CRISM - ICRIS
Canadian Research Initiative in Substance Matters
Initiative Canadienne de Recherche sur les Impacts des Substances psychoactives

CRISM Emerging Health Threat (EHT) – Implementation Science Program on Opioid Interventions and Services

REQUEST FOR PROPOSALS

Background

The opioid crisis continues to pose a significant public health threat in Canada, with high rates of overdose and opioid-related harm across provinces. Emergency departments (EDs) often serve as critical points of intervention for individuals experiencing harms related to opioid use; however, despite interest and willingness on behalf of clinicians, many EDs lack the standardized protocols, resources, and training needed to provide a variety of substance use related interventions, including the effective initiation and maintenance of OAT. The Canadian Research Initiative in Substance Matters (CRISM) has completed several components of a broader CIHR-funded ED OAT expansion project in recent years, notably a systematic review of emergency department-initiated interventions for patients with opioid use disorder (OUD), a national survey of physicians' attitudes and practices on prescribing OAT, qualitative interviews of Canadian emergency physicians' attitudes towards initiating OAT in the ED, and a survey of patients' attitudes towards the initiation of OAT within the emergency setting. In the latest phase, CRISM investigators conducted a Delphi study with a panel of pan-Canadian subject experts and other relevant parties to develop a checklist (see "Checklist" below) of ED best practices for people with OUD. People with lived and living experience of substance use provided input into the list of items for the first round.

This implementation and evaluation initiative is led by Dr. Andrew Kestler in the Department of Emergency Medicine at the University of British Columbia in Vancouver and Dr. Kathryn Dong in the Department of Emergency Medicine at the University of Alberta in Edmonton. The next phase of this work involves supporting ten EDs across Canada to implement and evaluate the checklist, in collaboration with the Canadian Association of Emergency Physicians (CAEP) Addictions Committee.

Details

The CAEP/CRISM team is now accepting applications from EDs that have the capacity to implement all or part of the best practice checklist, including providing evaluation data to measure the success of the checklist towards improving care for people with OUD. Approximately ten pilot EDs across Canada will be selected to receive up to a maximum of $10,000 to conduct implementation and evaluation activities. EDs selected to pilot the best practices checklist will be asked to provide baseline and post-implementation data on OUD services provided. Participating EDs will receive logistical support from CRISM and expert advice from the CAEP/CRISM team. We intend to involve sites at a wide variety of stages of engagement with substance use/harm reduction policy and practice, so please consider applying!

Application Process

To apply, the site must complete the application by June 30, 2025 (23h59 EST). This Word version of the application is available so that site team members can collaborate on the application. Sites must provide general information, information on their capacity and readiness to implement the best practices checklist, motivation and goals for participation, potential barriers and facilitators, and a budget including in-kind contributions. Sites will be selected in early July 2025, with implementation to begin in August 2025. Each ED will be able to set their own implementation and evaluation goals, with some shared objectives established across all sites.

Timeline for Implementation and Evaluation Activities

June 30, 2025	Proposals due from interested EDs
July 15, 2025	Selection of participating EDs
August 2025 – February 2026	Implementation work in pilot sites
March 1, 2026	Final data and reports due from pilot sites

For further inquiries, please contact: Bluma Blake Kleiner, Research Coordinator, CRISM Québec (bluma.blake.kleiner.chum@ssss.gouv.qc.ca)

CHECKLIST

Statement number	Statements
	Emergency department services offered
1	Buprenorphine/naloxone and/or other opioid agonist treatment medications are readily available 24/7 (or during all emergency department operating hours).
2	There are take-home naloxone kits readily available in the emergency department.
3	Short-acting full agonist opioids are available and can be used to treat opioid withdrawal in any emergency department patient, if needed.
	Staffing
4	There are physicians with expertise in addiction medicine available to provide consultations in the emergency department, either in person or virtually (can be from a different department or facility).
5	There is a case manager, social worker, or similar to connect people to housing supports, income supports, and other relevant community services.
	Education/training
6	Orientation for new emergency department staff and physicians includes information on caring for people with opioid use disorder, drug poisoning prevention, and information on local resources and referral pathways.
7	There is regular and incentivized addiction, substance use, and/or harm reduction-focused education and training for physicians, nurses, and other emergency department staff.
	Protocols and policies
8	There is a protocol or order set for the initiation of opioid agonist treatment (buprenorphine/naloxone, methadone, and/or slow-release oral morphine) in the emergency department and/or immediately after discharge.
9	There is a protocol or order set for the management of opioid withdrawal in people with opioid use disorder in the emergency department.
	Referrals from the emergency department
10	There are referral pathways to opioid agonist treatment prescribers and clinics with integrated healthcare services and other psychosocial supports (in-person or virtual).
11	There are referral pathways to harm reduction services including supervised consumption services, and syringe and other supply distribution programs.

12 There are referral pathways to mental health and psychiatry services.

Rural and remote services

13 For people living in rural or remote areas, there is a virtual clinic that provides care for people with opioid use disorder.

APPLICATION

Section 1. Site Information

Please answer all questions to the best of your abilities.

1. Name of hospital and health authority (both required)

Hospital: Health authority:

2. Location (address, town/city, province/territory)

Address: Town/city: Province/territory:

3. Area classification
   - □ Urban
   - □ Suburban
   - □ Rural

4. ED patient volume (annual visits) _____

5. Description of patient population served (e.g., ages served [adult, pediatric, all ages]; % of patients with substance related concerns [if known]; % of patients with housing insecurity [if known]; other relevant information)

6. Site lead(s) (name, role, contact information [phone number and email address])

Name: Role: Phone number: Email address:

7. Team members (Each team must have one physician and one non-physician as members.)

8. Your name, role, and contact information (phone number and email address) if different from above

Name:

Role:

Phone number:

Email address:

Section 2. Current State Assessment

In this section, you will be asked to provide information about your ED's current practices related to OUD management in the ED based on our best practices checklist. We are looking for a diverse mix of sites, from those who have not implemented any items on the checklist to those who have implemented some or most of the items.

