Ep. 5: The Opioid Epidemic I: Addiction and Treatment

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Dr. Mario Ramirez: Hello, and welcome to another episode of *OnAir: Health Care*. I'm Dr. Mario Ramirez, a consultant here at Akin Gump.

Matt Hittle: I am Matt Hittle, a senior policy advisor here at the firm.

Dr. Mario Ramirez: Matt, I'm really excited about our discussion today. We have over the last few months covered a range of topics, and today we're going to be talking about the opioid epidemic, which is something that I think has been back of mind for a lot of folks throughout the pandemic and has sort of fallen off a lot of people's radars. But according to provisional CDC data that was released earlier this month, drug overdose deaths have increased more than 30% between March 2020 and March 2021. And we think this figure probably undercounts the number of deaths that are really out there.

Matt Hittle: Yeah, it's really stunning. When you go to the CDC's website, you'll see the stunning chart that shows all but three states saw some kind of increase in overdose deaths during that time. Notably: Vermont, an 85% increase in overdose deaths; West Virginia, a 62% increase. Three states—New Jersey, New Hampshire and South Dakota—noted decreases: New Jersey with a 1% decrease, New Hampshire with 3%, and South Dakota with a surprising 17% decrease, which is a major outlier. But of course, as you note, these are undercounts at this point, and they will probably be refined as time goes on.

Dr. Mario Ramirez: It's interesting. The CDC attributes a lot of this to illicit opioids and fentanyl imports from overseas. Although the CDC doesn't really expand on the reason that they think people are overdosing, I think there are a lot of news reports out there and a lot of other research that has blamed some of this on the isolation caused by the pandemic. Other reasons include easy access to fentanyl and other illicits, as well as the rollback in access to mental health and effective treatment programs.

Matt Hittle: Indeed. Well, I think that's a good table setting for what we're about to do here. We're going to begin today a series of episodes digging into what some have

termed an “epidemic inside a pandemic.” We're going to be talking with people who have been working on addiction treatment issues for many years.

Dr. Mario Ramirez: On that note, I'm super excited that we're going to be welcoming our guest, Gary Mendell, who is the founder and CEO of a nonprofit organization named Shatterproof that I think is doing a lot of really interesting and innovative work in working to revolutionize addiction treatment and break down the stigma around it. I know that we're looking forward to the discussion. Why don't we go ahead and jump in?

So we're going to start by welcoming Gary Mendell to the show. Gary, thanks for joining us. Gary is the CEO at Shatterproof, and Gary, I was hoping you could start by just telling us a little bit about yourself and about the organization. I know that the story is very personal for you. I was hoping you could tell us a little more about how the organization came to be.

Gary Mendell: Sure, thanks for asking. My career was not in the health care industry nor nonprofit. I was building my business, raising my family, and my older son Brian became addicted to alcohol and then drugs. He tried really hard to beat this disease. Over eight years, he attended eight different treatment programs and appeared to be doing well. But addiction doesn't always work that way. On October 20, 2011, I was woken up in the middle of the night and told that my son Brian had just died. He was 25 years old, and he hadn't used a substance in 13 months. And equally tragic, it wasn't just addiction that took my son's life. It was the feeling of shame that he had every morning when he opened his eyes, feeling like an outcast all day long, feeling like a failure that caused him to wake up that morning and research suicide notes, and write a note of his own, and take his own life.

It obviously doesn't get much worse than that as a father. After his death, I really struggled with two questions: What could I have done differently as a father? What could be done to spare other families of the tragedy my family had suffered? After a couple months of making sure I was emotionally ready to do so, I took time away from my business, and I traveled the country for three months in search of answers to those two questions.

As I did so, one fact that I learned really destroyed me all over again and stood above everything else that I learned. It did answer those two questions. I learned that our federal government had provided grants of tens of billions of dollars to researchers all across the country in the decades prior to my son dying. Those researchers had successfully used that funding and created a wonderful body of knowledge; knowledge that had proven through randomly controlled trials to be able to significantly prevent many of our loved ones from using drugs and becoming addicted; knowledge that had proven to improve outcomes in treatment for those who needed a treatment, and research that had been proven to reduce the shame and stigma had taken my son's life. What was so tragic is all this information was sitting in peer-reviewed medical journals, and hardly any of it was being implemented.

