THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Op-Ed

The Opioid Crisis From Research to Practice

JOSHUA M. SHARFSTEIN

In 2015, researchers from Yale University published a randomized, controlled trial on the treatment of opioid addiction.[1] The study asked whether patients identified in the emergency department would benefit from prompt access to the well-proven medication buprenorphine, including onsite prior to discharge. The researchers were questioning not what, how, why, or who—but where.

The results of their study were that patients who received access to buprenorphine in the emergency department were twice as likely to remain engaged in treatment 30 days later compared with those who just received a referral, 78% versus 37%. (In the third arm of the study, only 45% of those who received a brief intervention and referral but no buprenorphine in the emergency department remained in treatment 30 days later.)

Effective treatment for opioid use disorder is associated with a much lower risk of overdose, infection, and criminal behavior, as well as a substantially greater chance of employment and life success.[2] Given the magnitude of the opioid crisis, with more than 28,000 deaths each year and rising in the United States, the Yale study should have caused an earthquake in clinical medicine. Instead, it registered barely a tremor. Few emergency departments in the United States routinely offer access to this treatment.

On November 17, 2016, the surgeon general released a landmark report entitled "Facing Addiction in America." Citing the Yale study, the report states, "Buprenorphine . . . treatment for opioid misuse should . . . be available in emergency departments."[3]

The surgeon general's report also provides insight into why so little progress toward this goal has been made:

> Until recently, substance misuse problems and substance use disorders were viewed as social problems, best managed at the individual and family levels, and sometimes through the existing social infrastructure [such as the criminal justice system]. . . . Despite a compelling

The Milbank Quarterly, Vol. 95, No. 1, 2017 (pp. 24-27)
© 2017 Milbank Memorial Fund. Published by Wiley Periodicals Inc.

> national need for treatment, the existing health care system was neither trained to care for nor especially eager to accept patients with substance use disorders.

The reluctance of health care professionals to treat the disease of addiction is easy to spot. Many health care professionals use outdated and dehumanizing names for addicted patients, including "junkies," "crackheads," and "substance abusers." Studies have documented less regard among physicians for patients suffering from opioid use disorder than for patients with other illnesses, including alcohol use disorder and mental illness.[4]

This stigma may be subtly reinforced by otherwise well-intentioned efforts to reduce the problematic prescribing of opioid medications. There are major efforts under way to improve prescribing practices in emergency departments and other acute care settings, by teaching physicians to identify patients who are addicted to opioids. Sadly, far less attention has been paid to helping patients once they have been so identified, and the result is that many individuals with addiction turn to illicit and far more dangerous sources of opioids.

The imbalance between great interest in improving the ways doctors prescribe pain medications and far less commitment to expanding access to addiction treatment is most evident with the Joint Commission, the major private organization that accredits hospitals. The organization issued an unusual statement defending itself against allegations that its standards for pain treatment may have contributed to the opioid epidemic.Yet the Joint Commission has not taken steps toward requiring hospitals to provide effective addiction treatment to those in need.

To be fair, even if all emergency departments offered the first dose of buprenorphine treatment onsite, many patients would have trouble finding a suitable treatment program for follow-up care. Many addiction clinics have an ideological bias against evidence-based medications like buprenorphine. In addition, both public and private payers have made reimbursement difficult for the relatively few physicians who are ready to accept patients for medication-assisted treatment. As the surgeon general's report notes, only 1 in 5 patients in need of effective treatment for opioid use disorder actually receives it.

When health care stumbles, public health agencies have an obligation to step in. The surgeon general's call for addiction to be treated "with

the same skill and compassion with which we approach heart disease, diabetes, and cancer" is an excellent point of reference. If hospitals were not willing or able to provide lifesaving therapies for these conditions, public health leaders would move quickly to ensure access to addiction treatment.

Public health can set standards for appropriate access to care in emergency departments. Indeed, at the state level, Rhode Island's health commissioner has proposed a voluntary emergency department and hospital designation for addiction treatment.[5] As proposed, level 3 facilities would screen for addiction, offer naloxone prescriptions to appropriate patients, and refer them to community-based care. Level 2 facilities would also provide medication-assisted treatment in the emergency department, such as by giving an initial dose of buprenorphine to appropriate patients. Level 1 facilities would do all these things plus maintain a center of excellence for the ongoing treatment of opioid use disorder.

Public health can promote new incentives and investments in treatment capacity. The Rhode Island physicians' licensing board is encouraging doctors to participate in buprenorphine training; the state's Medicaid program is supporting centers of excellence to serve thousands of patients; and the state's correctional system is now offering medication-based treatment to those in need.

It's even possible for those public health professionals who are also physicians to help clinicians in the health care system rise to this challenge. In areas suffering from overdose outbreaks but without meaningful access to care, the US Department of Health and Human Services should deploy staff in its Commissioned Corps to provide needed treatment and train local clinicians.

At the policy level, the Substance Abuse and Mental Health Services Administration should help states strengthen their addiction treatment systems through new standards, education, and regulation. For its part, the Drug Enforcement Administration should encourage more physicians and other qualified health professionals to become certified to prescribe buprenorphine, perhaps by waiving the registration fee for those who do so.

It would be a grave mistake to allow the Yale study to sit on a shelf. The surgeon general has called the opioid epidemic a "moral test for America." Passing this test requires translating evidence into action.

References

1. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015;313(16):1636-1644.
2. National Institutes on Drug Abuse. *Principles of Drug Addiction Treatment, a Research-Based Guide*. 3rd ed. NIH Publication 12-4180. December 2012. https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podat_1.pdf. Accessed December 4, 2016.
3. US Department of Health and Human Services (HHS), Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.
4. Meltzer EC, Suppes A, Burns S, et al. Stigmatization of substance use disorders among internal medicine residents. *Subst Abuse*. 2013;34(4):356-362.
5. Proposed Hospital Standards. PreventOverdoseRI.org. July 13, 2016. http://preventoverdoseri.org/our-action-plan/ed-standards/. Accessed December 4, 2016.

Address correspondence to: Joshua M. Sharfstein, Johns Hopkins Bloomberg School of Public Health, 615 N Wolfe St, Ste W1033D, Baltimore, MD 21205 (email: Joshua.Sharfstein@jhu.edu).