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Ontario Medical Students Association
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POLICY PAPER

Improving Care for Individuals with Opioid Use Disorder in the Emergency Department Setting

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SUMMARY:

Summarized Background

The opioid crisis in Canada, marked by 40,620 toxicity deaths from January 2016 to June 2023 and a 165% increase in opioid-related emergency department (ED) visits in Ontario from 2009 to 2019, demands immediate action. Since the 1980s, the crisis has been fueled by a 3000% increase in opioid prescriptions and inadequate oversight, leading to widespread misuse. Vulnerable groups, including low-income individuals, people experiencing homelessness, and First Nations communities, are disproportionately affected due to socioeconomic challenges (3,6). People who use drugs in Ontario visit EDs seven times more than the general population, yet often face inadequate care, with 19% leaving before being seen. Despite the proven benefits of opioid agonist therapy (OAT) and its incorporation into the guidelines for management of opioid-use disorder, its use remains low among ED patients, with only 1 in 18 receiving OAT. Urgent action is needed to improve access to OAT and enhance care through evidence-based strategies and medical education.

Summarized Recommendations

- Implementation of comprehensive, standardized protocols for screening and treatment of substance use disorders.
- Supplementary training on trauma-informed care for all medical trainees and healthcare providers working in emergency and urgent care centres.
- Streamlined access to follow up care and support for substance use disorders.
- Comprehensive opioid toxicity training for medical learners.

INTRODUCTION

The surge in opioid-related mortality and morbidity in Canada demands urgent attention, starting with addressing persistent gaps in care and treatment for individuals who use drugs. Between January 2016 and June 2023, there were 40,620 opioid toxicity deaths in Canada (1). From 2009 to 2019, there were

86,403 opioid-related emergency department (ED) visits in Ontario specifically, with the incidence increasing by 165% within that time frame (2). The present opioid crisis originated in the 1980s and we have since seen an over 3000% increase in opioid prescription rates (3). Overprescription compounded by inadequate regulatory oversight has led to widespread availability and misuse of opioids, contributing to the current epidemic (4). The burden of opioid-related mortality and morbidity extends beyond the individual user; it adversely affects families, friends, work, and the health system overall, costing the Canadian healthcare system $519 million in 2020 (5).

Although opioid-related mortality and morbidity affect people from all communities, studies have found that certain communities are disproportionately impacted. Low-income individuals, those experiencing homelessness, individuals involved in the criminal justice system, as well as those with lower education levels and belonging to First Nations communities have higher risk of opioid-related death and overdose due to a number of socioeconomic and systemic challenges (3,6). Disproportionate impacts on these communities are particularly concerning due to their already elevated likelihood of experiencing unmet healthcare needs and insufficient access to treatment.

People who use drugs (PWUD) in Ontario have 7 times the ED visits compared to the general population (7), but they often receive inadequate care and poor treatment within EDs, with 19% of opioid overdose patients leaving the ED before being seen or against medical advice (8). Common reasons for leaving include experience of stigmatization, neglect, lack of empathy, inadequate pain and withdrawal management, and misunderstandings with healthcare providers (9). These experiences are incredibly dangerous, as the patient leaves without the medical attention that they need, risking worsening health outcomes and the development of an unwillingness to seek healthcare in the future (9). A total of 13.6% of patients with opioid-related deaths had a hospital encounter within 1 week of death, indicating a missed opportunity for adequate medical intervention (10).

Opioid agonist therapy (OAT) utilizes methadone or buprenorphine, agonists of the mu opioid receptor, to help mitigate cravings and withdrawal symptoms while attenuating the effects of illicit opioids (11). OAT has been shown to be effective in promoting abstinence, increasing treatment retention, and reducing mortality (12,13). Some argue that OAT is simply substituting one drug for another, and that we should look towards opioid antagonists such as naloxone and naltrexone, which do not have the potential for abuse. However, antagonist induction of acute withdrawal and lack of reinforcement contribute to poor compliance rates, with less than 20% of patients continuing with opioid antagonist treatment at 6 months (11,14).