So, in answer to your question of how this organization came to be, what became very clear to me is what this country needed was an organization that was run like a business, that would block and tackle and ensure that this research that existed would get implemented. So I decided to leave my business and spend

two years developing a business plan to launch a national nonprofit that would engage millions of Americans and empower those Americans to create the change that's needed: empower those Americans to get this research implemented to protect our families.

Dr. Mario Ramirez: That's an incredibly powerful story. Matt and I have children of our own. As a physician myself, I can only imagine how difficult that must have been, Gary. I think the ability to try and translate that experience and build off of that to create an organization like Shatterproof is really powerful. I'd like to dive into that point about the stigma issue that you brought up. And particularly, one of the things that Shatterproof has worked on is coalescence around something called the Collaborative Care Model. Can you tell us a little bit about that and some of the challenges that you've encountered as you've tried to amplify that model?

Gary Mendell: Sure. The Collaborative Care Model is a perfect example of what I was referring to, of research that exists that was not being implemented. It's a very simple model of paying for addiction treatment, instead of paying for a session with a primary care practitioner, or instead of paying for treatment in a specialty provider. This model is very simple. It pays for the services of three professionals: a primary care doctor, a care coordinator, and one of two specialty consultants—either a psychiatrist or an addiction specialist. Either one of those two are typically outside the practice and are brought in as a consultant. But you put those three together, and research has proven through over 80 randomly controlled trials that it improves the outcomes of those in treatment. For addiction specifically, an over 50% improvement in outcomes—over 50%. So there is a perfect example of what research, all the funding that has gone into prove that something works, saves people's lives and has not been implemented.

At the time we got involved with that model, there were 14 states that had activated the billing codes that had been approved by the Centers for Medicare and Medicaid Services (CMS). The other 36 states had not even activated the codes. In most of the 14 states, even though the codes had been activated, they weren't being implemented. So that's a perfect example of an organization like us coming in, working with the 14 states to activate the codes through a manual that we've created, and educating Medicaid offices on the steps it needs to take to implement the codes, and in the other 36 states to get the codes first turned on so they can begin the implementation, which again is fairly simple. But change takes time. But we're getting it done. Just in the last few months, California has activated the codes, Texas has activated the codes, Massachusetts has activated the codes. So just in the last few months, it's gone from 14 states to 17, and we have many others that we're in conversations right now that we believe will be activating the codes in the coming months.

Matt Hittle: Gary, why do you think that some states have been slow to implement the codes? What's been the difficulty with the uptake so far?

Gary Mendell: Great question. Change takes time. People are busy; they have a lot of priorities. A lot of wonderfully smart, well-meaning people are just torn in different directions. It's a matter of our coming in and building a relationship with them and educating them to something that will actually improve outcomes, lower costs, etc.

There's also some issues related to the business side of getting accurate billing for the new codes. That needs to be put in place. Medicaid agencies want to start measuring outcomes; they've got to put that in place. There's a learning curve. But it all can be done, and it's fairly simple. It just takes a little time, and it takes an organization like us with our public policy team. They have three priorities: last year, this year, and next year. This is one of those three. We're going into states, we're not coming in with 20 suggestions of how to change policies. When we go into a state there's only one of two policies we're talking to them about, this and another one. That's it.

Dr. Mario Ramirez: In addition to the Collaborative Care Model, Gary, I know that one of Shatterproof's priorities has been focusing on the need for federal legislation and a requirement for accrediting bodies within the medical education establishment to actually do more about teaching towards opioid addiction and alcohol addiction, and effective measures to addressing these problems that I think have gone underaddressed, particularly during the pandemic, but really over the last 20 years. Can you tell us a little bit about that work?

Gary Mendell: Sure. Unlike the Collaborative Care Model, which is really under the domain of state Medicaid agencies, putting in place a system where the approximately one million currently active physicians are educated on the basics on the prevention, treatment, and recovery of addiction is more of a national issue. It can be done nationally obviously much faster than going state by state. Currently in the United States, three out of four students who graduate medical school have not had any coursework on the prevention, treatment, and recovery of addiction, which is unbelievable when you think about it. It's the third-largest cause of death in this country behind heart disease and cancer, putting aside the temporary horrific situation with COVID. The third-largest cause of death, and three out of four students graduate medical school without any coursework.

