

CAEP Position Statement: Emergency department management of people with opioid use disorder

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INTRODUCTION

Deaths due to opioid overdose have reached unprecedented levels in Canada; over 12,800 opioid-related deaths occurred between January 2016 and March 2019, and overdose death rates increased by approximately 50% from 2016 to 2018.¹ In 2016, Health Canada declared the opioid epidemic a national public health crisis,² and life expectancy increases have halted in Canada for the first time in decades.³ Children are not exempt from this crisis, and the Chief Public Health Officer of Canada has recently prioritized the prevention of problematic substance use among Canadian youth.⁴

In 2014, the overall health care costs of substance use in Canada were estimated to be \$11.1 billion, of which 2.8% (\$0.3 billion) were attributed to opioids.⁵ Since then, health care use resulting from opioid use has increased dramatically. Opioid-related hospitalizations increased by 27% between 2013 and 2017.⁶ From 2016 to 2017, emergency department (ED) visits due to opioids increased by 73% in Ontario, and 23% in Alberta.⁶ Furthermore, youth aged 15 to 24 years have the highest and fastest-growing rates of ED visits related to opioids, tripling over the past 5 years.⁶

EDs are often the main source of health care for patients with substance use disorders.⁷ ED visits are crucial opportunities to identify and address the complex needs of patients who are socially and medically marginalized.⁸ Those who visit the ED frequently are at significant risk of subsequent overdose.⁹ People who overdose are more likely to have visited an ED in the preceding year, and are more likely than the average patient to have left without being seen or against medical advice.¹⁰

In the context of a national opioid crisis, there is a professional imperative for emergency providers to take evidence-based steps to prevent future morbidity and mortality resulting from opioid use and from common presentations of opioid-related illness in ED settings. Nonfatal opioid overdose, rapid opioid tapering, and opioid withdrawal are significant risk factors for subsequent death due to opioid overdose.^{11,12} In Canada, ED-based interventions for opioid use disorder have been shown to be effective and acceptable to patients.¹³⁻¹⁶

CAEP supports a broad and multi-faceted public health approach to addressing this complex health crisis and embraces an evidence-based harm reduction approach to substance use, which aims to reduce

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the harms of substance use without mandating abstinence.^{17,18} This position statement offers recommendations designed to position emergency medicine, emergency health care providers, and EDs as key partners in a broad and intersectoral strategy to address Canada's opioid crisis for Canadians of all ages.

The scope of this position statement is limited to clinical practice in the ED. The recommendations in this position statement are applicable and adaptable across urban, suburban, and rural practice environments nationwide, although reasonable modifications may be required to suit local patient needs, demographics, and epidemiology. These recommendations were not developed according to systematic review or guideline methodologies and should not be interpreted as a clinical practice guideline. This position statement is intended to advance common practice, and not to establish a standard of care.

LIST OF RECOMMENDATIONS

1. Use case-finding strategies to identify opioid and other substance use disorders

- a) Patients who present with possible sequelae of opioid use disorder should be engaged in a non-judgmental conversation about their substance use history and possible substance use disorders. Providers should consider using available tools to identify patients with opioid use disorder despite the lack of validation in the ED setting.
- b) Urine drug screens should not be used to diagnose, or rule-out opioid use disorder in the ED due to their low sensitivity and specificity.

2. Initiate first-line opioid agonist treatment in patients with opioid use disorder

- a) Patients who meet criteria for opioid use disorder should be offered buprenorphine/naloxone initiation in the ED. Take-home doses may be dispensed as an alternate approach to buprenorphine/naloxone initiation in the ED.
- b) Providers should be familiar with other forms of opioid agonist therapy, such as methadone and sustained release oral morphine.
- c) Providers should treat opioid withdrawal early, aggressively, and compassionately to reduce the risk of fatal overdose.

