



Expanding access to buprenorphine/naloxone in the emergency department

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There is no end in sight for the ongoing tragedy of opioid overdose deaths in Canada. Despite efforts across all levels of government to reduce opioid-related harms since the declaration of a national opioid public health crisis in 2016, approximately 14 hospitalizations and 20 deaths still occur daily from opioid poisoning [1]. The COVID-19 pandemic has only worsened rates of hospitalizations and overdose-related deaths in many Canadian jurisdictions, and this trend remains unchanged [1]. We must act urgently to improve emergency department (ED) care for people who use opioids, and mitigate the devastating consequences that continue to result from an unpredictable and increasingly toxic illegal drug supply [1].

In British Columbia, ED patients who were discharged after an opioid-related overdose were at significantly higher risk of mortality within 12 months following the index ED visit compared to those with non-opioid-related ED visits [2]. Growing evidence demonstrates the feasibility and effectiveness of buprenorphine/naloxone initiation as a life-saving intervention in the ED [3]. In their article, Stone et al. present results from their cross-provincial quality improvement initiative aimed at increasing ED prescribing of buprenorphine/naloxone [4], which is recommended as first-line treatment for opioid use disorder [3]. Their intervention provided EDs across Alberta with resources (provider education, medication supplies, order sets, and patient-facing materials) paired with referral pathways that guaranteed access to

the next-day outpatient follow-up for ED patients who were started on buprenorphine–naloxone [4].

We applaud Stone and colleagues for designing and implementing a robust quality improvement initiative that successfully increased rates of buprenorphine–naloxone initiation in EDs across Alberta with modest outpatient follow-up, substantial treatment adherence at 180 days following the index ED visit, and minimal adverse events [4]. Stone et al. offer an ideal model of ED addiction care in which an evidence-based medical intervention is embedded within a pathway that does not require the patient or ED provider to navigate access to follow-up care [4]. Furthermore, their initiative effectively addresses recommendations from the Canadian Association of Emergency Physicians (CAEP) to improve ED care for people who use opioids, such as offering first-line treatment, and improving transitions of care to community providers following ED discharge [3].

Previous research on Canadian ED physicians' perspectives conducted just prior to the COVID-19 pandemic identified key facilitators of buprenorphine/naloxone initiation in the ED, including standardized treatment protocols, dedicated human resources, and joint system and patient engagement [5]. Stone et al. address implementation barriers and facilitators in the design of their quality improvement initiative [4]. They offer a systems-based approach to large-scale implementation with several benefits, including buy-in from health system leadership that is necessary for such programs to be successful. Through the removal of barriers for individual ED clinicians and with organizational commitment to helping patients with opioid use disorder, these processes may also help to reduce stigma associated with seeking treatment.

We wish to highlight several key considerations for expanding access to buprenorphine/naloxone in the ED. First, ED buprenorphine/naloxone pathways must be easily adaptable to local ED contexts. Standardized protocols can ensure consistent clinical practice across sites, reduce duplication of efforts in developing similar interventions,

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and facilitate the collection of comparable data for evaluation. However, protocols must remain flexible to meet the unique implementation needs identified by local EDs (e.g., availability of community addiction providers and departmental resource constraints). Provincial/regional health authorities and health networks must be explicit in their support of local EDs, and contribute tangible resources toward reducing barriers for ED providers wherever possible. Interdisciplinary teams, as utilized by Stone et al. to design locally appropriate pathways for implementation [4], can help improve the identification and care of individuals with opioid use disorder in the ED. Furthermore, individuals with lived experience should be stakeholders at all stages of pathway development to ensure that programs are low-barrier, patient-centered, and culturally appropriate and safe for people who use substances.

Successful large-scale implementation of ED buprenorphine–naloxone pathways and ongoing quality improvement will require accessible support for ED providers. This may be in the form of experienced ED staff, specialized addiction team members, or provincial addiction specialist support available through consultation [5]. Addiction medicine is a rapidly evolving field in which innovative research and timely knowledge translation are crucial to improving patient outcomes. Canadian ED providers have also endorsed the need for improved access to incentivized training opportunities in opioid agonist therapy [5]. Key competencies required for the care of people who use substances should be embedded within medical school and residency curricula, as well as within continuing medical education for ED physicians. Addiction medicine should be recognized as a core component of emergency medicine, and supporting access to addiction medicine fellowship training for Canadian emergency medicine residents will increase the number of dual-trained clinicians who can provide expert care and support attuned to the unique needs of EDs.

Finally, as we work toward scaling up access to buprenorphine–naloxone across EDs, we must prioritize transition of care following discharge. Access to community addiction care can be fragmented and difficult to navigate, leaving ED providers frustrated and patients vulnerable to harm from loss to follow-up. Indeed, Canadian ED physicians have identified “access to streamlined and timely follow-up care in the community” as a key facilitator of ED buprenorphine–naloxone initiation [5]. EDs situated in communities with limited outpatient addiction care availability

should be supported with virtual referral options. Easily accessible, single referral pathways that do not require pre-booked appointments can reduce barriers to continuation of buprenorphine/naloxone for patients. EDs must remain open for patients to return for temporizing opioid agonist therapy as part of the continuum of care of people who use substances.

Stone et al. offer a model that can be referenced by ED providers, administrators, and policy makers who wish to expand access to buprenorphine/naloxone. Moving forward, by continuing with efforts such as those outlined here and by Stone et al., we believe that the field of Emergency Medicine can continue its mission of providing high-quality, evidence-based care to everyone, especially to our most marginalized patient populations.

Declarations

Conflict of interest The authors have no conflicts of interest to declare.

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