Episode 74: Opioid Crisis Engagement

On this episode: Dr. Jed Wolpaw and Dr. Chad Brummett

In this episode, episode 74, I welcome Dr. Chad Brummett to the show. Chad is the co-director of the Opioid Prescribing Engagement Network (OPEN) in Michigan and leads some fantastic and extremely effective initiatives to combat the opioid crisis. His website has more details and materials for anyone interested in starting similar initiatives elsewhere. Michigan-open.org. Also check out the previous episode on the opioid crisis.

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What is the "opioid crisis"

- In 2016, losing 115 people per day to opioids
- Estimated 130-150 people per day in 2018
- ↑ in street fentanyl and cheaper, more available heroin. ↑ in heroin, most through opioid use disorder, start from prescription opiates.
- Opioid Use Disorder DSM 5 criteria

What role do providers play in perpetuating this problem?

- Misconceptions due to bad marketing / policies
- Use for real/acute pain, can't be addicted = not true
- When we prescribe, leads patient down potential path of dependence/addiction, and contribute to patient's family/community via unused pills

How does one know the appropriate amount to prescribe?

- Dartmouth group – in Annals of Surgery, suggested that ~70% of pills prescribed go unused in surgery.
- In Michigan: 1.8 mil surgeries/year. Each prescribed 45 pill equivalents of 5mg hydrocodone. Using 35 pill average, estimated 62 million pills from just surgeries.
- Nationally: 50 million surgeries/year. 100 million procedures. Most prescribed, and opiates. >1 billion pills in excess!
- Groups are calling patients and asking how many pills they've used. Collaborators in Michigan came together and established a follow-up for opiates prescribed, which led to data-driven prescribing recommendations in October 2017. This process is data-driven, and not just one center.
    - There was a 5-fold decrease in pills prescribed for laparoscopic cholecystectomies, and a 50% reduction for major surgeries, where patients were getting 90-100 average pills/month.
    - Method is better than just using time limit. For example, a 7-day limit can be 2 pills every four hours as needed, which amounts to 84 pills. The highest recommendation by the group was 45 pills.
    - JAMA Surgery 2017: Lap cholecystectomy recommendation is 15 pills, and median use decreased after being prescribed less pills. Refill rate decreased from 4% to 3%.
    - Am J Ob/Gyn 2016: Patients after cesarean section put into low/medium/high group based on number of pills prescribed. High group used more without improvement in satisfaction, pain or refill rate. Less pills prescribed didn't change refill rate.
- PA and 'mid-level' providers prescribing more, possibly due to concern for burden of refill.
- Annals of Surgery: Used national payer data, and found no association between # of pills prescribed and likelihood to refill. People called for refill 7% of time.

How did you bring this data across towards education projects?

- For the lap cholecystectomy project, only created a single voice-over PowerPoint that surgery residents watched. Nothing mandated. This led to 50 pills → 15 pills prescribed. Spillover effect where residents applied same logic to other procedures (Lap appendectomy/thyroid/bariatric), and also to new interns!
- Other institutions/interested parties should check out Opioidprescribing.info to get more engaged.

Tell me more about pill drives.

- Started by holding the drive with police department in Ann Arbor. In 4 hours, 40 pounds of pills collected. This success led to another drive in September 2017, where 8 sites collected 900 pounds of pills. Growing to > 20 cities this spring, and moving towards national drive.
- Created community awareness about effects of unused pills in medicine cabinet.
- Tool kit on mi-open website. Weekly phone calls to offer help to expand this. Create awareness and engagement!

How would you recommend getting rid of unused pills if no active drives?

- FDA says you can mix it with kitty litter/dog waste, then toss it. Or by flushing down the toilet.
- It's not easy to remove opioids via water treatment. Several cities found traces of medication in their water supply!
- DEA has website. Police have drop offs. Some pharmacies are DEA-approved for disposal.
- If you can't do these, better to get rid of them today with kitty litter/ dog waste method.

Tell me more about the frustrations of primary care providers (PCP) with long-term opiate use.

- For new persistent use: surgeons are dominant prescribers in the first 3 months. Then PCP takes over. We need to tighten this transition of care, need new care models.

Downsides of chronic opioid use?

- To be clear, some patients seeing a pain doctor are still on opioids, and do well chronically. But no one on high dose doing well [eg 90mg/day of morphine, per CDC recommendations].
- Dr. Jenna Goesling investigating behavioral aspects of opioid use, such as between opioid use and depression.
- Darthmouth: ~1/2 pts coming into pain clinic report 1hr or less of pain relief, but still call it beneficial.
- We should try to understand more: how do people perceive benefit? How do we help them see that these haven't been helpful?
- Patients are scared that if they are off opioids, they will be worse. May not be better, but more functional, more awake, better mood. This is noticed by. Can't just make this about pain. Think about global use.

What role do general anesthesiologists play?

- "Opioid-free anesthesia"
    - Some data shows patients that had remifentanyl or fentanyl in OR use more opioid postop, and possibly have more pain. We don't know long term outcomes, so can't say that this is the answer.
    - State of consciousness does matter. Dr. George Mashour found that patients who receive ketamine under general anesthesia are affected differently than when awake. Use with caution. Pause and think!
    - Do all patients coming in for cataracts need 12.5/25 mcg fentanyl? No! perhaps we're too protocolized.
- Use of regional/multimodal pain control
    - Nothing jumping off page but the big gap is prescribing behavior. Patient is better but still go home with 60 pills!

    - JACS 2017: One of best predictor for how much people use their opioids after discharge is how much they used in the day before hospital. So as an anesthesiologist, have a conversation about those pills – eg if patient discharged with 70 pills, ask if prescriber was aware that for the last day, patient used 1 or no pills. Get people to think a little bit!
- Think not just optimizing preop, but also postop. For example, try to get a patient who comes in on 50 pills to leave on no more than that. Think about the transition of care.

What about NSAIDs and ibuprofen?

- The two big non-opioid pain medications are NSAIDs and ibuprofen. Some meta-analyses show that short course of NSAID don't have adverse effects that we were worried about. In fact, the morbidity is better in this group. Be wary of contraindications [renal/ulcer]. Should change expectations.
- New York Times: Patient from the United States underwent a hysterectomy in Europe, but wasn't prescribed opiates as expected. Doctors gave her herbal tea, and she ended up doing well.
- JAMA: No association between # of opioids prescribed and satisfaction score.

Is it true that tramadol safer than oxycodone?

- All opioids have addiction potential. See UK w tramadol epidemic!
- Boko Haram in Africa using tramadol to get people addicted then perpetuate terror!

Where do drug companies stand in our efforts to reduce the number of unused opioids?

- No pushback yet, but may come from generic companies and 3rd party distributers
- In 2012: hydrocodone most common prescription in the US, and now it's still top 5..
- Even if numbers reduced today, mortality won't change today. But this is about the long view!
- ↑ prescribing → ↑ mortality.

What do you think about Chad's work? Are you interested in getting involved? Are you doing anything similar? What are you doing about the opioid crisis? What do you think about intraop use of opioids?