Bobby Mukkamala, MD, on tangible actions to reverse the overdose epidemic [Podcast]
AMA Update

Bobby Mukkamala, MD, on tangible actions to reverse the overdose epidemic

Aug 30, 2022

Listen on Simplecast

Featured topic and speakers

In today’s COVID-19 Update, Aug. 31 marks International Overdose Awareness Day. AMA Chief Experience Officer Todd Unger is joined by Bobby Mukkamala, MD, immediate past chair of the AMA Board of Trustees and chair of the AMA Substance Use and Pain Care Task Force, to discuss the AMA’s advocacy work to help #EndOverdose. Also covering tangible actions physicians and policymakers can take now, before the end of the year, and in Congress and state legislatures across the United States—to help save lives and reduce harm.

Visit End-overdose-epidemic.org for more information.

Stay up to date on all the latest advocacy news by subscribing to AMA Advocacy Update.

Learn more at the AMA COVID-19 resource center.

Speaker

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

Transcript

Unger: Hello. This is the American Medical Association's COVID-19 Update video and podcast. In recognition of International Overdose Awareness Day on August 31, today we're bringing you a special episode on the national overdose epidemic including AMA's advocacy work and actions physicians and policymakers can take to help save lives and reduce harm. I'm joined by Dr. Bobby Mukkamala, an otolaryngologist from Flint, Michigan, who's immediate past 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, it's a pleasure to have you back.

**Dr. Mukkamala:** Good to be here, Todd.

**Unger:** Unfortunately, since we last talked, the trajectory of this epidemic has not changed a lot and we continue to see overdose deaths increasing in the U.S. More recently, we learned about large increases among youth and huge racial disparities within the numbers of people dying from a drug-related overdose. Why don't we start by what you can tell us about that.

**Dr. Mukkamala:** Yeah, thanks, Todd. And let's first just remember that while the number of deaths itself is record-setting and gut-wrenching to be sure—more than 100,000 in 2021—every single death was somebody's son or daughter or husband, wife, friend, family member and statistics sometimes make us forget about the reality that we're losing across generations in this preventable epidemic. But the data also shows us trends where we need to focus as you mentioned, so among the top line findings from the 2022 overdose report is that in addition to a huge surge in overdose mortality, we also have learned that Black, American Indian and Native Alaskan Americans are dying at the fastest rates. And among all populations young people are dying faster than any other group so lots of revelations here as the data is emerging and none of it is great news.

**Unger:** What's driving the increases that we're seeing year over year?

**Dr. Mukkamala:** These increases are primarily due to three main drivers. One of them, perhaps the most obvious one, is that illicit manufactured fentanyl is the driver of most of these deaths and not—so that's not the stuff that's prescribed. That's not stuff that's coming from my office or from the operating room. That's stuff that people are getting illicitly.

Other factor is ongoing barriers to evidence-based care for those with a substance use disorder. So barriers to pain care and harm reduction services.

And then finally this continued stigma that's associated with having a substance use disorder, a pain or a need for harm reduction services but there's tangible actions that we can take to reverse this and reduce the mortality and improve outcomes. But this is going to require a shift in thinking, a commitment to action and the cooperation of policymakers frankly and other stakeholders to work with physicians in organized medicine to meet this challenge. It's going to take effort. It's not the kind of thing that you just give it time and it'll solve itself. Not even close. And so we need to fix the problems in our own house within medicine because stigma is still a problem in our own medical communities and we need to work to eliminate that.

**Unger:** Well let's talk a little bit more in detail about the shift in thinking that's required. You said obviously this is not a problem that's going to go away. We've got to make some kind of change here. What are you talking about?
Dr. Mukkamala: Well we continue to see a flawed approach that's aimed more at the supply side restrictions than treatment for individuals with a substance use disorder or with pain when, in fact, the reductions in opioid prescriptions alone does nothing to reduce mortality. So nationally opioid prescriptions are down nearly 50% in the last decade so a dramatic reduction because of efforts that physicians have made. Every state has seen a dramatic decrease and yet every state has also seen staggering increases in drug-related mortality primarily again due to illicit fentanyl but also methamphetamine and cocaine.

So by a shift in thinking, the AMA means that we've got to recognize that mandates such as prescription drug monitoring programs, the PDMPs, aren't going to reduce the deaths or increase access to care. And so while there is an increase in use of these PDMPs, in 2021, more than one billion queries of people checking PDMPs as they're writing prescriptions and that's great but there's no evidence that increased use of these programs leads to a decreased mortality. In fact, despite that increase in use, we're seeing an increase in mortality. So by a shift in thinking, what we're urging is for policymakers to focus on removing the barriers to evidence-based care rather than just implementing supply side restrictions. So at this point in the epidemic, we've got to be clear that this epidemic will not improve unless the focus is on evidence-based overdose prevention and treatment.

