

Shifting the conversation about substance use disorder with Bobby Mukkamala, MD

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, AMA Chief Experience Officer Todd Unger discusses the AMA's ongoing advocacy work to combat the overdose epidemic with Bobby Mukkamala, MD, an otolaryngologist from Flint, Michigan. Dr. Mukkamala is chair of the AMA Board of Trustees and chair of the AMA Substance Use and Pain Care Task Force.

To learn more about the AMA's efforts to end the overdose epidemic and get involved, visit: end-overdose-epidemic.org

Be sure to check out the recording of AMA's new Advocacy Insights webinar focused on the overdose epidemic on April 12.

Speaker

- Bobby Mukkamala, MD, otolaryngologist; chair, AMA Board of Trustees; chair, AMA Substance Use and Pain Care Task Force

Transcript

Unger: Hello. This is the American Medical Association's Moving Medicine video and podcast. Today we're talking with Dr. Bobby Mukkamala, an otolaryngologist from Flint, Michigan, about AMA's

ongoing advocacy work to combat the overdose epidemic. Dr. Mukkamala is also chair of the AMA Board of Trustees and chair of the AMA Substance Use and Pain Care Task Force.

I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Mukkamala, welcome back. Glad to have a chance to talk to you because we got some updates in the world, especially with trends regarding overdose deaths. And that's what we're going to be talking about here and what the AMA is doing about it. Why don't we start by just talking a little bit about the numbers?

Dr. Mukkamala: Sure. Yeah. Thanks, Todd. It's good to be back with you as well. So, according to provisional data published in March of this past year by the CDC's National Center for Health Statistics, annual drug overdose deaths have reached another record high in the U.S., so sort of a dubious distinction.

This data estimates that about 105,752 people to be exact have died of drug overdose in the 12-month period ending in October 2021, so pretty recent data. I mean, that's about the same number of people that can fit into University of Michigan football stadium just right down the road here. And when you think about that, the staggering number, which is, again, another way to look at it is a 300-person airplane crashing and everyone on board dying every day of the year is how you get to that number.

And about two thirds of those deaths involve synthetic opioids, such as fentanyl. So, overdose deaths involving these drugs have nearly doubled over the past two years, so clearly concerning numbers in a concerning direction.

Unger: Well, those are staggering figures and the fentanyl-fueled growth in those numbers, also, obviously a huge area of concern. Let's talk about other factors that might be contributing to the increase. Number one, the pandemic, so we'll talk a little bit more about that.

The AMA has advocated that addressing this epidemic, it requires a shift in thinking and so I want to talk to you a little bit about what that is, where we were before and how we're approaching this now in terms of some of those key pillars in terms of reducing harm, increasing access to care and reducing deaths. Let's start by, what do you mean when you talk about reducing harm?

Dr. Mukkamala: Yep. No, it's a great question. So, harm reduction commonly is thought to refer to being a focus on Naloxone. It's the life-saving opioid overdose reversal drug. It's what you give to somebody when you see them blue and you think it's drug overdose and you give it to them. It literally immediately reverses that overdose and they start breathing again.

It saved tens of thousands of lives and the AMA encourages physicians to prescribe it to our patients at risk of overdose. It's just one of those things. It's like we see AICDs in places all over the place. Naloxone is also like that. That's what we want to have available.

So, harm reduction, though, includes access to needle and syringe exchanges, in addition to Naloxone, services to reduce the spread of these blood-borne infectious diseases. And it includes making sure that laws help pregnant and parenting women and families get treatment for a substance use disorder rather than threatening them with punishment. So, all of these interventions reduce the harm of that substance use disorder, reduce the risk of a fatal overdose.

It includes ensuring that medications for treating opioid use disorder and care for mental illness is provided to all who need it in the nation's jails and prisons, oftentimes a place where people are denied the ability to get these medical conditions treated, where the stigma follows them into jails and prisons, and they're not getting treatment for these medical conditions.

It includes strategies such as harm reduction centers for safe drug use, as well as distributing fentanyl test strips to people who use drugs so that they know what they're getting isn't going to kill them, right? They're dealing with a medical condition. They're using but they're using in a way that they can at least assure themselves that they know what they're using.

And it includes ensuring patients with pain receive the care they need when they need it, so not forgetting that in addition to dealing with substance use disorder, we have legitimate pain needs in our patient population.

Unger: So, that is a more expansive view of harm reduction and obviously, there's a legislative aspect to really meeting what you're laying out in terms of that definition. Let's talk a little bit about the progress and getting legislation passed that focuses on some of those things that you laid out in terms of harm reduction.

