Dr. Anna Lembke

Mark Masselli: This is Conversation on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, we are still looking at some fallout from the Republican attempt to repeal and replace ObamaCare. While the Senate failed to get the majority to vote in favor of their Bill, there are still strategies the White House could use to undermine the Affordable Care Act.

Margaret Flinter: Some Senators are planning to forge ahead with hearings that are aimed at finding ways to stabilize these markets, especially in the pockets around the country, where customers who are seeking coverage simply have no insurers to choose from.

Mark Masselli: You know, Margaret, the insurance exchanges setup under the Affordable Care Act are doing pretty well. The marketplaces are stabilizing in States where their support for the Affordable Care Act, the ACA has remained intact for the time being with Mitch McConnell's last effort to repeal falling short of votes.

Margaret Flinter: Well Mark, it is important to note here that the Senators, who quickly announced that they wouldn't support repeal, that was Senator Capito of West Virginia, Senator Collins of Maine, said this would seriously derail efforts to curb the opioid epidemic, not just in their States, but around the country.

Mark Masselli: On that note, Margaret, the Center for Disease Control and Prevention and other experts predict that the number of overdose deaths is expected to increase this year from last year's high of roughly 50,000.

Margaret Flinter: This is truly an unbelievable and frightening public health crisis, Mark, with no simple solutions and no end in sight. We thought we would review an interview we did within the past year with Dr. Anna Lembke. She is an addiction specialist at Stanford Medical Center and she has written a very compelling and important book on the topic Drug Dealer MDs, How doctors were duped, patients got hooked, and why it is so hard to stop. It is a very tough look at how opioid prescribing got so out of control.

Mark Masselli: Lori Robertson also stops by. The Managing Editor of FactCheck.org, who is always on the hunt for misstatements spoken about health policy in the public domain, but no matter what the topic, you can hear all of our shows by going to www.chcradio.com.

Margaret Flinter: And as always if you have comments, please email us at www.chcradio@chc1.com or find us on Facebook or Twitter, because we love to hear from you. And we'll get you our interview with Dr. Anna Lembke in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. After a seven-year odyssey to repeal and replace ObamaCare, it appears the GOP has hit a dead end. The Republican controlled Senate plan to replace the Affordable Care Act failed to garner enough support from all Republicans and a follow up attempt to simply repeal the law never got off the ground either. So, what's next in the quest for health reform? The highly partisan Congress is likely to have to crack the door open at least slightly to the idea of bipartisan negotiation to address what needs fixing into healthcare law. Senator John Cornyn, a Republican from Texas said he felt it was unfortunate that they might have to start negotiating now across the aisle. He claimed democrats were unwilling to concede structural challenges in the Affordable Care Act. President Trump, who had campaigned heavily on repeal and replace of ObamaCare, has said publicly that may be he should just let it die. Meanwhile funding for the children's health insurance program or CHIP is going to expire after September 30th. Bills to address the subsidy payments and CHIP will likely require 60 votes for passage in the Senate. It is a barometer of how inclined Republicans and Democrats might be to work together on these important issues. Meanwhile entering into the dog days of summers, there are renewed concerns across the nation's southern interior about the resurgence of the Zika virus and cities like Houston are making ready; the nation's fourth largest city has increased budgets for mosquito control partnering with tech giants Microsoft and Google to initiate innovative approaches to containing mosquito born illnesses. Zika infections across Central America and the Caribbean are down significantly, about 90%, but the risk still remains. There are outbreaks being reported in the countries of Peru and Argentina. Currently, there are about 20 vaccines for Zika in varying stages of development. The opioid crisis has led to a rise and another health realty; a dramatic spike in the number of babies being born opioid dependent as well. This rates for babies born to opioid withdrawal has increased nearly fivefold in the U.S. and the problem is particularly acute in rural areas. Meanwhile, Missouri has become the final State in the nation to create a prescription drug monitoring program. Governor Eric Greitens signed an executive order aimed at combating a scourge that's killed more than 900 residents in the last year. Missouri has been the lone holdout for many years. The nation's Governors met in Rhode Island for the annual meeting recently and held a special session on the mounting opioid crisis. There is significant bipartisan agreement that a national agenda needs to be scaled up across multiple sectors to address what's become the leading cause of accidental death in this country. And trying to lose weight, well artificial sweeteners may not get you there. A study done at the University of Manitoba found that there is no clear benefit for weight loss and there is a potential association with increased weight gain, diabetes, and other health concerns. The observation of those studies actually found a small increase in BMI associated with the use of sweeteners. Everyday about 41% of

