Understanding the Variation in Ordering Practices of Opioid Prescriptions Post Prostatectomy

PURC Opioid Working Group Survey Results

July 2019
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Message from the Chair

Dear Colleagues,

Opioid addiction has reached critical levels and is now being viewed as a public health crisis in the U.S. In 2016, opioid use disorder affected 2.1 million Americans leading to over 42,000 overdose deaths; 17,000 the overdoses involved a prescription opioid. Surgeons are at the forefront of this problem; of patients obtaining long-term opioid therapy at a pain clinic, nearly one-third report that their initial opioid prescription was from a surgeon. In addition, a portion of prescribed opioids are often unused, with many patients consuming fewer than half the amount prescribed, and up to 90% of patients having opioids left over.

The purpose of the Opioid Working Group is to explore, characterize and address the landscape of appropriate opioid stewardship with the goal of raising awareness of the opioid epidemic and supporting practitioners and practices in decreasing opioid over-prescription.

The recent PURC opioid survey generated valuable data characterizing practice patterns and potential barriers and facilitators to improving opioid stewardship after prostatectomies among PURC physicians. Whereas the majority of PURC physicians are aware of the opioid epidemic and receive education, the majority of patients are not appropriately screened for risk factors for opioid dependence and do not receive appropriate information about alternative medications and how to dispose of opioid medications. Furthermore, many providers are prescribing large amounts of opioid medications after prostatectomy, even with evidence that the majority of opioids prescribed are not used.

Clearly this is an area in need of further study in order to evaluate what barriers exist to reduce the over-prescription of opioid in our patients, and to improve access to decision support for providers to improve opioid stewardship.

Sincerely,

Dan Lee MD, MS

Opioid Working Group Chair

The PURC Opioid Working Group was initiated with its first monthly meeting on December 12th, 2018. The members of the Opioid Working Group, including myself, are as follows: Claudette Fonshell, MSN, RN – PURC Program Manager, Ruchika Talwar, MD – University of Pennsylvania, Jeffrey Tomaszewski, MD – MD Anderson Cancer Center at Cooper, Serge Ginzburg, MD – Einstein Healthcare Network, Shreyas Joshi, MD – Fox Chase Cancer Center, Thenappan Chandrasekar, MD – Thomas Jefferson University.
PURC Collaborative Overview

**Background**

Established in February 2015, PURC is an initiative that brings urology practices together in a physician-led, data sharing and improvement collaborative aimed at advancing the quality of diagnosis and care for men with prostate cancer. Participating practices submit data into the PURC registry on a variety of prostate cancer quality measure categories, including biopsy, imaging, treatment, radical prostatectomy, cancer characteristics, and volume. Today, the nine (9) participating practices have entered approximately 12,000 patients into the PURC data portal.

**Collaborative Goals**

1. Provide a reliable, sustainable platform for prostate cancer data collection
2. Reduce variation in care delivery and utilization of services for men with newly diagnosed prostate cancer
3. To measure, understand, and influence outcomes following prostate biopsy and radical prostatectomy
4. Improve patient-centered decision making among men faced with treatment choices for clinically localized prostate cancer

**Collaborative Participants**

- Einstein Health Network
- Fox Chase Cancer Center
- Geisinger Health System
- Hospital of the University of Pennsylvania
- Jefferson Urology Associates
- MD Anderson at Cooper University Hospital
- Penn State Milton S. Hershey Medical Center
- Temple University Hospital
- MidLantic Urology, LLC

**Physician Leadership**

- **PURC Executive Director**: Robert Uzzo, MD, FACS; Fox Chase Cancer Center
- **Regional Clinical Champion**: Marc Smaldone, MD, MHSP; Fox Chase Cancer Center
• Practice Site Physician Champions:
  o John Danella, MD; Geisinger Health System
  o Serge Ginzburg, MD; Einstein Health Network
  o Thomas Guzzo, MD, MPH; Hospital of the University of Pennsylvania
  o Thomas Lanchoney, MD, FACS; MidLantic Urology, LLC
  o Jay Raman, MD; Penn State Milton S. Hershey Medical Center
  o Adam Reese, MD; Temple University Hospital
  o Jeffrey Tomaszewski, MD; MD Anderson at Cooper University Hospital
  o Edouard Trabulsi, MD, FACS; Jefferson Urology Associates

