Bobby Mukkamala, MD, on steps to address the overdose epidemic

AMA's Moving Medicine video series amplifies physician voices and highlights developments and achievements throughout medicine.

Featured topic and speakers

In today’s episode of Moving Medicine, in recognition of International Overdose Awareness Day, Bobby Mukkamala, MD, chair of the AMA Board of Trustees and the AMA task force working to prevent deaths and improve patient outcomes, discusses the AMA’s efforts to address the national overdose epidemic, help patients in pain and improve access to evidence-based care—and how physicians can get involved.

Speaker

- Bobby Mukkamala, MD, chair, AMA Board of Trustees and AMA task force on the overdose epidemic

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today, in recognition of International Overdose Awareness Day, we're talking with Dr. Bobby Mukkamala, an otolaryngologist from Flint, Michigan, about the AMA's efforts to address the national overdose epidemic. Dr. Mukkamala is chair of the AMA Board of Trustees and chair of the AMA task force, working to prevent deaths and improve patient outcomes. I'm Todd Unger, AMA's chief experience officer in Chicago. Thanks for joining us, Dr. Mukkamala. The AMA has been leading efforts for years to help end the national overdose epidemic, help patients in pain and improve access to evidence-
based care. Can you talk to us a little bit more about the task force that you're now chairing and how it furthers previous efforts in the space?

Dr. Mukkamala: Sure, absolutely. And thank you, Todd, for having me here to discuss this important topic. Over the course of the past several years, the AMA has convened more than 25 national specialty and state medical societies. Basically, everybody that has some stake in taking care of patients that are in pain and dealing with opioids. We've convened them in the form of two task forces over the course of the past several years, urging physicians to take action to improve opioid prescribing practices, increase access to evidence-based care for these opioid use disorders in these patients and then also provide evidence-based compassionate care for these patients in pain. And so, the balance between sort of looking at how opioids were used and then also patients that are experiencing pain and how do we manage both of those things. They were sort of dealt with in two different task forces.

Both of these task forces have worked to provide actionable, measurable recommendations and principles. Something that guide physicians as we navigate through all this and as well as state and federal policy makers, and pretty much any other stakeholders, somebody that has an interest in solving this problem with us through this work. Just in the past few months, these two task forces have now united into a new version of this task force, with an effort to sort of directly address the changing overdose epidemic. We've all sort of heard statistics about how it's not so much prescription opioids. It's now sort of the illicit drugs that we're hearing about. So, focusing on particularly removing racial and health-related inequities and also providing updated recommendations to physicians and policy makers and other stakeholders. So, combined the task forces and now we're going to focus our efforts in this direction.

Unger: What's obviously a tough and complex challenge but there have been some big wins to date. How would you describe those?

Dr. Mukkamala: Yeah, the work of the task force and the physicians involved nationwide have really helped to lead significant reductions in opioid prescribing. Anyone that's sort of been looking at this data, more than 44% reduction in opioid prescribing since 2011, so in the past decade. That's a dramatic reduction. And now, there's also more than a 100,000 physicians that are federally certified to provide care for opioid use disorder. We had a fraction of that, like 25,000, just a few years ago. It's really ramped up our capacity to help our patients with pain and opioid use disorder by getting them trained. And finally, the AMA and every state medical society have worked hard to ensure that state laws allow greater access to life-saving measures, like the reversal drug, naloxone. And it would be wonderful to be able to get it for a little cheaper than $130 per package. We're still working on the cost side of things but working with every state legislature to get access to this life-saving drug when we come upon somebody that is in an overdose situation.
Unger: Well, you mentioned cost is an obstacle there. Despite these wins, and that 44% reduction is a really big number, you're still facing pretty significant challenges out there. Can you talk about the big challenges that remain for you and the task force?

Dr. Mukkamala: Yeah, and you're so right. Despite all of the effort, we could look at what we just talked about and think, "Wow, we're doing great," but the reality is we're not. And that's because the target has shifted a little bit. It used to be prescription opioids where our focus was, but now more people than ever are dying primarily due to illicit, so not prescription-related but illicit use of fentanyl, methamphetamines, cocaine. And the other side of that coin though is that with restriction of access to opioids in a clinical setting, patients with pain continue to suffer because of an abrupt restriction and access to the medication used to treat them. So, lots of moving pieces here and so we've done a great amount of work trying to deal with prescription opioid use but now the target has moved to this illicit use.

And health insurance companies continue to make it somewhat difficult for patients to get access to evidence-based treatment for opioid use disorder. Sometimes, that's medications and the prior authorizations required to get those. Sometimes, it's a procedure. If it's something that's a nerve issue and a procedure can help that issue and eliminate the need for access to opioids, there's a lot of red tape oftentimes to get that authorized. So, the prior authorization hurdle to do the right thing for our patients in pain. And if it wasn't for naloxone, tens of thousands more of our loved ones would have died. We need to do even more with the naloxone and access to sterile needles and syringe exchanges and these programs to sort of reduce the harm, what we call harm reduction measures. Lots of work that we need to do and those challenges are still out there.