American adults consume some product with an artificial sweetener in it. I am Marianne O'Hare with these Healthcare Headlines.

Mark Masselli: We are speaking today with Dr. Anna Lembke, Chief of Addiction Medicine and Assistant Professor at Stanford University School of Medicine, with her primary research focused on why patients become addicted to prescription drugs. Dr. Lembke has published over 50 peer review articles and publications such as the New England Journal of Medicine and the Journal of the American Medical Association. She is the author of Drug Dealer MD, how doctors were duped, patient got hooked, and why it is so hard to stop. She earned her undergrad degree at Yale and her medical degree from Stanford University School of Medicine. Dr. Lembke, welcome to Conversations on Healthcare.

Dr. Anna Lembke: Thank you for inviting me.

Mark Masselli: Well, as you so clearly articulated we are in this midst of a devastating public health crisis in the country, some 50,000 people a year are dying from overdoses, which is sort of reminds me back to the days of the Vietnam war. Your book, Drug Dealer MD takes an unflinching look at what you see as one of the critical components of the epidemic, the dramatic rise in the number of prescription, clinicians have written for opioids in recent years and I am wondering if you could help your listeners understand the scope of America's addiction crisis.

Dr. Anna Lembke: Yeah, and I am glad you referenced the Vietnam era, because that was the opioid epidemic just prior to this one and this one certainly surpasses that in scope and devastation. Drug overdoses today are the leading cause of accidental death in this country surpassing deaths due to motor vehicle accidents for the first time in our history. And of the 50,000 annual drug related deaths, about half of those involve some kind of prescription drug. There has been a quadrupling of the number of deaths since 1999 and along with that a quadrupling in the number of prescriptions doctors have written for opioid painkillers, so what we have here is really a very clear epidemic of over prescribing just to get people perspective on this is that the U.S. consumes about 90% of the world's prescription opioids, we are constituting only about 4% of the world's population.

Mark Masselli: Amazing.

Margaret Flinter: Well, Dr. Lembke, I think it is important for our listeners to may be start a little bit at the beginning of what we now understand about addiction from thinking of this as a moral failure or understanding just how complex the medical behavioral and psychiatric underpinnings are, what's the description of addiction, the diagnostic description if you will and what does this mean within the larger context of healthcare and how we address it?

Dr. Anna Lembke: Probably, the best way to describe the disease of addiction is to tell you an anecdote about a patient of mine, who called me in desperation one day and said “you know, Dr. Lembke, I am surrounded by empty vodka bottles. I cannot stop drinking, can you help me?” This is somebody who fully recognized that she had the disease of addiction to alcohol. She clearly could describe her situation, but she was unable to stop drinking without help. In order to get her help, I had to tell her to go to her nearest emergency room and tell them that she was suicidal and she said, but Dr. Lembke, I am not suicidal, that’s why I am calling you, I want to live and I said to her, I know that, but if you go to the emergency room and tell that you want to be admitted for alcohol detox, they won’t admit you, because insurance companies don’t pay for that, so you have tell them that you are suicidal and then they will admit you and I will treat your alcohol detox. So what we have here is a huge-huge medical condition, public health problem and yet we don’t have a way to get people ready access and ready treatment paid for by their insurance company, so instead what are we doing, we are spending 400-plus billion dollars per year paying for the downstream effects of addiction.