Executive Team and Working Groups

An executive team convenes on a triannual basis for the purpose of evaluating collaborative progress and determining collaborative direction. The committee, which consists of physician champions, clinical abstractors, urology leaders, and patient advocates, is chaired by Marc Smaldone, MD, Fox Chase Cancer Center and supported by the Health Care Improvement Foundation. The purpose of the executive team meetings is for members to collaborate and provide expert input into the following:

• Continual analysis and evaluation of regional patterns of care and treatment outcomes;
• Identification of unwarranted variations in care and outcomes;
• Identification of specific care processes associated with better patient outcomes;
• Development and dissemination of improvement strategies and best practices;
• Periodic review of program activities and deliverables to ensure optimal support of participants.

In addition, PURC has established five (5) working groups, which are comprised of providers and clinical abstractors from participating practices. The working groups allow for the opportunity to review registry data, to develop measures, to identify quality improvement opportunities, and to share protocols and experiences. Working groups share their findings and recommendations with the executive team for continued collaborative discussion. The five (5) working groups are as follows:

• Active Surveillance Working Group, Chair Adam Reese, MD; Temple University Hospital
• Biopsy Working Group, Chair Thomas Lanchoney, MD FACS ; Urology Health Specialists
• Genomics Working Group, Chair Jeffrey Tomaszewski, MD; MD Anderson at Cooper University Hospital
• Imaging Working Group, Chair Serge Ginzburg, MD, FACS; Einstein Health System
• Opioid Working Group, Chair Daniel Lee, MD, MS; Hospital of the University of Pennsylvania
Survey Results

Survey Development and Administration

On July 2, 2019 PURC distributed a web-based survey to all actively participating urologists via email with the objective of understanding the ordering practices of, and thus the variation of, opioid prescriptions within the organization. The Opioid Working Group, chaired by Daniel Lee, MD, requested the development and distribution of the survey with the intent of using the results to identify variation in practice patterns of writing opioid prescriptions and to determine where potential barriers to improving opioid stewardship post-prostatectomy exist.

The Understanding the Variation of Ordering Practices of Opioid Prescriptions Post Prostatectomy Survey asked twenty-four (24) questions in total. The first five questions gathered demographic information from the prescribers who completed the survey, including hospital role, years of practice, type of practice, and whether or not they perform radical prostatectomies. The sixth question attempted to gain insight into the prescribers’ beliefs regarding the relationship between opioid prescriptions and addiction. The next section focused on understanding the opioid education or training that providers have had. The following four questions asked prescribers how they screened their patients for opioid dependence risk factors. Questions 15 through 18 addressed personal prescribing patterns post prostatectomy. The last required set of questions focused on the strategies that prescribers use to try and avoid opioids.

Survey Response and Demographics

The PURC coordinating center distributed the survey to 97 active providers in the nine organizations participating in PURC. The survey was open for seventeen days, closing on July 17, 2019. All nine (9) of the organizations participated in the survey: eight (8) academic organizations and one (1) private organization. Seventy-four providers completed the survey, resulting in a response rate of 76.3%. It should be noted that the data abstractors within the PURC collaborative further distributed the survey and an additional 18 (non-attending) prescribers are included in the total number of those who completed the survey. These 18 prescribers made up 23.7% of those who completed the survey. All 74 providers entered their current role at their hospital; fifty-six (56) identified as Attendings (75.68%), eleven (11) as Residents (14.86%), three (3) as Nurse Practitioners (4.05%), two (2) as Physician Assistants (2.70%), and (2) as Other (2.70%). Of those surveyed, 37 (50%) performed robotic prostatectomies, with 20 (50%) performing 1-4 prostatectomies per month and 10 (25%)
performing more than 10 prostatectomies per month. Thirty-eight percent of the respondents have been in practice for 0-5 years, with 41% in practice for 10 years or more. Seventy-five percent (75%) of the respondents were from an academic practice.