Unger: In preparation for this segment, I just kind of was looking to learn a little bit more about fentanyl and there was an amazing visual out there that shows the difference in what constitutes kind of a deadly quantity of fentanyl versus heroin. It's pretty stunning to see that kind of worked its way into this system. It must complicate things greatly for the efforts that you're doing now. You mentioned there's this new, combined task force. How do you work to address the fact that even if you're making headway in these other things, the ground shifts on you like this? What do you do to address that?

Dr. Mukkamala: Yeah, I think the answer to that is we get people around the table that are fluent in all of the aspects of this problem. A very talented group of people that we've collected around the table, passionate people. They represent very capable organizations that are dealing with exactly this. And I'm excited when I hear the conversations that take place when we convene virtually of late, of course, and the ideas that come from those conversations. Every one of these members has a unique experience that they bring to this dialogue at the ground level, on the frontline of this work, that will inform our collective work so then we can do the advocacy. For the resources, we need to help our patients, right? So, it's a direct link between the frontline sort of soldiers in this work to sort of keep people safe from whether it's prescription opioids or illicit opioids to the policy makers.
Linking that experience with the solution, that’s so important. It comes from these conversations. And some of the ideas that have come from the conversations, a sustainable infrastructure to provide this care, something that gets us out of crisis mode. Nobody likes to constantly be playing whack-a-mole, sort of dealing with the most latest thing that pops up. It would be wonderful to sort of have something that keeps any mole from popping up, getting rid of barriers to care, multidisciplinary access to care, harm reduction that we talked about. And then, collaboration between groups. It’s not just siloed thinking with employers, thinking on their own but what those solutions should be. Physicians thinking on their own, lawmakers thinking on their own, but actual collaboration so that everybody, who we all want the same thing, can actually have that dialogue together.

And then, finally, sort of looking at it through the lens of equity. Access to resources are not the same. What somebody in an affluent suburb has as far as access to treatment of their opioid issue is not going to be the same as what somebody in the inner city has access to. Whether that's insurance reasons, whether it’s just distance. It might be 45 miles for somebody to get to a treatment facility, versus five miles in a suburb. These are the kind of things that this group is focused on, trying to eliminate more barriers to get people closer to the care that they need.

Unger: You mentioned earlier a figure I just wanted to kind of out, about 100,000 physicians being trained. And I wanted to touch on this kind of training because you, yourself, have undergone this additional training, which is I think probably not as common for an ENT. Can you talk about why you did that and why it’s important for other physicians to get the same kind of training in this arena?

Dr. Mukkamala: Yeah. Thank you. This is something that ... A few years ago, I was involved within the AMA and working on bringing attention to this issue, chairing this task force, for example. And I just never liked the idea of talking about something or asking people to do something that I hadn’t done myself. And so, telling people to go get their waiver training as a component of a solution for dealing with opioid use disorder and this crisis that we have in our country is not something that I wanted to do without doing it myself. I took that waiver training. It's odd for an otolaryngologist to do that. Certainly, it's not something that I practice but I did the eight hours of training just to see how much of a hurdle is it. Because if I did it and it was going to be a huge hurdle, then I feel uncomfortable asking other physicians to do it and we should lower the height of that hurdle.

I did it in a weekend and I learned a lot from it. And so, then I could confidently say to other people that this is something that you should do. And I sort of realized at that moment the metaphor, for example, half a generation ago, physicians were very unlikely to treat psychiatric diagnosis. They weren't likely to prescribe medication for psychiatric diagnosis. It was something that was out of their comfort zone. Whether that was depression, whether it was bipolar disorder, they would refer to a psychiatrist or a psychologist for that. But now, pretty much every primary care physician feels comfortable starting that treatment. And what is the reason for that? Well, because they ramped up their education on that topic. And I think this is going to be the same way. I think that it's going to be ...
and we’ve already seen it.

As we mentioned, the numbers of people that have gotten their waiver training is quadrupled in just the past several years. And so, I think it will be something that we can build a comfort level among primary care physicians, so that they’re not only going to be comfortable prescribing an antidepressant to a depressed patient but they will be comfortable prescribing buprenorphine to somebody with an opioid use disorder.

**Unger:** You mentioned ground shifting as something complicating this whole situation and COVID-19 is certainly a ground shifter. Can you talk about the impact that the pandemic has had in terms of overdoses? It’s been pretty dramatic.

**Dr. Mukkamala:** Yeah, absolutely. It’s such a difficult time, and anybody that’s treated people with opioid use disorder realizes that any stress like a pandemic and it doesn’t even have to be a pandemic. It can be vehicles trouble. It can be trouble at home, marital trouble. It can be trouble with children. But then, the pandemic is sort of the mega trouble. And so, CDC’s provisional data indicates that 93,000 people have died from drug overdoses in 2020 alone. That’s an increase of nearly 30% from deaths predicted for 2019. So, absolutely, it’s added to the already difficult burden faced by people with opioid use disorder.