Mark Masselli: In your book, Drug Dealer MD, you focus on what you call prescription drugs as the new gateway drugs and I am wondering what role the pharmaceutical industry has played in this latest chapter of the drug addiction scenario and well meaning doctors were duped into complicity.

Dr. Anna Lembke: Right, so my title, Drug Dealer MD is you know intentionally provocative, but also a little bit misleading, because I really do feel that this epidemic is driven primarily not by pill mill doctors exchanging prescription for cash, but by well intentioned compassionate doctors and the way that doctors are really duped is that they were misled to believe that the evidence supported the use of opioids in the treatment of chronic pain and we now know that there is essentially no evidence that opioids when prescribed long-term helps chronic pain. The reason for that is because people develop tolerance due to the process called neuroadaptation and the opioid just simply don’t work anymore. So what happened in the 1908s is some thought leaders within medicine suggested that we should more liberally prescribe opioid. Out of good intentions came a bad idea. It was essentially the pharmaceutical industry; what they did was more like a Trojan Horse approach and they infiltrated big medicine by making all kinds of partnerships with the Joint Commission, with the FDA, funneling money into these organizations, into pain societies that opioids work long-term for pain, even though there was really scant evidence. In this era of so called evidence-based medicine, there is enormous pressure on doctors to practice medicine supported by the evidence and they were told that the evidence supported using opioid chronically for pain even though that wasn’t true. So it got to be a kind of a group think and then of course there were many factors within healthcare delivery that made using opioids to treat complex problems like pain an easy solution.

Margaret Flinter: I appreciate that you acknowledge the clinicians are motivated to do right by their patients, but there is this conundrum where dramatic lack of training in this area of understanding and assessing, and diagnosing and managing and treating chronic pain, what are we going to do about this to help both clinicians and consumers move forward to get a better handle on how we manage chronic pain going forward?

Dr. Anna Lembke: I do feel positive that that we are about to make a big shift in medical school education, I was recently a part of a White House Symposium, where lot of educators from around the country talking about how we can revamp the medical school curriculum to better address the issue of addiction, but we currently have a terrible situation in which the visions learn almost nothing in most medical schools on how to target and treat addiction and much of their pain education emphasizes getting patients on opioids and let me tell you it is a lot easier to get them on than to get off. I don't think education alone is going to be enough. We really have to restructure some of the incentives within the healthcare delivery system.

Mark Masselli: We are speaking today with Dr. Anna Lembke, Chief of Addiction Medicine at Stanford University School of Medicine. She is author of Drug Dealer MD. Dr. Lembke pulled a thread a little on this notion of solutions and one of the things that we do at our Weitzman Institute is that we have a nation wide pain ECHO. Physicians and nurse practitioners, other providers are able to present cases to addiction experts. Psychiatry, nursing, along with acupuncture and the like; what other tools are you seeing out there that the practicing provider might be able to use because they just don't have the right tools?

Dr. Anna Lembke: Fortunately, there is tremendous outreach now, the ECHO program is a great example of how to tap into addiction experts to learn how to handle these complex patients. There is a push in some States to get doctors to register and even access their prescription drug monitoring program, which is a good first step. Again, what concerns me though is beyond education, we need to actually make it economically feasible in awarding for healthcare systems and individuals doctors to pursue these efforts. So, you talk about how you have a team-based approach. You've got the, you know the orthopedic surgeon with the psychiatrist and a social worker and a primary care doctor, fantastic, but I would ask you, do you get reimbursed for that time?

Mark Masselli: No.

Dr. Anna Lembke: Why? You don't, so you know it is out of the goodness of your heart and you are aware of the public health crisis and that's fantastic, but we really need to restructure the reimbursement strategy so that we incentivize doctors to do the right thing, because otherwise you are not going to get systemic reform.