**Summary of Survey Results**

**Beliefs**

Overall, the vast majority of the respondents believe that opioid addiction is a major concern, and that opioid prescriptions have played a large part in exacerbating the situation. Of those who completed the survey, 93% believe that opioid prescriptions have contributed to the current opioid abuse epidemic and 93% believe that opioid addiction is a concern in their area. Despite the evidence that illustrates the problems that can result because of the over-prescription of opioids, 14% of those who completed the survey were either uncertain or did not believe that opioid prescriptions could lead to long-term dependence and 32% were either uncertain or believed that patients used the majority of their opioids.

**Practice Patterns: Important Barriers and Facilitators**

Education on opioid stewardship was prevalent among our providers. One hundred percent of the respondents had received some opioid education, with 75% receiving 3 hours or more in the past year. The survey responses provided 28 different education sources with the majority going to the Pennsylvania medical board and online resources. A low number (<9%) accessed the available educational resources through the American Urologic Association. Despite the fact that 100% of respondents received some opioid education, there are several important barriers that will need to be addressed in order to implement non-opioid or reduced opioid prescription protocols successfully.

Improving how providers review the patient level risk factors for opioid dependence could be an important lever to decreasing the long-term opioid risk after prostatectomy. Forty-two percent of the respondents said that they do not ask the patients directly about their opioid use history, and only 48% always check the Pennsylvania Drug Monitoring Program (PDMP) before prescribing opioids. Prior to prescribing opioids, 57% of providers do not screen for previous history of opioid abuse, 73% do not check for mental health disorders, and 82-96% do not screen for a history of chronic pain, fibromyalgia, or adolescent sexual abuse, which are all risk factors for opioid dependence. This represents an important educational opportunity for providers, as 43% have not had any training to address stigma or bias against patients with an opioid use disorder.
Patient education is another area where improvement can occur. Prior to prostatectomy, only 24% of providers discussed the risks of opioid use with their patients; 27% did not discuss or did not recall discussing pain expectations following surgery, and 35% did not or did not recall discussing alternatives to opioids for pain relief. Notably, only 8% of providers discussed how the patient should properly dispose of unused opioids.

One way in which opioid stewardship could be improved is by making adjustments in the amount of opioids prescribed through the Electronic Health Record (EHR). Thirty-four percent of providers noted that there is an automatic default number of opioid pills prescribed for prostatectomy patients from an order set, with a median number of 28 pills (range 20-30). The median number of pills distributed from providers who used the EHR default setting (28 pills) was significantly higher than if the number of pills were to be filled in (10 pills) by the prescriber. The default setting of the EHR could provide an opportunity to facilitate opioid stewardship by removing or changing the default options for prescriptions to lower amounts. At the Hospital of the University of Pennsylvania, such an adjustment was made in the EHR to change all the default selections of prescription medications to generics compared to brand name. The proportion of generic prescriptions increased from about 40% to above 90% with a simple change. Almost two-thirds (63.6%) of the providers were prescribing 11 or more opioid pills after prostatectomy, with 35% prescribing 20 or more opioid pills, which is equivalent to 150 oral morphine equivalents (OME). The published ORIOLES study from Johns Hopkins showed that 84% of patients undergoing prostatectomies required less than 112 OME, so this represents an opportunity for improvement.