1. Please indicate whether the practices in your ED currently align with our checklist by indicating yes, in part, or no.

Buprenorphine/naloxone and/or other opioid agonist treatment medications are readily available 24/7 (or during all emergency department opening hours).

□ Yes
□ In part
□ No

There are take-home naloxone kits readily available in the emergency department.

□ Yes
□ In part
□ No

Short-acting full agonist opioids are available and can be used to treat opioid withdrawal in any emergency department patient, if needed.

□ Yes
□ In part
□ No

There are physicians with expertise in addiction medicine available to provide consultations in the emergency department, either in person or virtually (can be from a different department or facility).

□ Yes
□ In part
□ No

There is a case manager, social worker, or similar to connect people to housing supports, income supports, and other relevant community services.

□ Yes
□ In part
□ No

Orientation for new emergency department staff and physicians includes information on caring for people with opioid use disorder, drug poisoning prevention, and information on local resources and referral pathways.

□ Yes
□ In part
□ No

There is regular and incentivized addiction, substance use, and/or harm reduction-focused education and training for physicians, nurses, and other emergency department staff.

□ Yes
□ In part
□ No

There is a protocol or order set for the initiation of opioid agonist treatment (buprenorphine/naloxone, methadone, and/or slow-release oral morphine) in the emergency department and/or immediately after discharge.

□ Yes
□ In part
□ No

There is a protocol or order set for the management of opioid withdrawal in people with opioid use disorder in the emergency department.

□ Yes
□ In part
□ No

There are referral pathways to opioid agonist treatment prescribers and clinics with integrated healthcare services and other psychosocial supports (in-person or virtual).

□ Yes
□ In part
□ No

There are referral pathways to harm reduction services including supervised consumption services, and syringe and other supply distribution programs.

□ Yes

□ In part
□ No

There are referral pathways to mental health and psychiatry services.

□ Yes
□ In part
□ No

For people living in rural or remote areas, there is a virtual clinic that provides care for people with opioid use disorder.

□ Yes
□ In part
□ No
□ Not applicable; my site is urban or suburban.

Section 3. Capacity and Readiness

This section will ask questions about your ED's capacity for quality improvement (QI) and implementation projects.

1. Your team has experience running previous QI projects.
   □ Yes
   □ In part
   □ No

2. Your team has working experience of QI methodology.
   □ Yes
   □ In part
   □ No

3. Your team has access to a data infrastructure that can collect data on OUD-related services delivered.
   □ Yes
   □ In part
   □ No

4. Your team has ED/hospital leadership support.
   □ Yes
   □ In part
   □ No

5. Anticipated project barriers

6. Anticipated facilitators (e.g., extensive prior QI experience, dedicated QI support team, etc.)

Section 4. Motivation and Goals

This section will ask about why you would like your emergency department to participate in our pilot project.

1. In your site, which checklist items (from our best practices checklist) are top priorities for improvement?

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□ There are take-home naloxone kits readily available in the emergency department.

□ Short-acting full agonist opioids are available and can be used to treat opioid withdrawal in any emergency department patient, if needed.

□ There are physicians with expertise in addiction medicine available to provide consultations in the emergency department, either in person or virtually (can be from a different department or facility).

□ There is a case manager, social worker, or similar to connect people to housing supports, income supports, and other relevant community services

□ Orientation for new emergency department staff and physicians includes information on caring for people with opioid use disorder, drug poisoning prevention, and information on local resources and referral pathways.

□ There is regular and incentivized addiction, substance use, and/or harm reduction-focused education and training for physicians, nurses, and other emergency department staff.

□ There is a protocol or order set for the initiation of opioid agonist treatment (buprenorphine/naloxone, methadone, and/or slow-release oral morphine) in the emergency department and/or immediately after discharge.

□ There is a protocol or order set for the management of opioid withdrawal in people with opioid use disorder in the emergency department.

□ There are referral pathways to opioid agonist treatment prescribers and clinics with integrated healthcare services and other psychosocial supports (in-person or virtual).

□ There are referral pathways to harm reduction services including supervised consumption services, and syringe and other supply distribution programs.

□ There are referral pathways to mental health and psychiatry services.

□ For people living in rural or remote areas, there is a virtual clinic that provides care for people with opioid use disorder.

2. Why is your site interested in participating in an implementation project for best practices with people who use opioids?

3. What do you hope that your site achieves by implementing the best practices checklist?

4. How does your site plan to sustain changes, including ongoing implementation, following the completion of the pilot project?

Section 5. Requested Budget

This section will ask you to identify your budget and any other relevant financial information.

1. Please attach a spreadsheet of your anticipated budget for the project. Each emergency department may access up to $10,000 in funding. Please include details for each item you list and a dollar amount for each. Please also indicate the total amount you anticipate for budgetary expenditures. Eligible expenses are those that are put towards the direct costs of the funded research project and include equipment and supplies (including software and electronic devices) used for data collection, hospitality costs for networking, and educational expenses incurred during staff trainings. Ineligible expenses include basic utilities and internet costs, alcoholic beverages, and administrative charges and fees. All eligible expenses must be justified with supporting evidence.

2. Are there any other sources of funding, including in-kind contributions from your emergency department? If yes, please attach a spreadsheet with details on your other sources of funding.