As of 2018, the Canadian Opioid Use Disorder (OUD) clinical management guidelines recommend that OAT be initiated for all patients with OUD whenever feasible (15). Despite this, a recent study completed in Ontario found that OAT is significantly underused among ED patients, with only 1 in 18 patients receiving OAT (16). From 2014 to 2021, ED visits and deaths for opioid-related toxicities among young adults and adolescents have increased, but OAT recipients have decreased, from 4,288 to 1,879 recipients (10). While the benefits of OAT treatment are well-known to healthcare professionals, there are various system-level barriers that exist that lead to low rates of OAT prescription. Physicians have noted system-level barriers including lack of experience and formal OAT training, lack of a standardized ED approach and protocols, and unreliable and inaccessible OAT follow-up care for patients (17). Additionally, the stigma associated with opioid use disorder can deter healthcare providers from engaging in OAT.

Currently, the Canadian Competency-Based Medical Education (CBME) framework lacks defined competencies for addiction medicine, which represents a significant gap in medical training (18). Without specific competencies, residency programs may not emphasize crucial skills such as screening, assessment, and treatment of addiction (such as with OAT), leaving physicians inadequately prepared for the management of OUD patients in clinical practice. Physicians also commonly report limited exposure to and memory of teaching related to opioid prescribing during medical school (19).

In light of these alarming trends and the significant impact of inadequate care for individuals presenting with opioid-related emergencies, urgent action is needed to implement comprehensive strategies that prioritize timely access to treatments and supports.

One such evidence-based tool for screening and management of OUD is Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT involves systematic screening for patients with OUD or those who are at risk, delivery of a brief intervention, and referral to long term treatment (20). Implementation of this tool has shown success in reducing drug use and improving health and socioeconomic outcomes (21).

PRINCIPLES

The Ontario Medical Students Association (OMSA) makes its recommendations using the following guiding principles:

1. No person should go without medically necessary treatment due to discrimination; stigmatization; or structural, financial, or geographical barriers.
2. There should be a prioritization of patient-centered care, patient dignity, and respect.
3. All efforts should be made to adopt evidence-based practices for assessment, treatment, and management.

RECOMMENDATIONS

The OMSA recommends the following:

1. That all hospitals providing emergency or urgent care services should implement comprehensive, standardized protocols for screening and treatment of opioid use disorders.

SBIRT is an evidence-based screening tool that improves early intervention and treatment of substance use disorders (20). SBIRT involves the following core components (20,22,23):

A. Screening: Systematic identification of those with substance use disorders or those who are at risk of developing substance use disorders using validated screening tools. Screening helps to determine the severity of substance use and the level of intervention required.

B. Brief intervention: A brief, typically 5–10 minute, conversation that serves to increase motivation for substance use avoidance or teach behaviour change skills. Brief intervention is indicated for individuals at low to moderate risk.

C. Brief treatment: Delivery of time-limited treatments such as cognitive behavioural or motivational enhancement therapy for patients who are at higher risk or in the early stages of dependence. Treatment is typically delivered over the course of 4–8 sessions.

D. Referral to treatment: Provides those who are at higher risk or showing serious signs of dependence with access to specialized care.

E. Integration and coordination activities: Integration and coordination of all four components into a network that supports connections between early intervention and referral to specialized care.

SBIRT training significantly improved confidence, responsibility to intervene, and actual utilization of SBIRT skills among ED healthcare providers (24) and has been found to reduce healthcare costs by 21% (25). Similar positive findings were observed when SBIRT was implemented for medical trainees at the University of Vermont. The use of SBIRT significantly increased self-reported satisfaction with

management, appropriate advice to patients, knowledge, and communication skills related to clinical encounters involving individuals living with drug misuse issues (26). SBIRT implementation in EDs and clinics within six US states resulted in a significant 67.7% reduction in drug use; increased general health, mental health, and employment; and reduced homelessness and reported arrests at 6-month follow-up (21).

Implementation: We recommend that EDs and urgent care settings across Ontario implement standardized SBIRT screening protocols for OUDs. The successful implementation demands a multi-faceted approach, including ongoing SBIRT training and integration of SBIRT into the electronic health record (EHR).

A. **Ongoing SBIRT Training:** We recommend consulting with the Brief Negotiated Interview and Active Referral to Treatment (BNI-ART) Institute at the Boston University School of Public Health, an organization recommended by the Centre for Addiction and Mental Health (CAMH) for provision of SBIRT training, implementation, and quality assurance (22), to facilitate ongoing training and ensure the maintenance of standards of care over time (22). In evaluating the success of the training process, it will be important to engage both healthcare providers as well as patients to gather comprehensive feedback and identify areas for improvement. Evaluation of the effectiveness of the training processes may include measurement of opioid-related mortality rates, opioid-related ED visits, rate of OAT administration to individuals with opioid use disorder, and patient-reported outcomes such as treatment satisfaction.