Finally, the results of the survey demonstrated that there are several important barriers to opioid stewardship to consider. One such barrier is the lack of standardized opioid prescribing recommendations or guidelines. Seventy-five percent (75%) of providers do not use any of the known prescribing recommendations to provide adequate pain relief while not overprescribing opioids. This also represents an opportunity for future studies: to accurately measure what pain patients have after undergoing radical prostatectomies, investigate alternatives to opioid medications, and implement new strategies to improve care. Improved dissemination and education of available resources and the most recent data from sources such as the U.S. Drug Enforcement Agency and Centers for Disease Control would also provide more useful information at the point of care for providers. When providers were asked about potential barriers to decreasing or stopping opioid prescriptions after prostatectomies, 71% were concerned about inadequate pain control, and 27% were uncertain about the effectiveness of non-opioid medications. Patient factors were important to consider, as 49% reported that patient demands for opioids were a significant barrier, and 7% were concerned of litigation for inadequate pain control. About a third of respondents replied that logistical issues were a significant barrier, as 27% reported that opioids were given as part of routine prescribing practices, and 31% reported that the opioid prescriptions were handled by somebody else besides the primary provider.
Recommendations

The results of the survey can be used as a reference to guide prescribers in the PURC collaborative with future interventions to reduce opioid use. The findings of the survey illustrated that significant knowledge gaps exist among providers. Filling these gaps could represent easy way to improve care. Accessing PDMP is mandatory prior to prescribing any opioid and should always be checked. Therefore, an easy intervention geared towards accessing PDMP and building it into the clinical workflow prior to writing an opioid prescription could significantly improve knowledge of the patient’s previous opioid history and opioid stewardship at the point of care. Reviewing the existing literature about prescribing guidelines and the recommendations available and having such literature easily accessible could improve opioid stewardship. In addition, education about the efficacy of alternative treatments and the existing evidence of opioid over-prescriptions for prostatectomies could help to reduce opioid use overall.

The results of the survey also demonstrated that improvement in patient education preoperatively could significantly improve opioid stewardship. The vast majority of risk factors for opioid dependence are not routinely screened for (in some cases up to 80-90%). In addition, postoperative pain management is an area that can see significant improvement with regard to the overall discussion of opioid use with patients, expectations of pain control, and alternatives to opioids. A significant part of opioid stewardship is honest discussion with patients about the possible risks and benefits and treatment options available. It should be noted that the percentage of patients who received any education on opioid disposal is low. Providing patient-facing educational material at key touch points in their care may be, therefore, an easy way to make a significant advancement in opioid stewardship.

Finally, technology could be utilized to facilitate opioid stewardship, by making the “right” choice the “easy” choice. For example, the programing of the EHR can be changed to reduce the default number of pills it prompts or to remove any default option that it provides. This course of action could contribute to a dramatic decrease in the number of pills prescribed. In addition, reviewing the results of future studies can ameliorate the knowledge that exists surrounding of opioid need after prostatectomy and usage patterns. One study being performed at the Hospital of the University of Pennsylvania is using artificial intelligence-based chat-bots to help measure the pain levels in patients post-prostatectomy, evaluate opioid prescriptions and usage, and deliver decision support for the patient to contact providers about adequate or inadequate pain control. These studies will provide comprehensive information about providing the proper pain control to the afflicted patients at the right time.
Most importantly, the vast majority of the providers were interested in changing existing practice patterns, and hopefully implementing strategies that decrease and possibly eliminate opioid prescriptions post-prostatectomy in PURC centers.
Next Steps

The survey identified knowledge and practice pattern gaps that can be easily addressed to improve opioid stewardship. These can be broken down into the following key areas of improvement. The chart below highlights the identified key areas:

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Means of Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving proper opioid disposal education</td>
<td></td>
</tr>
<tr>
<td>2. Improving preoperative risk assessment</td>
<td></td>
</tr>
<tr>
<td>3. Improving utilization and documentation of PDMP</td>
<td>Provider education</td>
</tr>
<tr>
<td>4. Improving knowledge of opioid alternatives</td>
<td></td>
</tr>
<tr>
<td>5. Improving knowledge of existing tools</td>
<td></td>
</tr>
<tr>
<td>6. Decrease opioid prescription numbers</td>
<td>Remove defaults in EHR and Opioid Reduction protocol</td>
</tr>
<tr>
<td>7. Measure patient pain level, satisfaction, pill used</td>
<td>Opioid Reduction protocol</td>
</tr>
</tbody>
</table>

