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Putting Parity into Practice – Integrating Opioid-Use Disorder Treatment into the Hospital Setting

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zales, the Court upheld the federal statute in part because “a fetus is a living organism within the womb, whether or not it is viable outside the womb” and “choosing not to prohibit [a brutal and inhumane procedure] will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life.” One

 An audio interview with Dr. Charo is available at NEJM.org

can easily imagine similar language in a decision that up-

holds prohibitions on second-trimester D&E procedures or 20-week bans by deferring to disputed legislative findings about fetal pain.

This scenario is not idle speculation. The Zika virus can have

devastating effects on fetal development that cannot be detected until well into the second trimester. If courts fail to examine the real motivations behind the spate of new laws premised on fetal pain and therefore uphold 20-week bans, anesthesia requirements, or procedure limitations out of judicial deference to legislative findings, the *Whole Woman's Health* decision would no longer be a whole women's victory.

Disclosure forms provided by the author are available at NEJM.org.

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Putting Parity into Practice — Integrating Opioid-Use Disorder Treatment into the Hospital Setting

Laura Fanucchi, M.D., M.P.H., and Michelle R. Lofwall, M.D.

Mr. M. was hospitalized with endocarditis caused by his use of injected opioids. After receiving two valve replacements, he remained in the hospital for several weeks — even after his condition had stabilized — to complete a course of antibiotics, because there was no other option for transitional care. During his admission, addiction counselors recommended that he receive abstinence-based treatment after discharge. Mr. M. was not interested in such treatment, however, and repeatedly requested opioids for pain and withdrawal symptoms. These requests, which the care team interpreted as “drug-seeking behavior” that should not be reinforced, caused conflicts between Mr. M. and his clinicians.

As Mr. M. began to feel better,

he spent less time in his room and more time walking the halls and venturing outside the hospital building, arousing concern that he was obtaining and using illicit opioids. Nursing staff requested that hospital security conduct room searches, and the physician team asked Mr. M. to sign a behavioral contract promising to refrain from illicit drug use.

After discharge, Mr. M. did not keep his follow-up appointments, continued to inject opioids, and was admitted months later with prosthetic-valve endocarditis. Though a repeat valve-replacement procedure was performed, he died from complications of endocarditis after another prolonged hospitalization.

This unfortunate outcome was not entirely unexpected. The risk

of death or reoperation between 90 and 180 days after an index surgery for endocarditis is 10 times as high among persons who inject drugs as among those who do not.¹ These outcomes probably reflect inadequately treated addiction, ongoing injection-drug use, and potential overdose. It is premature to argue that treating such patients for infections is medically futile and wasteful of resources when their underlying opioid-use disorder (OUD) has not yet been treated in an evidence-based manner. Typically, the focus of the hospitalization is on managing the infection,² and common interventions related to OUD, such as restricting pain medications and the patient's mobility, not only erode the doctor-patient relationship but are also ineffective. This

dynamic, along with undertreated pain and opioid withdrawal, probably contributes to the high rates of discharge against medical advice (11 to 12%) among hospitalized patients with OUD.³

Hospitalizations for severe infections associated with OUD, such as endocarditis and osteomyelitis, have doubled in the United States over the past decade and are frequently prolonged and resource-intensive.³ Once their condition has stabilized, most patients with such infections complete intravenous antibiotic therapy either at home with home health support or in a postacute care facility. But patients with medically and psychosocially complex conditions, such as OUD, are often denied admission to skilled nursing facilities,³ and residential addiction-treatment programs are generally not equipped to manage coexisting medical illnesses. These constraints, coupled with concerns that such patients will continue to use injected opioids and will fail to adhere to an antibiotic regimen after discharge, mean that they often remain in the hospital for weeks while receiving intravenous antibiotics.³ This costly clinical choice is intended to be the safest option; however, without simultaneous treatment of OUD — the underlying cause of the infection — a host of other problems ensue.

We believe there is an urgent need to integrate evidence-based medication-assisted treatment (MAT) for OUD — naltrexone, buprenorphine, or methadone therapy — into hospital care. MAT has been shown to reduce illicit opioid use and related morbidity and mortality.⁴ In addition, methadone and buprenorphine help in managing pain and withdrawal, which could reduce clinician-patient conflict, help engage

patients in care, and reduce the number of discharges that occur against medical advice. Research has shown that buprenorphine treatment for OUD can be initiated successfully in acute care settings such as emergency departments and then continued on an outpatient basis.⁵

Since relapse rates without MAT (in detoxification or abstinence-only programs) exceed 80%,⁴ it seems logical to initiate MAT during hospitalization — though doing so won't be easy. The many barriers include the limited availability of outpatient buprenorphine providers and licensed methadone clinics, as well as difficulties with insurance coverage. Furthermore, stringent federal privacy regulations specific to the treatment of substance-use disorder, though intended to protect patients, effectively segregate such treatment from general medical care, thereby impeding the development of integrated care systems.