   OMSA's role during implementation involves working directly with deans of medical schools and emergency medicine course coordinators/program directors across Ontario. OMSA could facilitate partnerships between these academic leaders and the BNI-ART Institute to ensure that SBIRT training is up-to-date, evidence-based, and integrated into medical curricula. This approach would not only enhance the training provided but also ensure that it aligns with the latest research and best practices, ultimately contributing to improved patient outcomes.

B. **Integration of SBIRT into the EHR:** We recommend incorporating SBIRT screening tools, checklists, alerts, and service provision data directly into EHRs used in EDs (27). This approach aims to enhance the standardization and efficiency of care delivery for individuals with substance use disorders.

   OMSA's role during implementation involves advocating to current MPPs and Ontario Health officials for government funding and resources specifically allocated to facilitate timely modifications to EHRs. This advocacy could include working with key stakeholders, such as deans of medical schools, healthcare IT professionals, and community health leaders, to develop a strong case for the necessity of these EHR modifications. OMSA could also organize meetings and forums with policymakers to discuss the importance of integrating SBIRT tools into EHRs and the potential positive impact on patient care. It is also imperative that these changes are implemented equitably across EDs throughout the province, to ensure that all patients receive the highest quality of care regardless of their geographic location or healthcare institution. Before implementation, OMSA should advocate for the inclusion of community representatives in the planning and evaluation process, ensuring that the needs of diverse populations are considered and addressed.

2. That all medical trainees and healthcare professionals working in emergency or urgent care settings should receive supplementary training on trauma-informed care.

Trauma-informed care is an approach to healthcare delivery that relies on the principles of patient safety, collaboration, empowerment, trust, and choice (28). The use of this approach promotes compassionate care of patients with ongoing physical and psychological symptoms of trauma, which often contribute to OUD (28). Trauma-informed care approaches have been found to reduce substance abuse and improve treatment retention (29).

We recommend that healthcare education programs (medical schools and healthcare institutions) incorporate additional trauma-informed care training to address the structural violence inherent in the healthcare system. Such structural violence often contributes to the stigmatization and mistreatment experienced by PWUD in EDs (30). Additional trauma-informed care training may mitigate barriers to high-quality care that PWUDs experience by equipping medical trainees and healthcare professionals with the knowledge and skills needed to identify and address trauma-related issues with sensitivity and understanding. The integration of trauma-informed care within organizations serving communities with substance use, addiction, mental health disorders, and those currently or at risk for homelessness, has been found to lead to increased client satisfaction, higher number of planned discharges and even improved workplace satisfaction (31).

While some medical schools in Canada have started to incorporate trauma-informed care training into their curricula, we encourage all medical schools and healthcare institutions in Canada to prioritize the integration of trauma-informed care training as a mandatory and standardized component of their medical education curricula. Students who receive training in trauma-informed care report that they are better able to recognize clinical manifestations of adverse childhood experience exposure, and ask about and respond to experiences of trauma (32).

Implementation: We recommend the integration of trauma-informed care in undergraduate medical education and healthcare education.

A. **Mandatory experiences:** We recommend that medical schools encourage or mandate participation in electives, longitudinal experiences, field visits, and research projects where learners can gain clinical exposure to and expertise in caring for patient populations experiencing addiction.

   OMSA's role may include collaborating with deans of medical schools and community health leaders to integrate these opportunities into the core medical curriculum. This could involve developing partnerships with local healthcare institutions, community organizations, and public health agencies that work directly with these communities, thereby creating a network of field placements and research opportunities focused on addiction care.

B. **Comprehensive didactic training:** The experiences can be supplemented by didactic training in trauma-informed care which could take the form of case-based learning, seminars, or expert panels. These mediums for trauma-informed care training have been found to result in successful outcomes, including ED clinicians reporting increased expertise and confidence in delivering care for marginalized patients, and improved quality of service ratings and consistency of referrals for ED patients (33).

   OMSA's role could include working with faculty development committees and community stakeholders to design and deliver this training, ensuring it is tailored to address the specific needs and challenges faced by these communities. By focusing on areas with high rates of drug addiction, OMSA can help medical schools produce graduates who are not only skilled in addiction care but also well-informed about the social determinants of health that affect these populations, ultimately leading to better care outcomes.

