“Opioids Equal Heroin”

David B. Nash, MD, MBA
Editor-in-Chief, American Health & Drug Benefits
Founding Dean, Jefferson College of Population Health, Philadelphia, PA

Mea culpa—I just didn’t get it! I had read multiple front-page articles in the Philadelphia Inquirer over months, but it just did not get past my “bad news” filter. Then, I watched HBO’s 1-hour special documentary, Warning: This Drug May Kill You, and it clicked! Finally, over Mother’s Day weekend, I sat down with one of my twin daughters, a rising Chief Resident in Medicine, and she connected the dots for me. This was good timing, because within days of watching that riveting documentary and learning more medicine from my daughter, our college—Jefferson College of Population Health (JCPH)—served as the host institution for the first visit of the publisher and editors of Modern Healthcare to Philadelphia. The purpose of the visit was to hold a 2-hour breakfast policy briefing on the population health aspects of the opioid epidemic.

Although the space here precludes a detailed summary of this event, let me set the stage and offer some take-home messages. Although JCPH hosted the event, Modern Healthcare and its educational team were clearly in charge. Merrill Goozner, Editor Emeritus, hosted a panel discussion, which included the state of Pennsylvania immediate past Secretary of Health, Karen Murphy, RN, PhD; the Chief Medical Officer of Temple University Health System, Susan L. Freeman, MD, MS; and yours truly. The agenda called for us to answer several kickoff questions and then to conduct a comprehensive conversation on the population health aspects of the opioid epidemic.

Appropriately, former Secretary Murphy talked about our statewide opioid drug tracking system, known as the Prescription Drug Monitoring Program (PDMP). She did a great job describing how Democratic Governor Tom Wolf has devoted tens of millions of new dollars in an attempt to stem the tide of death from this national scourge. By checking with the PDMP, providers learn which patient is using which drug, and for what reason. Dr Freeman, who works at a resource-constrained, state-supported academic medical center in one of our toughest neighborhoods, talked about her role in connecting with all the community organizations necessary to tackle this challenge.

As a nonexpert on the science of addiction, I thought that my role was to connect the dots between a report from the Brookings Institution, which essentially says that “addiction thrives when people and communities don’t,” and population health. The report states that, “deaths from drugs, alcohol, and suicide…can be traced to waning economic opportunities and a frayed social fabric. In other words, deaths that spring from lack of hope, purpose, and opportunity.” I tried to get the audience to appreciate the powerful social determinants that have contributed mightily to the opioid epidemic.

Sure, many providers are guilty of overprescribing opioids, and, yes, persons who one would not dream of becoming heroin addicts have become victims of this iatrogenic catastrophe statewide. But the root cause of the current dilemma has been in motion for probably a decade, with our ability to trace it back to the Great Recession of 2008.

I asked the audience to take the core tenets of population health and apply them to the opioid epidemic. For example, we need to reduce the unexplained clinical variation in opioid prescribing patterns by emergency department physicians. This was brought to light by a seminal study in the New England Journal of Medicine demonstrating that even in an individual emergency department, physicians have widely varied opioid prescribing practices.

Let’s consider standards and guidelines that are publicly available, such as those from the Centers for Disease Control & Prevention (CDC), and disseminate them more widely. Let’s further connect these guidelines to an economic incentive, and close the feedback loop with providers. Let’s measure how we are doing as healthcare providers in adhering to guidelines, and publicly commit to a time frame for measurable improvement. Again, we need to apply the tenets of population-based care.

Let’s better understand community-based coalitions, such as the community-based overdose prevention program, Project Lazarus, in rural North Carolina, and distill the take-home messages to urban Philadelphia. Project Lazarus teaches us that it’s all about reducing the supply of drugs, reducing the harm that drugs cause, and reducing the demand for these drugs. One can only ac-
We recognized that it will truly take a village to make any early progress in reducing the mortality and morbidity associated with this plague. To me, the opioid epidemic looks very much like the early stages of the AIDS epidemic in 1981 and 1982. I hope we can muster the social forces necessary to make progress and learn from our mistakes.

I pointed out to the nearly 250 attendees at the policy briefing that our academic medical center never hesitates to replace a heart valve, irrevocably damaged by endocarditis secondary to infected needle use, but we can’t seem to find the resources to practice upstream population-based medicine. In other words, “shut the faucet off rather than mop the floor.” Let’s embed more behavioral health experts in primary care practices so we can tackle this problem before patients use dirty needles, which leads to cellulitis, endocarditis, and heart valve replacement.

Although the tenets of population health, coupled with guidelines from experts such as those at the CDC, certainly are appealing, especially to our faculty, the panel also recognized that we are working against the backdrop of our current political system, which seems immune to this problem. Specifically, recently, even senior Trump Administration officials, such as former Secretary of Health & Human Services Tom Price, MD, have made pronouncements regarding the futility of therapy for opioid addicts, which contradicts a decades’ worth of accumulated evidence. How can we make progress when senior national leaders seem to have their head literally buried in the prejudicial sand?

Finally, Philadelphia is the home of 5 major academic medical centers, including 2 of the largest private medical colleges, Drexel University College of Medicine and our sister college, Sidney Kimmel Medical College. Imagine if we made a citywide commitment to push education about addiction and behavioral economics deeper into the medical education continuum? How about focusing on these issues in Undergraduate Medical Education and Graduate Medical Education and making it mandatory? As medical education leaders, we have to do a better job in preparing providers who are better equipped than I certainly was, to be part of the team tackling this population-based problem. Let’s start by spreading the word that opioids equal heroin.

Our panel certainly did not solve this problem, but we elicited some key tenets of population health. We recognized that it will truly take a village to make any early progress in reducing the mortality and morbidity associated with this plague. To me, the opioid epidemic looks very much like the early stages of the AIDS epidemic in 1981 and 1982. I hope we can muster the social forces necessary to make progress and learn from our mistakes of more than 30 years ago.

As always, I am interested in your views, and you can reach me at david.nash@jefferson.edu.

References