Dr. Mukkamala: Yeah. Yeah. So, the AMA has really long been advocates for comprehensive harm reduction services, and we've seen some recent wins both at the federal and the state level. So, just as an example, New Mexico's governor signed a harm reduction bill that's strongly supported by the AMA and the New Mexico Medical Society. And what this does is it authorizes the use of fentanyl test strips and other drug checking supplies, which are important, again as we mentioned, harm reduction measures to save lives from fatal fentanyl overdoses.

Similarly, in Wisconsin, just this past March the governor signed a new bill that removes fentanyl test strips from the state's drug paraphernalia law. Right? So, it's no longer illegal to have these things that will literally save lives. And again, this was strongly supported by the Wisconsin Medical Society and the AMA.

And Maryland is focusing on another issue, fund allocation, so considering a new bill that would ensure that this opioid litigation settlement fund money from major distributors goes to public health and treatment. And that's something that the AMA and MedChi, the Maryland State Medical Society strongly support. So, AMA encourages all states to enact legislation similar to what we're seeing here

in these states.

Unger: Is it really a state-by-state thing? You mentioned the federal level.

Dr. Mukkamala: Yep. Yep. So, I mean, there are things that ... Honestly, it is mostly state by state because the rules differ so much and what we want to do is make sure that states don't have to reinvent that wheel every time.

So, if we in Michigan said, "Hey, that's a great idea. Let's make sure that opioid settlement funds are used properly," we don't have to write that from scratch. Right? And the AMA is very good about having model legislation and showing one state what another state is doing but at the federal level, again, that we have model legislation that can help to get us where we need to be for those things that are governed by federal law as opposed to state law.

Unger: It sounds like that model legislation is really important, as you said, not to reinvent the wheel and to help propagate great ideas across the country, state by state. Now, you also mentioned Naloxone and I understand there are efforts underway to make this drug available over the counter. Where does that stand and why is that so important?

Dr. Mukkamala: Yeah. We need to start thinking about Naloxone as a lifesaving tool like an EpiPen, like the automatic external defibrillators I mentioned or even condoms. So, part of this involves removing the stigma about overdose.

For example, there's no stigma for using an EpiPen or a defibrillator people. Don't try to have an anaphylactic reaction. If we see a blue patient, the only thing that goes through our mind is how to make them pink again, how to get oxygen in them. The adrenaline of that moment takes over and we go into lifesaving mode.

So, whether a patient is blue from eating a peanut that they're allergic to or from having a heart attack or from an overdose to an opioid, a physician's compassion and care is the same. So, making Naloxone available over the counter, removing its prescription status, changing state laws to allow for greater distribution of Naloxone is key to helping save these lives and getting rid of that stigma.

So, we encourage state physician leaders, whether it's a state physician or surgeon general or a public health agency official to sign county and statewide, preferably statewide, standing orders for Naloxone that would enable individuals to obtain Naloxone directly from a pharmacist without a patient-specific prescription. We need to lower the barrier to getting this life saving drug.

We've also ... the AMA has asked the Biden administration to take additional steps to remove the prescription status of Naloxone, which would be huge in accomplishing that ease of access. It can't save a life if it's unaffordable or if it's unaccessible for any reason and that's what we're trying to

change.

Unger: Now, along those lines, you've also stressed how important it is to take a treatment-based approach rather than a punitive approach to substance abuse disorder, particularly when it comes to pregnant and parenting women and families. Have we made any progress on that front?

Dr. Mukkamala: Yeah, we have. The AMA continues to advocate in support of these evidence-based treatments for pregnant people, newborns, children and their families. So, the AMA Board of Trustees just approved a new AMA model state bill, what we referenced a little bit earlier as far as this model legislation, to help states craft legislation to protect pregnant, postpartum and parenting people and families. And this joins other model bills that we have to increase access to Naloxone, ensure access to medications to treat opioid use disorder and prohibit corporate pharmacy interference in the practice of medicine.

We also just held a webinar addressing this issue as part of the AMA Advocacy Insights webinar series and that webinar took a close look at the effects of the epidemic on children and adolescents in particular, in historically marginalized and minoritized individuals in patients with pain from the perspective of physicians who provide care to these patient populations.

So, lots of important conversation, looking at these more distilled down to the people that we would see in our offices on a daily basis. So, if physicians missed it, that webinar, we will post it on the AMA website next week and you can find it by searching for AMA Advocacy Insights.