Unger: Back to one of those key—the root factors here, illicit manufactured fentanyl. What is the approach the AMA is advocating for here?

Dr. Mukkamala: Let's start with harm reduction. So the AMA is focused on increasing access to a broad array of harm reduction services that includes removing the prescription status of naloxone to make it available over the counter. So while this year's overdose report shows access to naloxone has increased, it still remains limited by its prescription status and this continues to be a great—lead to a great shortage of access to community-based naloxone out there. So we've urged naloxone manufacturers to rise and meet this challenge by submitting OTC applications to the FDA or have the FDA do it themselves. But so far neither has taken this action that we think is necessary.

For example, I give this example that ICDs, these defibrillators that were literally shocking people out of their arrhythmia, you see them in malls and airplanes all over the place because they're safe to use for somebody to just put it on and shock somebody's heart. And yet naloxone, which saves arguably more lives, is still behind the counter. So the other thing is we need to decriminalize the use of fentanyl testing strips and other drug checking supplies. So the AMA is pleased that the administration now allows states to use federal dollars to purchase fentanyl test strips and the AMA has helped multiple states pass laws decriminalizing the use of these strips. But many more states need to take this action, so I would urge people that are listening to call their state legislators today to urge their support of this action.

Also we've got to remove restrictions on syringe service programs like the one to one needle exchange requirements and zoning restrictions. And so the AMA strongly urges state legislators to
take action to do this. And the AMA is urging investment in pilot programs. This isn't something that we each have to reinvent this wheel. This is something that a pilot program, if it shows promise at an overdose prevention site, other people can replicate it and the data shows that these interventions actually work to save lives.

So taken together, these are just among some of the collective action that's needed. And the states may not be ready to do everything but there are many options and every single one will help. So whatever a state can incorporate in their treatment will be useful and save lives.

Unger: And one thing you keep stressing is evidence-based care and you mentioned we see barriers to that. What are some of those barriers? How do we get past them and deliver what you're saying is required here?

Dr. Mukkamala: Yeah, it's a great question. It's really remarkable, Todd, that every year that this epidemic becomes worse, health insurance companies still refuse to work with us to help our patients. And there's just there are a few barriers that we could end today if health insurance companies or policy makers would take action.

So first, these companies, health insurance companies, continue to require prior authorization for medications to treat opioid use disorder. And it's worse that chain pharmacies and pharmacy benefit management companies are increasing administrative barriers to medications for opioid use disorder. It's unconscionable that medications to help somebody stay alive are buried under a morass of red tape. And that's not going to change unless policymakers join us to prohibit prior authorization and other red tape regarding access to medications for opioid use disorder.

And second, state and federal law require what's called parity between medical and surgical benefits and mental health and substance use disorder benefits. And so this law is more than a decade old but health insurance companies routinely violate it. So, for example, if a patient has a heart attack, he or she is going to receive immediate care. They can go to any emergency room down the street and get care knowing that it's covered, possibly even surgery, the follow-up care, the rehabilitation, all the things that go along with that. That is not something that people struggle to find care for. And they'll get the rehabilitation, everything.

But when a patient experiences an overdose instead of a heart attack and thankfully survives that overdose, the health insurance companies will routinely deny almost every type of treatment whether it's inpatient, whether it's outpatient, whether it's medication to treat that opioid use disorder. So such a glaring contrast between somebody that has a myocardial infarction and the mobilization of the entire system to keep that person alive versus somebody that has a near-death experience due to an overdose from opioid use disorder and the multiple barriers, that is not parity. That's parity in name only but not in practicality, and that's why more people are dying.
And third, but by no means the last of the list, we should be training physicians early on in their careers to treat substance use disorder. This means medical schools should have core faculty in addiction medicine or addiction psychiatry who can provide students with a foundational education and substance use disorder. Right here in Michigan, we’re seeing one of the universities, every student that graduates gets the training to prescribe buprenorphine for substance use disorder but what they’re running into is the faculty don’t feel comfortable doing it. So the students have more comfort treating people with substance use disorder than the faculty.

We need to change that. We need to raise the level of comfort. The analogy I use is there's people that a generation ago were really reluctant to prescribe antidepressants for people with psychiatric disorder. Now every physician is comfortable doing that. That's a generational change. It's the same generational change that we want to see here.