Conclusion

The *Understanding the Variation in Ordering Practices of Opioid Prescriptions Post Prostatectomy* revealed extensive knowledge disparities among providers about opioid stewardship, and significant gaps in the evidence-to-practice continuum of care. With future studies, we hope to establish a better understanding of the context for providers in prescribing opioids, provide decision support to improve opioid stewardship and reduce waste, and improve opportunities to decrease the risk of opioid overexposure for patients.
Appendix: Survey Results

Demographics

1. Please select your current role (n=74):

<table>
<thead>
<tr>
<th>Role</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending</td>
<td>75.68%</td>
</tr>
<tr>
<td>Resident</td>
<td>14.86%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>4.05%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>2.70%</td>
</tr>
<tr>
<td>Other</td>
<td>2.70%</td>
</tr>
</tbody>
</table>

2. Do you perform radical prostatectomies? (n = 74)

<table>
<thead>
<tr>
<th>Response</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50.00%</td>
</tr>
<tr>
<td>No</td>
<td>50.00%</td>
</tr>
</tbody>
</table>
3. If you perform radical prostatectomies, how many do you perform per month? (n = 40)

4. How long have you been in practice? (n = 71)
5. What is your practice type? (n = 73)

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic or Faculty Practice</td>
<td>75.34%</td>
</tr>
<tr>
<td>Hospital Employed</td>
<td>17.81%</td>
</tr>
<tr>
<td>Group Private Practice</td>
<td>5.48%</td>
</tr>
<tr>
<td>Government</td>
<td>1.37%</td>
</tr>
<tr>
<td>Solo Practice Type</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Beliefs

6. Please indicate your agreement with the following statements about your practice (n = 71):

- Post-operative opioids can lead to long term dependence
  - Strongly Agree: 23.94%
  - Agree: 61.97%
  - Neutral: 8.45%
  - Disagree: 5.63%
  - Strongly Disagree: 0.00%

- Opioid addiction is a concern in my area
  - Strongly Agree: 50.70%
  - Agree: 42.25%
  - Neutral: 7.04%
  - Disagree: 0.00%
  - Strongly Disagree: 0.00%

- Prescription opioids have contributed to the opioid epidemic
  - Strongly Agree: 45.07%
  - Agree: 47.89%
  - Neutral: 5.63%
  - Disagree: 1.41%
  - Strongly Disagree: 9.86%

- Patients use the majority of the opioid pills prescribed to them
  - Strongly Agree: 1.41%
  - Agree: 52.11%
  - Neutral: 21.13%
  - Disagree: 15.49%
  - Strongly Disagree: 0.00%
Education

7. In the last 12 months, where have you received your opioid education or training? (n = 66)

There were 116 varied responses to this question based on individual experience. The top three (3) responses to this question were as follows:

- 27.59% (32 individual responses) indicated that education or training occurred through the organization
- 16.38% (19 individual responses) indicated education or training occurred online
- 15.52% (18 individual responses) indicated that education or training occurred through Continued Medical Education (CME)
- 40.51% (47 individual responses) indicated other sources as a mean by which prescribers received education or training.

8. How many hours of education or training have you received? (n = 68)

<table>
<thead>
<tr>
<th>Hours</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 hours</td>
<td>25.00%</td>
</tr>
<tr>
<td>3-4 hours</td>
<td>54.41%</td>
</tr>
<tr>
<td>5+ hours</td>
<td>20.59%</td>
</tr>
</tbody>
</table>
9. Has your education or training addressed stigma/bias against patients with opioid use disorder? (n = 68)