Margaret Flinter: Dr. Lembke, it's really just within the last decade that those of us on the frontlines of primary care have been asked to play an active role in the treatment of drug dependency, particularly medication-assisted treatments, Suboxone being the most common one. Talk about the use of medical interventions for addiction management if you will.

Dr. Anna Lembke: Yes, I think it's fascinating that primary care doctors are expected to solve this problem, like as if they didn't have enough to do already. Alright, so let's talk about Suboxone first; I can. I have also life changing success with Suboxone and the evidence is overwhelming that it is very effective, not just to reduce; however, I am very concerned that this is kind of a typical knee jerk reaction, yet one more pill that we are prescribing and although Suboxone is effective, I don't think it's as effective as it could be if it were combined with psychosocial intervention, then it really should be. There are lots of different interventions that work for the treatment of addiction. You know, individual therapy, group therapy, family therapy, there are other medications besides Suboxone for opioid addiction namely something called naltrexone, which blocks the mu-opioid receptor and so it can also, in those individuals they report actual decreased craving, so that's a fascinating thing to note and then there are also a lot of community level interventions that are very helpful.

Mark Masselli: You know you have pharmaceutical industry, which is developing and promoting drugs and you have the FDA, which is empowered to really review drugs to improve the public health and protecting consumers and something went wrong here. What would you say are the strengths and weaknesses in that relationship between the FDA and the pharmaceutical industry and what could be a better process?

Dr. Anna Lembke: So the FDA was essentially asleep at the wheel; lot of prescription opioid crisis was unfolding even as people were dying of prescription opioid overdoses, they were doing very little to prevent pharma from misbranding opioids as non-addictive. In addition to approving new drugs, it is to police these drugs after they are out there and make sure there aren't new adverse consequences that come up and they really didn't do this, even as for example Purdue Pharma, the makers of OxyContin were advertising that less than 1% of patients would get addicted. The FDA did nothing about it. The other thing about the FDA is they have a very compromised relationship with pharmacy in which the pharmaceutical industry advises them on how to devise their studies to approve opioid. In the 1990s, the FDA changed their approval process for new opioids to a study designed called enriched enrollment. Essentially it's a way of making it easier for new opioids to get approved and they did this, you know, in collusion at large meetings funded by big pharma, so they rescheduled the hydrocodone products to Schedule II to make it harder for doctors prescribing and that was a step forward, but essentially in 2013, they approved Zohydro, which is a long-acting formulation of hydrocodone. The FDA is now strongly promoting what they call abuse deterrent alternatives of opioids. So what does

this mean? Formulations of opioids that are hard to crush and snort or crush and inject, however there is no evidence that abuse deterrent formulations mitigate the risk of addiction because the most common way to misuse opioids is to just ingest them as you normally would, right. A good example of a recent abuse deterrent formulation Opana released in 2011 was supposedly an abuse deterrent formulation of an opioid and it was at the Center of the HIV epidemic in Indiana. The FDA and pharmaceutical industry should not be cooperating on the level that they are cooperating. The FDA has to do a better job policing. They shouldn't be approving opioids. We have enough.

Margaret Flinter: Well, Dr. Lembkin, I am sure you've been very engaged in following policies that have been discussed. What should we and our listeners look forward to possibly seeing in terms of legislative or policy changes?

Dr. Anna Lembke: Well, as you know, Obama pledged 1.1 billion to try to fight opioid addiction. A lot of that has gone into increasing access to Suboxone prescribing, which is great, because as I said before, it works, but I would love to see some of those monies go towards psychosocial interventions and actually paying doctors to spend time helping their patients get off of opioids, which is a long-term and laborious process, as well as providing non-opioid alternatives to pain from psychotherapy to acupuncture to trigger point massage, whatever it is. You know, if you are going to ask primary care doctors to take care of not just diabetes, hypertension, and heart disease, but also addiction, homelessness, and unemployment, that you give them the resources to do that.