Implementing evidence-based care for hospitalized patients with OUD may substantially improve outcomes and reduce costs. A reasonable first step is to ensure that all patients admitted to the hospital with an opioid overdose, or a medical illness with concomitant opioid use, receive a comprehensive assessment for substance-use disorder. If there is a current diagnosis of OUD, we believe that informed consent and initiation of MAT for OUD should be a priority.

Some patients may not want to accept MAT even if it is recommended, but health care providers can still apply harm-reduction practices such as standardized treatment of pain and withdrawal during hospitalization; education of patients and families about how to inject safely, how to obtain clean needles, and how to

avoid, recognize, and treat opioid overdose; and provision at discharge of prescriptions for intranasal naloxone. These simple actions can reduce morbidity and mortality and communicate that the health care community is invested in treating and minimizing complications of OUD. Demonstrating with our actions that we know OUD is an illness rather than a moral failing is critical for patients. That message differs greatly from the one that was sent to Mr. M.

Clinical research is also urgently needed. People who inject drugs have been excluded from studies of outpatient parenteral antibiotic therapy — an omission that leaves providers without an evidence base to support ambulatory transitional management of infections. There are no data to suggest that keeping these patients in the hospital affects rates of completion of antibiotic treatment or of reoperation or that doing so prevents illicit drug use. There may in fact be harm associated with prolonged hospitalization, such as increased risk of opioid overdose because of reduced physiological tolerance after weeks of relative opioid abstinence in the hospital; there are reports of fatal overdoses after people who inject drugs leave jails or detox programs.

Additional research is needed to better define the underlying substance-use disorders, motivations for treatment, and available social support to help guide treatment of patients admitted to the hospital with infections and OUD. We must also effectively address the treatment of pain, an often complex but essential aspect of care, if we are to keep patients engaged. Perhaps patients who are highly motivated, are accepting of MAT, and have social

support to assist with ongoing medical treatment would be candidates for innovative transitional care programs aimed at supporting remission of OUD, avoiding reinfection, and reducing costs.

The unfortunate case of Mr. M. highlights the fact that the current approach to hospitalized patients with OUD and infections is far from optimal. Hospitals will have to be part of any comprehensive plan to address the opioid epidemic. Currently, we are not routinely assessing the severity or treatment needs of the underlying OUD, initiating evidence-based treatments, and supporting risk reduction. Though OUD is a complex medical illness amenable to treatment, stigma and conflict unfortunately continue to influence care, frustrate providers, and marginalize patients.

The Affordable Care Act mandates parity between treatment of substance-use disorders and that of other medical illnesses, and the American Board of Medical Specialties now recognizes addiction medicine as a medical subspecialty. Since there are not enough trained addiction medicine physicians to curb the opioid epidemic, we believe education about evidence-based OUD treatment should be expanded to all members of the care team and integrated into standard hospital care. Education coupled with expanded treatment resources can improve patients' experience, increase adherence to treatment recommendations, and improve health outcomes. It is time to put parity into practice.

Disclosure forms provided by the authors are available at NEJM.org.

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From AIDS to Opioids — How to Combat an Epidemic

Arthur R. Williams, M.D., M.B.E., and Adam Bisaga, M.D.

The United States is facing a vast epidemic of opioid-related deaths. More than 2.4 million Americans have a severe opioid-use disorder (OUD) involving dependence on pain medications, heroin, or both, and rates of drug-overdose deaths in this country have outpaced mortality from motor vehicle accidents since 2013. The rising death toll has been rivaled in modern history only by that at the peak of the AIDS epidemic in the early 1990s. Although these epidemics differ in nature, the large-scale, highly coordinated response to AIDS that was eventually mounted may be instructive for combating the opioid epidemic.

In the face of growing alarm in communities nationwide, the

U.S. Senate recently passed the Comprehensive Addiction and Recovery Act (CARA), which takes incremental steps to combat the epidemic. President Barack Obama signed it into law in July, despite the fact that Congress withheld funding. In his 2017 budget proposal, Obama had incorporated \$1.1 billion for expanding access to evidence-based care, including medication-assisted treatment (MAT) using methadone, buprenorphine, or injectable naltrexone. Funding would be targeted to hardest-hit states and those proposing the most promising interventions for getting needed treatment to people with OUD.

Funding is critically important and long overdue — but will be insufficient without structural

changes, revised regulations, and improved services to help connect marginalized populations with programs and providers that use modern, science-based approaches to treat OUD as a chronic medical condition. Despite the existence of pharmacologic and behavioral treatments based on a generation of research, most treatment programs do not offer evidence-based care and have minimal physician involvement.^{1,2} The substance-abuse treatment system (programs accredited by the Substance Abuse and Mental Health Services Administration) has thus far struggled to implement practices based on science. Too often, treatment centers operate under outdated institutional ideologies favoring abstinence-only approach-