3. Provide overdose education and naloxone distribution and other harm reduction interventions

- a) Overdose education and naloxone distribution should be offered early in the ED visit to all patients who are at risk of opioid overdose, and those who may witness an opioid overdose in the future, e.g., friends, partners, and family members of those who use opioids.
- b) Sterile drug consumption supplies (e.g., needles, syringes, alcohol swabs, pipes, and smoking kits, and a safe disposal method for used supplies) should be provided to patients to reduce the harms and complications associated with substance use.
- c) Patients at risk of overdose should be counseled on harm reduction practices and directed to local needle and syringe programs, overdose prevention sites, and/or supervised consumption sites.

4. Reduce harm from opioids prescribed in the emergency department

- a) EDs should establish opioid prescribing policies that align local practices by providing guidance on screening, risk assessment, opioid selection, and judicious course duration to reduce risk of subsequent opioid use disorder.
- b) Patients who are prescribed opioids from the ED should be counseled on the risks of adverse events, overdose, and dependence, and provided instructions for safer storage and disposal.

5. Improve transition of care and social stabilization

- a) EDs should develop local referral pathways to community-based providers for patients with identified opioid use disorders.
- b) Providers should identify patients with social factors that may inhibit engagement in treatment (e.g., unstable housing, disrupted home environments, lack of medication coverage, lack of identification/health care coverage), and initiate referrals to local supports.
- c) Missed scheduled doses of opioid agonist therapy (e.g., methadone, buprenorphine/naloxone) should be provided in the ED to patients on stable treatment, after confirming the time of last dosing with the patient's community pharmacy. If patients have missed doses before the day of the ED visit, consider

contacting their primary provider to discuss dose replacement as per provincial guidelines.

- d) EDs should ensure that treatment is provided in a patient-centered and compassionate manner that is free from judgment, bias, and discrimination.

GOING FORWARD

Substance use disorder education has been lacking across the spectrum of medical training.¹⁹ This lack of education and training has been identified as a major barrier to providing appropriate care for patients with substance use disorders, and must be addressed to build capacity across EDs in the country.^{15,20} There is evidence to suggest that physicians who have undergone training are more likely to provide treatment for opioid use disorder, such as buprenorphine/naloxone.²¹

The College of Family Physicians of Canada certifies family physicians who have added competence in Addiction Medicine.²² The Royal College of Physicians and Surgeons has also established an Area of Focused Competency in Addiction Medicine.²³ Within the Royal College's new competency-based residency curriculum, Canadian emergency medicine residents will need to develop proficiencies in addiction medicine, including those related to encounters with individuals with opioid use disorder.²⁴ CAEP will support educational initiatives and curriculum for areas of competency related to opioid use disorder for emergency physicians, and act as a platform for exchange of knowledge and best practices across the country.

Finally, further attention should be directed toward the challenges in assessing and monitoring the impact of the opioid crisis on EDs across the country. Inadequate ED data collection on opioid-related visits remains a significant barrier to public health planning. In 2018, Ontario, Alberta, and the Yukon were the only jurisdictions in which all EDs submitted sufficient data to the National Ambulatory Care Reporting System (NACRS) for analysis.⁶ As such, the most recent Canadian Institute for Health Information (CIHI) report on opioid-related harms only provided analyses on ED data and trends in ED visits in these jurisdictions.⁶ EDs across the country are encouraged to collaborate with public health organizations on data collection and surveillance, and improve monitoring of trends in ED visits due to opioids across the lifespan at the provincial and national levels.

CONCLUSIONS

Emergency physicians are on the front lines of the opioid crisis and must act to address Canada's largest public health emergency to date. The recommendations outlined in this position statement are important steps to ensure that people of all ages with opioid use disorders are provided equitable, compassionate, and evidence-based care in the ED setting. These recommendations can be implemented across urban and rural practice environments nationwide and should be adapted to meet patient needs and availability of resources locally.

Keywords: Harm reduction, naloxone, opioid prescribing, opioid use disorder, opioids, overdose prevention, pain management

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