So, the other large focus of our policy work is to get this implemented. Every student graduates medical school currently with an understanding of how the body works. Then if they want to specialize in heart disease or some other specialty, you go on to a residency and a fellowship or specialty care, but everyone graduates medical schools, all the students do, with a basic understanding of how the body works, and they should also graduate with a basic understanding of addiction.

We're approaching two ways to do so. One is federal legislation. The acronym is the MATE [*Medication Access and Training Expansion*] Act. We require doctors who have a DEA license to prescribe controlled substances to receive addiction training on a regular basis in continuing education courses. By the way, that has been introduced by Rep. Trahan (D-MA) in the House, and Sen. Bennet (D-CO) in the Senate. We have bipartisan cosponsors in both the House and the Senate. That's one avenue, and that is actually gaining some momentum in the United States Congress right now. We are driving that as hard as we can. I say driving, it's more like educating the staffs of legislators so they really understand the benefit of this.

At the same time, you have the accrediting bodies which accredit medical schools. If they were to require medical schools to give basic education about addiction to be an accredited medical school, that would do the same thing. So we're working both paths with the expectation that we will get one of them done.

Matt Hittle: The other thing that you're working on, as I understand it, is the Addiction Treatment Locator, Assessment, and Standards platform, or ATLAS. Just based on my cursory knowledge here, it meets a really interesting need that doesn't currently exist. Could you tell us about ATLAS and what it's designed to do?

Gary Mendell: Sure. If you were to have chest pains tonight and get rushed to the hospital, you would get tested. Based on those tests, there would be treatment recommended. That treatment recommended would be by a doctor who's gone to medical school, who has a specialty in heart disease, and you can go to 20 doctors with the same situation and it's going to be in a fairly tight band of the recommendations. Then how you're treated will be in a fairly tight band of treatment that's based on science, which has proven to be effective. Well, today that's not so for addiction treatment, because addiction treatment has been outside of the health care system, created decades ago with this "rehab system" outside of the health care system, where there hasn't been the standards of care. You asked a great question in follow-up to the previous question about so many students graduating medical schools not having any understanding of addiction treatment.

What ATLAS does is we created one national standard of care for the treatment of addiction, which—unbelievably—had not existed. It's our Shatterproof national standards of care, which are based on the 2016 Surgeon General's Report. So again, it's not us. We're just the energy, if you will, to take that science that was already proven and put together in the Surgeon General's Report and codify it in eight principles of care. The sequel to that, the next step, was to then create quality measures, information that we can gather from treatment providers, from patients, on evidence-based valid and reliable measures, and claims data, bringing in these three sources of information and show transparently to families looking for treatment, comparatively treatment program alongside treatment program, to show which ones were offering evidence-based practices and which ones were operating on the science of 20 or 30 years ago; which ones were current and which ones weren't.

We launched this in six states last July after developing it over a two-and-a-half year period. Those six states represent 13% of the United States population. We're now fully funded to expand into additional states, which as they're implemented next year, in total we'll now have ATLAS for 45% of the United States population. So, essentially, by the end of next year, approximately half of those looking for treatment in the United States, if they're aware of ATLAS and go to the website, treatmentatlas.org, will be able to see which treatment programs are offering the care that's based on science, and which ones are not. Certainly we plan to expand across the country to get the entire country covered as quickly as we can.

Dr. Mario Ramirez: That's fascinating, Gary. I will say from personal experience, I'm exactly one of those folks who went through medical school without any of the education about addiction or treatment that you talked about. Now that I'm in clinical practice, I still have difficulty finding the right addiction treatment centers to send people to for the different facets of their illness.

