Improving Community Follow-Up

For Patients Initiating Opioid Agonist Therapy in the Emergency Department

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Introduction and Background

Opioid use disorder (OUD) involves the misuse of diverted or prescribed medication or illicit drugs and is a chronic and relapsing condition that has significantly increased morbidity and mortality rates.

2016
BC declares a public health emergency

2022
2,272 people in BC died due to illicit drug toxicity

Opioid agonist therapy (OAT) is a safe and effective first-line treatment for moderate to severe OUD that has been shown to reduce all-cause mortality in patients with OUD by half. Medications such as suboxone, Kadian and methadone are prescribed to improve a patient's day-to-day function, reduce drug-related harms and cravings, and support long-term recovery.

OAT in the ED:

Patients with OUD are often at risk for adverse health events that require emergency department services (ED), making the ED an ideal opportunity for OUD screening, interventions, and treatment. OAT initiation in the ED has been effective throughout North America, including BC, resulting in improved uptake of OAT among patients. However, many EDs only offer passive referrals to outpatient addiction clinics, which is less effective. Currently, OAT initiation in the ED has yet to be trialed in the Island Health region.

Stakeholder Interview Questions

1. What is the current state of prescribing OAT therapy in the ED from your perspective?
2. What challenges does your role face?
3. What challenges do you think clients face?
4. What does your role in the ED need to help facilitate OAT care for patients?

Challenges with Initiating OAT in the ED

For the Emergency Department (ED)

- Staffing challenges
- Unclear protocols and lack of familiarity with OAT programs and resources, including the availability of suboxone TO-GO packs
- Long wait times leading to patients leaving before being seen
- Decreased staff motivation to initiate OAT due to lack of tangible results
- Limited hours of the hospital addictions team, peer support teams and Rapid Access Addiction Clinics (RAAC)
- Difficulty connecting patients with community supports at discharge
- Inconsistent documentation of TO-GO suboxone prescription
- Patients lost to follow-up due to no centralized or standardized referral system
- Patients often lack access to stable housing or cell phones, making it difficult to reach them
- Time-consuming protocols and forms required to initiate OAT in a busy ED

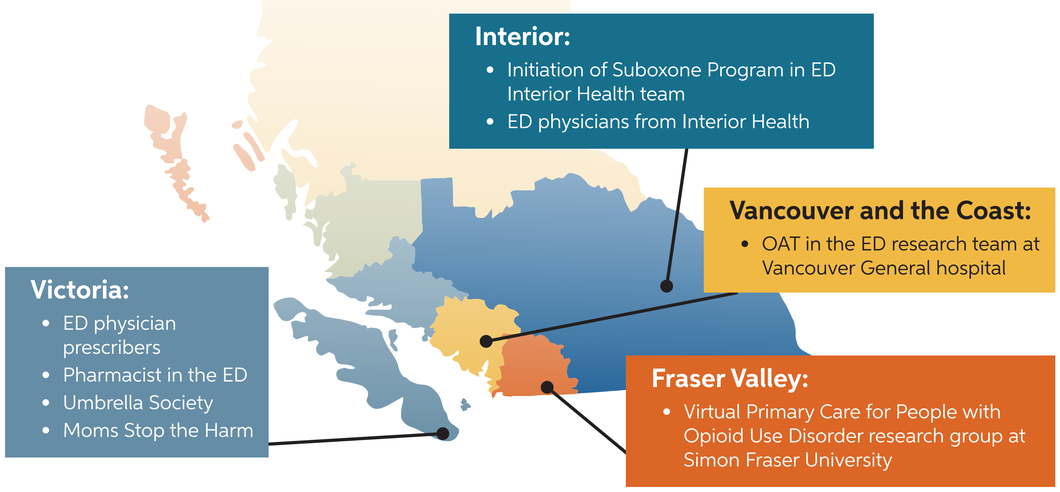
For Patients

- Stigma
- Patients in withdrawal are often not up-triaged and experience long wait times and delays in care
- Harm reduction options may not be what the patient wants
- Negative experiences with the healthcare system
- Limited access to addiction services
- OUD may not be the presenting problem
- Negative experiences with previous OAT therapies
- Difficulty navigating a complicated healthcare system
- Patients only receive 3-day suboxone TO-GO packs from the ED
- Difficulty maintaining dosing schedules to continue OAT
- Patients are often discharged into an environment not conducive to continuing OAT therapy (ie. unstable housing, an environment where substance use is common)
- Unclear messaging and communication from various healthcare teams

Methods

Key stakeholder interviews were conducted with the following:

Total interviews conducted: 10



Ideas to Address Challenges

- Create safe consumption sites close to the hospital
- Create nursing orders and educate nurses to help flag OUD, assess patient opioid withdrawal status, and help in patient education
- Increase triage value in the ED for opioid withdrawal
- Pre-printed order sets for ED staff to help increase access to OAT prescriptions
- Document patient testimonials and OAT results to improve ED staff morale
- Improve ED staff education about OAT prescribing, screening, and resources
- Email reminders about the OAT program to ED staff
- Increase access to suboxone TO-GO packs
- Provide micro-dosing options to patients to improve their experience with OAT initiation
- Increase peer support presence in the ED
- Increase hours for RAAC and addictions teams in the ED and community
- Create a centralized system for follow-up
- Improve communication among OAT providing services, and between providers and patients
- Improve documentation of OAT prescription and inductions
- Create a community team to aid patient transition from the ED to community support

Patient Journey* for Improved Outcomes with ED-Initiated OAT in Victoria

* This journey reflects the input gathered during the interview process

Patient with OUD arrives in ED and screened for OUD

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Peer support and social work are contacted. The patient is supported and offered treatment options, including OAT, and medically managed by ED physician. The addictions team is contacted for complex cases and for referrals.

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If the patient meets OAT induction criteria and wishes to start OAT, they are induced in the ED and referred to peer support, social work, RAAC and community supports.

OR

The patient is offered 3-day TO-GO pack, and the patient initiates OAT induction at home. The patient is referred to peer support, RAAC, social work and community support.

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RAAC, community supports, social work, and SURF[1] team follow up with patients to support them as OAT is continued.

1. Substance Use Follow-Up

SharedCare Partners for Patients

Victoria Division of Family Practice
An FPSC initiative

South Island Division of Family Practice
An FPSC initiative

The projects described here were funded through the Shared Care Committee, a joint committee of Doctors of BC and the BC Ministry of Health.