**Unger:** In some of our previous conversations, we talked about something that's very important not to forget which there are people out there that are experiencing a lot of pain. And we have to remember that this is about treating patients in pain. How do we lessen—excuse me—the barriers for patients like these?

**Dr. Mukkamala:** Yeah, you're absolutely right, Todd. Patients with pain have been made out to be scapegoats of this epidemic. There's no doubt that there have been bad actors running illegal pill mills but patients with pain are not criminals. They are patients and they deserve the same compassionate evidence-based care as every other patient whether it's a myocardial infarction or a bad hip or a substance use disorder. Those are all medical conditions.

I mentioned earlier how the nation's focus for the past decade has been primarily on reducing access to prescription opioids. So unfortunately these policies such as numeric thresholds on dose or quantity of opioid therapy have affected patients on long-term opioid therapy as well as patients with acute pain. So everyone has suffered, and the nation's epidemic has become worse primarily because of illicitly manufactured fentanyl.

So restricting access to legitimate pain care has not helped the nation's patients who rely on prescription opioid therapy. We need to remove the arbitrary restrictions on pain care including all the policies based on the 2016 flawed CDC opioid prescribing guideline that was based on arbitrary numbers and that's hurt a lot of people. So we're very pleased that the CDC has acknowledged its mistakes from—in 2016 and acknowledged that in 2019 and they're working to revise these flawed guidelines but we need the CDC and every state legislature, health insurer, pharmacy chain and others to take action and remove those numeric thresholds that are based on that flawed 2016 CDC guidelines.

And that's not to say that opioid therapy is for everybody. We also need to remove the restrictive formularies for non-opioid pharmacologic pain control options and the restrictive benefit design that
limits access to nonpharmacologic modalities including surgical and non-surgical options. We need every tool in the toolbox to be available to patients.

And while physicians took action to help reduce opioid prescribing, health insurers have done very little to increase access to non-opioid forms of care. So in other words, patients with pain have suffered by the loss of access to evidence-based care on one hand and continue to suffer by a loss of access to evidence-based care on the other. So the AMA strongly urges policymakers and others to help patients with pain because they've suffered enough.

**Unger:** That's a real conundrum, and I know that you, the AMA have been advocating for changes like this for some time. Have we seen any progress, any recent wins of late?

**Dr. Mukkamala:** Yeah, there's been progress and the AMA's very proud to be leading efforts on several fronts. So with respect to substance use disorders, we've helped remove prior authorization for medications for opioid use disorder in about 20 states and there's about a dozen states with strong mental health and substance use disorder parity laws, the stuff we were just talking about. And every state has pretty broad naloxone access laws. So these are good steps, and we're urging the state departments of insurance and state attorneys general to help ensure that health insurance companies are complying with these laws.

And we've helped several states decriminalize fentanyl test strips, and we've supported the overdose prevention pilot sites and the ones that we talked about like Rhode Island and New York. And we want—we need to learn from those efforts to improve them and then disseminate them to other states. And the AMA has strongly supported federal flexibilities to ensure that both audiovisual and audio-only telehealth access for substance use disorder treatment during this COVID pandemic is available and we're strongly advocating for these flexibilities to continue beyond this public health emergency.

I hate using the term silver lining as it relates to COVID but the use of telemedicine has really come out during COVID as an opportunity, particularly for those with substance use disorders. And we strongly supported increased access to mobile methadone vans to increase access in the rural and underserved areas. Now we need states to further invest in those policies to bring evidence-based care to more people with a substance use disorder, and the AMA and our partners have helped the CDC understand how those 2016 guidelines actually harmed patients.

But now we need policymakers' help to make take the next step, which is to remove those arbitrary thresholds. Those guidelines had a consequence. So changing the guidelines is fine but now we have to make sure that the follow through changes those unintended consequences.

We've had important policy wins but there's so much more to do. And the epidemic is getting worse and it's not going to get better until our patients receive evidence-based care. And this means that we've all got to work together to change our thinking and to take action. We have the tools to end this
epidemic. It’s just up to all of us to use them now.

**Unger:** Dr. Mukkamala, thank you so much for being here and for all the work that you and the task force continue to do to address the overdose epidemic. You want to learn more about the AMA’s efforts to end the overdose epidemic and get involved, visit end-overdose-epidemic.org. That’s end-overdose-epidemic.org.

We’ll be back soon with another episode. For all our videos and podcasts, visit ama-assn.org/podcasts. Thanks for joining us today and please take care.

**Disclaimer:** The viewpoints expressed in this podcast are those of the participants and/or do not necessarily reflect the views and policies of the AMA.