Gary Mendell: Right. Well, thank you for bringing that up. Think of the power of that. It's basically supply and demand as consumers go to ATLAS and compare treatment

programs and gravitate toward the ones that are offering science-based practices versus ones that aren't, and commercial payers use that information to build their networks and include treatment providers in their networks that are offering science-based care and exclude providers that are not offering science-based treatment. Well, you can check the box because the whole level of care in this country will be lifted because those providers that are not offering science-based care, consumers will not be headed toward them, they will not be in-network in insurance providers, and the whole quality of care will rise. It's not rocket science. It's basically blocking and tackling.

Dr. Mario Ramirez: If I could drill down on that a little bit, even with the ongoing pandemic, we know that Congress has allotted a significant amount of money, both under the Trump administration and the Biden administration, for opioid relief efforts. I think to your point, monies directed towards work like this will help raise all boats. But could you tell us a little bit about how effective those monies have been to date and what you think we should expect coming into the next year as far as further efforts as the opioid epidemic progresses?

Gary Mendell: Well, states not implementing ATLAS, where they have a quality measurement system, are bringing in the federal money, and then they're allocating it to the treatment industry within their state. That certainly is additive, and it's positive, and it's good. But think how much more additive and positive it can be if they allocated 2% or 3% of that funding to implement ATLAS so they can see the data and see which treatment programs were providing science-based care and which ones weren't, and allocate the funding to the programs that were offering science-based care—97% or 98% of that funding would be used so much more effectively. That's what we've been able to educate states on, and that's why states are bringing ATLAS into their state. But even though we'll have 45% of the population next year, there's still dozens of states that have not brought ATLAS in, which could get us to 60%, 70%, 80%, and ultimately 100% of the population having access to this, and so much better use of the federal funding if it's going towards science-based care.

Going forward, what the Biden administration is focused on are some really good things. One of them is our MATE Act, requiring all medical professionals in the field to have continuing education courses on the basics of the prevention and treatment and recovery of addiction. Acting Director of the Office of National Drug Control Policy Regina LaBelle has spoken several times in testimony to Congress about this. It's picking up momentum in both houses of Congress and we're hopeful that we'll get it through. We're also talking to the Biden administration about a convening of the accrediting bodies of the medical schools to encourage them to require this accreditation, the curriculum on the basics of the prevention and treatment and recovery of addiction.

Dr. Gupta, who will be the new Director of the Office of National Drug Control Policy, he understands this disease really well from his career in West Virginia. He has seen the destruction of families in his state, and he's also big on evidence-based, science-based prevention. It goes back to my opening remarks when I talked about traveling the country and learning that this information exists that wasn't being implemented. We've been talking most for the last 20 minutes or so about treatment, but information also exists on prevention, and the Biden administration, we believe, is going to be very strong in getting science-based prevention implemented as well.

Matt Hittle: Gary, you took the last question right out from under me. I was going to ask you about Dr. Gupta. I think that does it for all the questions we've got. Are there any final thoughts you want to share with our listeners before we let you go?

Gary Mendell: Sure, thanks for asking. This can be done. Addiction this year will take 200,000 lives in the United States—200,000 families in a cemetery burying someone they love that didn't have to die. I want to stress: didn't have to die, because our federal government has been funding wonderful research for decades. The research exists. So, for those listening who would like to help us move this along faster, please reach out to us at shatterproof.org or find me on LinkedIn or any other way. Together we can do this. Every person that joins with us is one more addition to the power we have to get this done. This is doable. So, thank you. Thank you for having me. Thank you for those who are listening. We can do this, we can protect our loved ones and our children, our grandchildren, our great-grandchildren. So, thank you.

Matt Hittle: Gary Mendell, founder and CEO of Shatterproof. Really appreciate you joining us today and sharing your powerful witness and sharing what Shatterproof has been up to these days. Thanks for being here.

Gary Mendell: My pleasure. Thank you for having me. The more that we can create awareness about what we're doing, the more people will join us and the more families we will save. So thank you.

Dr. Mario Ramirez: All right, Matt. Well, I think that brings us to the end of another fascinating discussion. We certainly want to thank Gary Mendell for his time today. I know I certainly learned a lot from the discussion. Signing off, I'm Dr. Mario Ramirez from Akin Gump.

Matt Hittle: I'm Matthew Hittle. Thanks for joining us today, and we'll see you next time on *OnAir: Health Care*.