PERSON, HOSPITAL, AND GEOGRAPHIC FACTORS ASSOCIATED WITH CONNECTION TO TREATMENT FOLLOWING HOSPITAL DISCHARGE FOR AN OPIOID TOXICITY

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Background:
People who use drugs report significant challenges interacting with the healthcare system, including experiences of stigma. Although the care received during hospitalizations for opioid toxicities present opportunities for support, initiation of opioid agonist treatment (OAT) following toxicities is low. Therefore, we determined factors associated with treatment initiation among people with opioid use disorder (OUD) following hospital discharge from an opioid toxicity.

Methods:
We conducted a population-based cohort study of people with OUD discharged alive from hospital following an opioid toxicity between January 1, 2014, to December 31, 2021, in Ontario, Canada. We used administrative healthcare data housed at ICES. We examined person, hospital, and public health unit (PHU) factors associated with initiation of OAT and/or safer opioid supply (SOS) within 30-days of discharge. Proportional hazards frailty models were used to account for repeated events and the clustering of hospital and PHU factors. Death was considered a competing risk, with hazards ratios (HR) calculated.

Results:
Overall, 13,463 individuals experienced 23,273 opioid toxicities, and were discharged from 175 hospitals across Ontario's 35 PHUs. Among these individuals (mean age=37.5), 66.4% were male. Person-level factors significantly associated with an increased hazard of OAT/SOS initiation included length of stay (days) in hospital (HR=1.27, 95% CI: 1.20, 1.34, p<.001). No hospital-level factors were significantly associated with OAT/SOS initiation. Finally, people discharged from hospitals in PHUs with the highest quantile rate of fatal opioid toxicities had an increased hazard of OAT/SOS initiation (HR=1.29, 95% CI: 1.01, 1.63, p=0.04) compared to PHUs in the lowest quantile.

Conclusion:
The identification of factors associated with treatment initiation following an opioid toxicity highlights areas for improvement of care and targeted interventions in hospitals, including how people with short stays in hospital and those seeking treatment in regions with less experience managing opioid toxicities can be better connected to community-based care.

Disclosure of Interest Statement:
No authors have conflicts of interest to declare.