them. It's not to force taper them because then they're just as vulnerable to going to the black market where the whole illicit drug supply has been poisoned with Fentanyl. So I think it has come back maybe a little too far and we just need more education about all of it.

Margaret Flinter: Yeah. Well it is a complicated issue. And you may have seen some polling that shows Democrats, and interestingly to me low income Republicans are generally more open to paying more taxes to fund opioid treatment programs. I think awareness is actually pretty high in the country that people are dying. I don't know anyone who doesn't know someone who lost a kid, or a parent, or a friend. But the polling also shows that Republicans and Democrats do not support placing a clinic close to them in their community, kind of like feels NIMBY problem. So it's a public perception issue, but it's also a real barrier. What have you seen? And is that part of the drive towards integrating treatment into maybe more generic health care systems or primary care systems? What are your thoughts on that?

Beth Macy: So, in Roanoke where I live, which is the largest city in the western half of Virginia, needle exchange finally became legal in 2017, I think. And it was a couple years before we actually got one open, because the law was initially written that city council and the chief of police had to sign off on it. So, finally, two years later, we get one in Roanoke. It's only the second one in the whole state. And then it gets closed by one little three minute story on a local CBS affiliate about

needle litter. So it's that nimbyism, it's that cave, citizens against virtually everything, and instead of sending a group of volunteers to fix the problem, let's just have a conversation. So what can we be doing better?

You saw the same thing happen in Charleston, West Virginia, when they located their needle exchange at the Public Health Department downtown across from their fancy mall that they were proud of, and then needle litter. And then that really blew up and became a huge political third rail. And you now have politicians there running on an anti-harm reduction platforms, which is just shocking because the city has the nation's most concerning HIV outbreak. So the thing that Roanoke did and what Charleston did, was going to people where they were, having mobile vans, so they can't say it's, you know, not my backyard, because it's all over the place. I mean, I think that's something that all communities need to look at, because it is politically more palatable. And in the words of Judge Slone, who I was talking about a little bit earlier, like when people are reluctant to start a new program like this, call it a pilot, just start doing it, and then show the results six months later, you know, and try to draw attention to this works, we did something new, the world didn't end, and people got better treatment.

Margaret Flinter: Good organizing strategy.

Mark Masselli: It is. Beth, one last question. You called on President Biden to end the ban on Federal funding of syringes. If he's listening right now, we hope he is at least on tape delay, how would you make the argument to him?

Beth Macy: I would say come visit some of the needle exchanges I've been to. People think they are these big scary places. They look like preschool classrooms. There are inspirational sayings up on the wall. People can come and get food. They can get non-judgmental connections to care. And we know their number one expense is buying the syringes. We know that people who visit syringe exchanges are five times more likely eventually to enter treatment. And that's what we all want. And I know he's read the research. I know he knows this. It's a political thing. And like Sheriff Kincaid did that began our conversation in Fairfax County, we've got to have courage.

Mark Masselli: Great.

Margaret Flinter: Well, thank you Beth for your incredible journalism. That's brought so much insight and attention to the opioid addiction issue. And thank you to our audience for being here. You can learn more about Conversations on Health Care and sign up for our email updates at www.chcradio.com. Beth, thank you again so much for joining us today.

Mark Masselli: Yeah.

Beth Macy: Thank you for having me.

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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 U.S. politics. Lori, what have you got for us this week?

Lori Robertson: The number of people without health insurance in the United States has gone down under President Joe Biden by 1.1 million people from 2020 to 2021. That's according to the Census Bureau's latest annual report. We looked into this, and many other statistical measures of Biden's presidency in our latest quarterly report that we call Biden's numbers. We published similar quarterly reports when Donald Trump was President and when Barack Obama was in the White House.

In 2020, 28.3 million people, or 8.6% of the U.S. population, lacked health insurance for the entire year. Those figures dropped to 27.2 million or 8.3% in 2021. The census report was published in September. Most of the population had employer-based insurance coverage in 2021. Altogether, 66% of Americans had private insurance, which includes work-based plans, TRICARE, which is insurance for military members and their families, and Affordable Care Act Marketplace plans. Public or government sponsored plans enrolled 35.7% of the population, split nearly evenly between Medicare and Medicaid.

The National Health Interview Survey which measures the number of uninsured at the time people were interviewed, found a decrease in the number of uninsured people of 1.6 million from 2020 to 2021. Early release figures from that survey show those lacking health insurance declined further in the first quarter of 2022. The estimates are that 8% of the population was uninsured in the first quarter, down from 8.8% in the fourth quarter of 2021.

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'd like checked, email us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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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. Health care providers are forever on the lookout for that magic elixir that can cure a host of chronic ills in one step. And in the case of obesity, depression, anxiety and stress, that elixir could be a number of steps as in taking a hike. A large study conducted by several institutions, including the University of Michigan and Edge Hill University in the UK, looked at the medicinal benefits derived from regular group hikes conducted in nature.

Dr. Sara Warber: We could see that these two different types of help for our mental wellbeing, they're operating independently. That means that if we go out in nature for a walk, we are getting an additional boost to our mental wellbeing.

Margaret Flinter: Researchers evaluated some 2000 participants in a program called Walking for Health in England which sponsored some 3000 walks per week across the country.

Dr. Sara Warber: There was investment in these walking groups, in training leaders to take people on walks, finding trails that were good for people they do, even if they had health problems.

Margaret Flinter: Dr. Sara Warber, Professor of Family Medicine at the University of Michigan School of Medicine, said this study showed a dramatic improvement in the mental wellbeing of participants.

Dr. Sara Warber: Depression was reduced, perceived stress was reduced, and there's been really lovely research that's shown that when we have positive emotions we actually have better health in the long run.

Margaret Flinter: And the effect was cumulative over time. Dr. Warber says this is the first study that revealed the added benefits of group hikes in nature and significant mitigation of depression.

Dr. Sara Warber: Because we're really interested in if you are more stressed would you get some better benefit from being in nature, and in fact, that did pan out.

Margaret Flinter: Walk for Health, a simple guided group nature hike program, which incentivizes folks suffering from depression and anxiety to step into the fresh air with others, improving their mood, reducing their depression, increasing their overall health at the same time, now that's a bright idea.

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Mark Masselli: I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

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Marianne O'Hare: Conversations on Health Care is recorded in the Knowledge and Technology Center Studios in Middletown, Connecticut, and is brought to you by the Community Health Center, now celebrating 50 years of providing quality care to the underserved where health care is a right, not a privilege, www.chc1.com and www.chcradio.com.

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