10. Prior to prostatectomy, does your patient receive education on the following? (n = 63)
Screening

11. Where do you identify a patient’s opioid use history? Please select all that apply (n = 69):

<table>
<thead>
<tr>
<th>Method</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Medical Record</td>
<td>82.61%</td>
</tr>
<tr>
<td>Patient interview</td>
<td>57.97%</td>
</tr>
<tr>
<td>A screening tool</td>
<td>4.35%</td>
</tr>
<tr>
<td>PA-Prescription Drug Monitoring Program (PDMP)</td>
<td>73.91%</td>
</tr>
<tr>
<td>I ask my nurse</td>
<td>5.80%</td>
</tr>
<tr>
<td>I do not look up a patient's opioid use history</td>
<td>1.45%</td>
</tr>
<tr>
<td>Unsure</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

12. How often do you query the PA-Prescription Drug Monitoring Program (PDMP) before writing an opioid prescription? (n = 69)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>47.83%</td>
</tr>
<tr>
<td>Often</td>
<td>21.74%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10.14%</td>
</tr>
<tr>
<td>Rarely</td>
<td>15.94%</td>
</tr>
<tr>
<td>Never</td>
<td>4.35%</td>
</tr>
</tbody>
</table>
13. Do you use a standardized screening tool or risk assessment to screen for the following conditions? (n = 68)

Comments to an “externally developed tool”:

- *Patient history*
- *Electronic Medical Record*

14. Do you screen for risk factors of dependence such as smoking, previous opioid use, and/or mental health disorders prior to prescribing opioids? (n = 67)
Prescribing Patterns

15. Following a prostatectomy, which oral opioid(s) do you most commonly prescribe on discharge? (n = 56)

![Graph showing prescribing patterns for various opioids]

Comments to “Other (please specify)”:
- Tramadol (50 mg)

16. Does your Electronic Health Record have a default number of pills that it prompts when ordering opioids? (n = 66)

![Graph showing responses to default pill selection]

Yes | No | If yes, please indicate the number of default pills selected by the EHR:
---|---|---
30.30% | 59.09% | 10.61%
Comments for the default number of pills the Electronic Health Record prompts when ordering opioids:

Of the 5 providers that responded to this question,

- 3 said that the EHR prompts 28 pills
- 1 provider said that the EHR prompts 30 pills
- 1 provider said the EHR prompts 20 pills

17. If you answered no to question 16, how many opioid pills do you routinely prescribe on discharge following a prostatectomy? (n = 46)

![Graph showing the distribution of responses to the number of pills prescribed on discharge following a prostatectomy.]

18. Which set of standardized opioid prescribing recommendations do you follow? Please select all that apply (n = 61):

![Graph showing the distribution of responses to the set of standardized opioid prescribing recommendations.]

Illinois
Michigan
OPEN
Mayo Clinic
John Hopkins
Other (please specify)
Center for Disease Control
City of Philadelphia
None

Responses 1.64% 1.64% 3.28% 3.28% 3.28% 6.56% 8.20% 75.41%
Comments for “Other (please specify)”: 
- New Internal Guidelines

**Opioid Avoidance Efforts**

19. What are some of the barriers that would prevent you from stopping altogether or decreasing the number of opioids prescribed after a radical prostatectomy? Please select all that apply (n = 59):

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate pain control</td>
<td>71.19%</td>
</tr>
<tr>
<td>Discharge orders are completed by other team members</td>
<td>30.51%</td>
</tr>
<tr>
<td>Uncertainty of effectiveness from other techniques</td>
<td>27.12%</td>
</tr>
<tr>
<td>Fear of litigation</td>
<td>6.78%</td>
</tr>
<tr>
<td>Patient demand</td>
<td>49.15%</td>
</tr>
<tr>
<td>Routine prescribing practices</td>
<td>27.12%</td>
</tr>
</tbody>
</table>

20. Would you be interested in implementing a non-opioid protocol for your post prostatectomy patients? (n = 61)

<table>
<thead>
<tr>
<th>Option</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>83.61%</td>
</tr>
<tr>
<td>No</td>
<td>16.39%</td>
</tr>
</tbody>
</table>