3. That processes for accessing community-based follow up care and support are streamlined.

It is imperative that there are established, streamlined pathways for individuals with OUDs to access community-based follow-up care and support services after seeking care in EDs. In a 2021 qualitative study, ED physicians consistently highlighted access to streamlined follow-up care as a critical facilitator of initiating opioid agonist therapy in the ED (17).

Lack of referral networks is a critical barrier to OAT initiation and continuation. Timely follow-ups every few days are important to OAT dosing titration and adherence to risk-mitigation strategies that may be used such as observed dosing. Canadian guidelines for OAT prescribing also recommend the combination of OAT with concurrent behavioral and social supports to optimize other determinants of health that influence substance use and quality of life, which referral networks would facilitate by ensuring seamless coordination of care and access to a variety of supportive services, ultimately enhancing the effectiveness and sustainability of OAT (34). We recommend that EDs prioritize not only the initiation of OAT among patients living with OUDs, but that they also ensure patients have appropriate follow-up post-discharge. This can be accomplished by connecting patients with community organizations that are appropriate and accessible for the specific patient (e.g., taking into consideration location, timing, patient preferences).

Implementation: The implementation of this recommendation will involve forming strong relationships with referral partners.

A. **Relationships with referral partners:** Hospitals should work directly with community opioid agonist therapy providers to establish rapid referral networks tailored to the communities that they serve, allow patients access to timely care, and minimize barriers to follow up (35). Follow-up care was a priority during the implementation of a 2014 state-wide campaign to expand the use of SBIRT for OUD in ED settings in Maryland, United States. The effort involved the creation of rapid referral networks to get patients accepted to community providers within 24 hours of discharge from the ED. This program showed success in that of the 666 Maryland ED patients who were administered buprenorphine for opioid withdrawal symptoms, 64.6% attended their first community-based follow up appointment (27). We encourage EDs in Ontario to follow a similar approach as the state of Maryland to streamline referral services for PWUD. Implementation strategies that contributed to their success included securing local, provincial, and federal funding and grants; piloting the program with program evaluations and gradual expansion over time; and hiring peer recovery coaches in EDs to expedite and streamline the referral process and ensure patients are enrolled in appropriate support services.

   OMSA's role might involve facilitating partnerships between hospitals, community OAT providers, and public health agencies. By bringing these stakeholders together, OMSA can help create a cohesive strategy for establishing effective referral networks. OMSA can advocate for policy changes and funding at the local, provincial, and federal levels to support the creation of rapid referral networks. This could involve lobbying for dedicated resources, grants, and incentives that encourage hospitals to integrate these networks into their care models.

4. That medical learners receive comprehensive opioid toxicity training.

Currently, there are no addiction medicine competencies defined in the CBME infrastructure (18). We implore OMSA to advocate to the Royal College of Physicians and Surgeons of Canada and residency program directors for the integration of addiction medicine as core components in medical training to improve physician expertise and comfort in managing opioid-related visits. Canadian medical residents reported that early exposure to addiction medicine was a motivating factor for pursuing training in OAT, but noted inadequate teaching regarding opioid prescription practices during undergraduate medical studies and lack of protected OAT training time in residency as barriers (19).

Implementation: The implementation of this recommendation will require development and incorporation of a comprehensive substance use disorder curriculum for medical learners and residents.

A. **Further substance use disorder education:** The implementation of an enhanced substance use disorder curriculum for internal medicine residents at Massachusetts General Hospital led to 23% improvement in preparedness to treat substance use disorders (36). A survey of undergraduate medical education (UGME), postgraduate medical education (PGME) and continuing professional development (CPD) experts from all medical schools in Canada endorsed

the need for ongoing opioids and addiction training in all years of medical education and beyond (37).

OMSA's role includes advocating to the Royal College of Physicians and Surgeons of Canada, as well as residency program directors, for the integration of addictions medicine as a core component in medical training to improve physician expertise and comfort in managing opioid-related visits. OMSA could work to form a task force dedicated to defining the specific addiction medicine skills and knowledge that should be integrated into CBME. This task force may include representatives from medical schools, residency programs, addiction medicine specialists, healthcare policy experts, and the general community to ensure that the curriculum is comprehensive, evidence-based, and aligned with the needs of individuals with substance use disorder.

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