Mark Masselli: We have been speaking today with Dr. Anna Lembke, Chief of Addiction Medicine at Stanford University School of Medicine and author of Drug Dealer MD, how doctors were duped, patients got hooked, and why it so hard to stop. You could learn more about her work by going to med.stanford.edu or you can follow her on Twitter@stanfordmed or at drugdelaermd. Dr. Lembke, thank you so much for joining us on Conversations on Healthcare today.

Dr. Anna Lembke: Thank you for having me.

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a non-partisan, 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: Republicans Senators revived their Healthcare Bill, the Better Care Reconciliation Act, but that wasn't enough to garner the support needed to pass the legislation. What were some of the changes to the latest effort to repeal and replace the Affordable Care Act? The revised Senate Bill would have enabled insurers to sell plans on the State or Federal marketplaces to also sell

noncompliant plan on the individual market outside of those marketplaces. A noncompliant plan could deny coverage or charge more based on health status and they wouldn't have to meet minimum benefit requirements or a limit on out of pocket cost sharing. Compliant plans would still be governed by those rules on the marketplaces and they'd still have to offer coverage regardless of preexisting condition. They also would have received funding for several years to help lower cost since policy holders with high health cost would likely choose those compliant plans. The revised bill still would institute a per capita cap or a block grant option for Medicaid funding, but it would have allowed the cap to be lifted in areas where public emergencies are declared. Unlike the first Senate Bill and the house GOP bill, the revised bill would have kept the ACA's 0.9% additional Medicare tax and 3.8% tax on investment income for high income earners. The nonpartisan Congressional budget office hadn't yet released an analysis of the revived legislation when it became clear that Senate Republicans didn't have to vote to pass it. Senate majority leader Mitch McConnell said he would instead bring a vote on a Bill that partially repealed the ACA with a two-year delay. A replacement would have to be worked out separately, but enough Republican Senators have come out against the partial repeal to block that effort too. And that's my Factcheck for this week. I am 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, email us at www.chcradio.com, we will have FactCheck.org's, Lori Robertson, check it out for you, here on Conversations on Healthcare.

Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. If music soothes the savage beast, the question they want to answer at the Sync Project is how exactly. There are lots of anecdotal study supporting music's ability to trigger memory or boost endurance or focus, but virtually nothing is known about how music truly impacts our physiological and neurological state. This is the question that intrigued scientist Ketki Karanam, a Systems Biology PhD from Harvard, who wondered, how could music be scientifically harnessed as a powerful precision medicine tool, they formed the Sync Project with a cross-section of neuroscientists, biologists, audio engineers, and even some rock stars like Peter Gabriel and started by using artificial intelligence systems to analyze existing play lists that purports or promote relaxation induced sleep, enhanced focus, or athletic performance.

Ketki Karanam: Once we have this set of songs that our machine learning algorithms predict to be effective for a specific activity, we can then draw on studies using these devices like your smart watches, your activity trackers, and actually look at how effective indeed it is, that song for that focus.

Margaret Flinter: Karanam and her colleagues note that most of us self-medicate with music already, so why not harness this ubiquitous tool that's available to all of us and develop strategies and systems that might replace pharmacological interventions with musical ones. The Sync Project is seeking a million volunteers to offer their music suggestions.

Ketki Karanam: We are literally walking around with you know 14 million songs in our pocket every single day, so we saw a great opportunity and really being able to understand how music was affecting us, both our psychological health, as well as the physiology.

Margaret Flinter: Karanam and her team see vast potential for reducing reliance on drugs by crafting personalized music interventions in the management of a variety of complex conditions, such as pain management, PTSD, even Parkinson's disease.

Ketki Karanam: In Parkinson's disease, patients have trouble coordinating movements, so by playing them the right kind of music, it can be an external auditory support to have that's going to help them walk more smoothly.

Margaret Flinter: The Sync Project, combining computer technology and neuroscience and musicology to harness the healing powers inherent in music, now that is a bright idea.

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Healthcare broadcast from the campus of WESU at Wesleyan University, streaming live at wesufm.org and brought to you by the community health center.