**Unger:** You mentioned before about how it would be nice to not be in a kind of a crisis scenario. It’s kind of paralleling in some respects where we are with public health and COVID-19 right now. How do we move out of this kind of crisis situation that you talked about into something that’s more resilient and in place in terms of kind of a public health framework to help stop and reduce the number of overdose deaths we’ve seen right now?

**Dr. Mukkamala:** Yeah. That is the key. Again, trying to get out of crisis mode into some, creating the infrastructure so that we cannot be constantly dealing with this in-crisis mode. The AMA provided feedback on the Biden administration's 2022 National Drug Control Strategy and there’s four key areas of strategic action. One of them, and we mentioned it already, is expanding access, reducing barriers to treatments in harm reduction services. Naloxone, sterile needle and syringe exchanges, drug checking supplies. And then, the other is a very important one and the big barrier is requiring all health insurance programs to remove these sometimes arbitrary restrictions for patients who benefit from opioid therapy. And then, making use of best practices that already exist. Sort of a critical review of programs and initiatives that have been federally funded to identify those that have reduced drug-related harms and improved patient outcomes. Sort of look at the data and let that drive the practice.

And then, finally, developing sort of a national standardized reporting system for key metrics on drug use. How are we doing? How are we measuring ourselves in this effort? Measures about drug use, including fatal and nonfatal overdoses. We hear a lot about the fatal overdoses but we need to have a better idea of how many close calls do we have because that also will help guide our future direction.

URL: https://www.ama-assn.org/delivering-care/public-health/bobby-mukkamala-md-steps-address-overdose-epidemic

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Unger: In a time when so many things are politicized, it does sound like this particular approach does have bipartisan support. Is that accurate?

Dr. Mukkamala: Absolutely. Yeah. Very much so just because, as I mentioned earlier, it's an urban problem, it's a suburban problem, it's everywhere. We do have broad bipartisan support. And there's a strong evidence based for that. Health insurance companies haven't taken these actions on their own in the states where the barriers have been removed in the legislature, care increases. And so, we need that bipartisan support to eliminate the barriers to proper care. And this needs to become the norm in every state across the country. We should look at those states that have done it as a model for everybody else.

Unger: You mentioned to me before about disparities. We've seen amazing, huge disparities on the COVID front. This is another area where it's so important to factor in disparities as just part of the solution. Can you talk to us about what that looks like?

Dr. Mukkamala: Absolutely. We're paying a lot of attention now to the disparities that exist in access to care and outcomes from care. Every element of our strategy needs to directly address these health care inequities and the social determinants of health. We know that a certain program may be useful but the distance of that program from the people that need it is a big factor. Just putting up the program is not enough but looking and seeing, "Okay, well, how many are there in a given state? Is it all in a certain geographic area where access for other people is going to be limited?" These are those social determinants of health. People need to be able to get to the resources that are created. And the data shows that the epidemic disproportionately affects marginalized and minoritized communities. That disparate effect includes access to substance use disorder, pain care and harm reduction. And it's not going to end without directly confronting and working to fix these sort of pervasive inequities that exist.

Unger: Dr. Mukkamala, for physicians who want to be part of that solution and work on fixing these problems, where should they go to learn more and get involved?

Dr. Mukkamala: Yeah, the main thing is that, for example, they can go to our resources within the AMA. The end-overdose-epidemic.org is a great place to start to learn about the AMA's work. We mentioned the data and using it and having a data dashboard, so that's something that we're also going to have. And we encourage every physician to work with their state medical societies and specialty societies and share the stories of those frontlines. That's where we are. When I operate on somebody's nose and I see that, when I prescribe the medication, that they have a score on that opioid use that's off the charts and I need to be able to plug them into resources, as an otolaryngologist, that's something that, honestly, a decade ago I would have punted. I'd said, "You know what? I'm not sure what to do." But with our advocacy and sort of building up these resources and increasing the comfort of physicians across the country to address those problems, instead of punting, we will have moved it in a huge step in the right direction.
Unger: Dr. Mukkamala, thank you so much for joining us today and sharing your perspective. Again, for those that are out there and want to get involved, end-overdose-epidemic.org. Check out that site for more information. That's it for today's episode. Dr. Mukkamala, thank you again for joining us. We'll be back soon with another Moving Medicine video and podcast. You can join us for future episodes by subscribing at ama-assn.org/podcasts. Thanks for joining us. Please take care.

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988 Suicide & Crisis Lifeline

With an increased number of people reporting worsening mental health in recent years, it is imperative that people are aware of the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) telephone program.

People experiencing a suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress can call, chat or text 988, and speak to trained crisis counselors. The national hotline is available 24 hours a day, 7 days a week.

The previous National Suicide Prevention Lifeline phone number (1-800-273-8255) will continue to be operational and route calls to 988 indefinitely.