Increasing access to naloxone in BC to reduce opioid overdose deaths

Opioid overdose is a public health issue in British Columbia. In 2009, more than 200 deaths were identified as illicit drug deaths (IDD),[1] opiates were found in 60%,[2] and an additional 74 deaths were in persons *prescribed* opioid medication.[3] In May 2011, the BC Coroners Service released a warning about a spike of heroin-related deaths due to increased heroin potency.[4] Unintentional death from opioid overdose is preventable with education and timely administration of naloxone, an opioid antagonist.[5] In BC, the current lack of naloxone availability outside primary care, hospital, and ambulance settings limits its lifesaving potential.

Naloxone has been approved for the reversal of opioid respiratory depression in Canada for over 40 years and is on the WHO Model List of Essential Medicines. Naloxone cannot be abused, and in the absence of narcotics, exhibits no pharmacological activity. Globally, naloxone access takes many forms including take-home-naloxone programs for people who use illicit drugs in Europe, Australia, and over 180 programs in the US; as part of a pain-management toolkit for people prescribed opioids; and availability for anyone who may witness an opioid overdose.[5]

Fourteen subpopulations have been identified at higher risk for overdose. These include previous overdose, recent discharge from prison or drug treatment, high-dose opioid prescription, opioid use with comorbidities (e.g., respiratory/hepatic/renal disease), initiation into opioid substitution therapy, and concurrent treatment involving antidepressants or benzodiazepines.[6] Naloxone may particularly benefit individuals who are reluctant to access emergency care or where emergency services are not readily available.

Recently, Ontario responded to the removal of OxyContin from the Canadian market by providing overdose prevention and response training and increasing access to naloxone province-wide.[7]

BC, a leader in harm reduction with the first officially sanctioned supervised injection facility (Insite) and the "first jurisdiction in Canada to recognize addiction as a chronic illness," has not fully utilized naloxone to address morbidity and mortality related to opioid overdose.

The BC Centre for Disease Control harm reduction program has engaged with stakeholders to identify barriers and ways to increase provincial naloxone access in order to prevent harms from overdose among people using both prescribed and illegal opioids. Current initiatives being explored include training peers to increase community capacity to administer naloxone, providing naloxone to patients discharged from hospital following an overdose, developing a provincial decision support tool for nurses, and adding naloxone to the Pharmacare formulary to reduce monetary barriers.

Intranasal naloxone is utilized at Insite and Vancouver outreach settings by the Portland Housing Society. However, overdose deaths occur throughout BC.[2] People who use drugs have requested training and access to intramuscular naloxone. Training can provide an opportunity to engage in meaningful dialogue and empower people who use opioids to take responsibility for themselves and others.

This article seeks to increase physician awareness about the safety, effectiveness, and evidence that increasing access to naloxone saves lives, as we proceed with planning and implementing a naloxone program in BC. For more information contact outreach@towardtheheart.com.

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References on page 251

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quate management of a patient with poorly controlled diabetes can result in many office visits, eventual admission to hospital requiring daily visits, and numerous follow-up visits after discharge. Under the fee-for-service system there is no alignment of reimbursement with the quality of care. Under the ACG model, the funding is fixed, and the practice and clinicians are motivated to prevent hospital admission and excess visits—a fundamental realignment of motivation.

While a rigorous study to measure and clarify the presumed benefits and savings has not been done, the fact that many practices are already operating under this system and their experiences suggest that such a system does in fact produce changes in practice and clinician behavior:

- These practices operate as health care teams, with numerous practice-funded ancillary providers, such as LPNs, RNs, and NPs.
- These practices have patient rosters far in excess of the average, suggesting increased capacity is possible with this model.
- All practices have embraced electronic medical records as necessary aids to the team-based care they provide.
- Hospital admission rates are significantly reduced for patients of these practices.
- All practices remain actively engaged in their local community hospital, with clinicians retaining admitting privileges.
- Patient acceptance and satisfaction is high.
- Physician satisfaction is high, with significant interest in the model among new family practice graduates.
- Attachment rates (patients receiving the majority of care) for these practices are extremely high (85% to 90%) compared with fee-for-service practices, which typically exhibit fragmented care and rates of 45% to 55%.

Given the above observations, and the fiscal imperative to manage our health care system optimally, a detailed cost-benefit analysis of the population-based funding model of primary care is critically important.

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Continued from page 231

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Continued from page 249

bound to defer to the relevant professional bodies to reach an opinion as to whether the care provided met appropriate standards. For example, a patient who felt that being prescribed a homeopathic remedy by a "professional" was poor care, would not be able to have their case heard by the court and have a scientific standard applied. Rather the court would allow the professional college to make the determination about whether the treatment given was appropriate.

Such a situation could, as the saying goes, put the fox in charge of the hen house and thwart the expectation that the best evidence and marriage of science and reason would be brought to bear for the benefit of the public.

Examples like these raise the spectre that logic and science are fragile gifts that, despite their beneficence, can easily be sidelined or lost. Hopefully, progress will continue. The gains made so far are sufficiently obvious, and the social and legal safeguards too important, to allow the course of reason in public policy to be trumped by politics and profit.

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