Unger: Excellent and do take a look at that. One topic you brought up earlier is coverage. It's always a discussion, especially for mental health issues and the AMA's been taking on insurance companies for failing to comply with mental health and substance use disorder laws. What is the background on that?

Dr. Mukkamala: Yeah. Health plans routinely violate the state and federal laws that are meant to guarantee evidence-based treatment for mental illness and substance use disorders, and those violations cause harm and sometimes death. The laws don't enforce themselves and that's why the AMA continues to urge policy makers at the state and federal level to take action when this is observed.

A recent report to Congress from the Departments of Labor, Health and Human Services, and the Treasury found that insurers' parity violations, the parity that's supposed to make her that if I have a broken femur, I get equal access to treatment whether or not it's that issue or a mental health issue, that both should have access to treatment and anybody can tell you that it's not parity. There isn't parity. But insurers' parody violations have continued and have become more serious since this law was enacted more than a decade ago.

So, it's not like it's recent change that needs to be complied with and they needs some time. A decade is plenty of time to get to parity and we haven't gotten there. So, the report found widespread violations affecting patients with autism, eating disorders, substance use disorders, violations that led to delays and denials of care, which of course leads to patient harm and likely avoidable deaths.

Just last week, the Rhode Island Insurance Commissioner found the UnitedHealth Group, a massive group, routinely denied and delayed care for over a four-year period. So, insurers will not change their behaviors without increased enforcement and accountability. And patients will therefore continue to suffer and more will die. And it's really up to policy makers to take action on this.

Unger: It's such an important role that the AMA plays there in bringing visibility to particular issues like that. And it's interesting to think about this issue overall of the overdose epidemic, how it's changed, become more complex from, let's say, when it was more of on a focus of reducing opioid prescriptions. When you think about the shift in the conversation, how has it changed since then, especially as we think about how to support patients with pain?

Dr. Mukkamala: Yeah. Unfortunately, there's been a much more aggressive effort to reduce opioid prescribing than to increase access to alternative pharmacologic or nonpharmacologic therapies, so a unilateral approach. And part of this is because of the laws and policies that are based on this 2016 CDC opioid prescribing guideline. That guideline, if the viewers don't recall, puts incredibly rigid limits on opioid therapy. And that list of misapplications of this 2016 guideline is long and it goes from coast to coast.

Its impact has been tremendous harm on patients with chronic pain, cancer, sickle cell disease, hospice patients. Just imagine having a loved one in hospice being refused pain medication or a cancer patient being told at the pharmacy counter that the pharmacist refuses to fill the opioid prescription because the patient is obviously addicted because they're in there for their sixth or seventh day and their rule internally is no more than three-day supply or a surgical patient whose insurance company denies coverage for a pain medication because, in the insurance company's view, three days of pain relief is enough for all patients.

Thankfully, the CDC is proposing to remove these inappropriate recommendations and the AMA is working with many to urge the CDC to make these proposed changes final.

Unger: Can you talk a little bit in terms of specifics about how the CDC's new draft addresses some of these concerns?

Dr. Mukkamala: Yeah. Yep. It does address a lot of those concerns. The new draft guideline, if followed by the policy makers ... Because again, just like it was misapplied, if they change it, then there needs to be a reaction that's favorable, which is to be followed by policy makers, health insurance companies and pharmacy chains to provide a path to remove these arbitrary prescribing

thresholds, so to restore balance and support comprehensive, compassionate care, as opposed to that line in the sand that says, "Nope, no more after three days."

So, in it the guideline says that it is not a replacement for clinical judgment or individualized person-centered care, that it's not intended to be applied as an inflexible standard of care or lead to the rapid tapering or discontinuation of opioids for patients. And it's not a law or a regulation or a policy that dictates clinical practice or a substitute for FDA-approved labeling.

So, it really sort of clarifies what it's not meant to do and it really acknowledges something that we've been saying all along, well before the guideline was published, that there isn't a one-size-fits-all fix for this problem. And this is a big win but there's still a whole lot of work to do. The AMA is, frankly, committed to working with everyone to ensure that evidence-based access to care for all of those with a substance use disorder, as well as those with pain, is available.

Unger: Dr. Mukkamala, thank you so much for your perspective and all of the continued work by you and the task force on the overdose epidemic. To learn more about the AMA's efforts to end the overdose epidemic and get involved, visit end-overdose-epidemic.org. You'll find that also in the description of this particular episode.

We'll be back with another Moving Medicine video and podcast. You can join us for future episodes and podcasts of Moving Medicine by subscribing at ama-assn.org/podcasts. Thanks for joining us today and 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.