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WELL | LIVE

At the Frontline of the Opioid Epidemic, but Unable to Help

By HELEN OUYANG, M.D. NOV. 10, 2016

I've gotten rather good lately at restricting how many painkiller prescriptions I give out in the emergency room where I work. New York State now requires that all prescriptions be filled electronically with a monitoring program targeting narcotics. Over the last several months I've been keeping track of exactly how many opioids I prescribe.

My log made me realize that I've been quite judicious with the drugs, especially for patients with ongoing, chronic pain. Studies have shown that opioids are not very effective in controlling pain that's not acute, like persistent low back pain. In fact, they may cause changes in the body that make the discomfort even more pronounced and harder to treat.

It's too early to know for sure, but I have a hunch that other physicians are changing their prescribing patterns too. When I explain to patients that I'm sending them home without a script for a fistful of oxycodone pills because of statewide initiatives limiting these prescriptions, they seem to understand, which makes me think other doctors are telling them the same. In the past, they would challenge my judgment or accuse me of practicing differently from my colleagues.

The emergency room may be the first — or last — resort for these patients. We're always open, and people looking for narcotic painkillers know they can come in any time without scheduling an appointment or taking a day off work. Some have

exhausted all the usual options, and have been cut off by their doctors who know their behavior well.

So they seek out the emergency room, rotating through different facilities and new doctors. Sadly, we also see some of them at the end of life, unconscious and not breathing. I've never felt more helpless than when I was trying to comfort a father whose 22-year-old son had overdosed and died — from an addiction he didn't even know his child had.

As an emergency physician, I have the great privilege of being the safety net for anyone who falls through the cracks of our health care system: the uninsured, the undocumented, the poor. But what kind of safety net am I providing for those addicted to opioids?

Sure, I may be able to deny patients more prescriptions. But that doesn't actually help them recover from their addiction, their illness. As a doctor, a healer, I'm supposed to help them with their problem, even if they aren't aware that they have a problem.

Ironically, though, the emergency room is one of the hardest places to actually get them help. Instead, an addict is rushed out the door and labeled a "drug seeker." Where else in medicine do we identify that a patient has an illness, document that it exists in the medical chart, but not try to help treat it?

In Boston, they are tackling the problem head on. Boston Medical Center, which calls itself "a safety-net hospital" for the metropolitan area, opened the Faster Paths to Treatment Opioid Urgent Care Center in August. One of the key innovations of the facility, a collaboration with the Boston Public Health Commission with a four-year, $2.9 million grant from the Massachusetts Department of Public Health, is in its name: Faster Paths.

Traditionally, there has been a long wait to get addicted patients into programs that can help. "We have learned from experience that one of the biggest barriers to effectiveness in treatment for substance use disorder is timeliness," said Edward Bernstein, a professor of emergency medicine and the director of the center. He thinks it's especially meaningful that the grant is provided to the emergency

department because the quick-response philosophies of both are similar: "We take care of things as soon as it comes up."

I know that barrier all too well. Too often, I've talked my patients into pursuing detoxification and rehabilitation, only to be told by the social worker that there are no programs available or that they have to wait for a spot to open up, or it's not covered by their insurance. Patients get frustrated, jeopardizing the likelihood that they'll seek intervention again; sometimes we get only that one chance to help them.

The Faster Paths opioid urgent care center is next to the hospital's emergency room, making it simple for patients to get immediate access. It offers comprehensive care, with counseling, case management, home visits and transportation to acute treatment, like detox. It also provides drugs like buprenorphine and naltrexone, medications used to treat opioid dependency, as well as naloxone rescue kits for overdoses.

The center will also have access to a large referral network, if inpatient treatment services and other higher-level care are needed. By also linking with psychiatric and primary care — in addition to helping patients with housing, education and any other social services they might need — it's meant to be comprehensive one-stop shopping.

The center has received nearly 400 patient visits already; the goal is to accommodate 1,000 patient visits a month by 2018. But there's no reason Boston's "treatment-on-demand" model could not be expanded to other treatment centers across the country.

An immense challenge in treating patients addicted to prescription painkillers is that it's not always obvious who they are. Sometimes, they're the people who would be the last ones suspected of struggling with opioid dependency. They don't have needle track-marks up and down their arms nor are they on the street corners peddling drugs. They live with their families and hold down jobs. They may be parents.

In the emergency room, though, we actually know who they are. We are also in a position to intervene. Why then are we not doing everything we possibly can to help

them?

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