

UC Irvine

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

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Permalink

<https://escholarship.org/uc/item/5p24n76b>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 27(3.1)

ISSN

1936-900X

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Publication Date

2026-06-14

DOI

10.5811/westjem.66259

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was used as the diagnosis time. Descriptive statistics were performed.

Results: We studied 248 patients with acute coronary occlusion on emergent coronary angiography; median age was 62 years (25th, 75th 54.5, 70), 183 (74%) were male, and 179 (72%) arrived via emergency medical services. The median interval from ED arrival to diagnosis by physicians was -3 (25th, 75th -14, 10) minutes and by the AI-ECG model was -5 (25th, 75th -18, 7) minutes. Of the 70/248 (28%) with differing diagnostic intervals, 67/70 (96%) were diagnosed earlier by the AI-ECG model and the median time difference (n=70) was 16 (25th, 75th 4, 48) minutes.

Conclusions: Application of an AI model for ECG interpretation in patients with suspected STEMI may decrease the time to diagnosis compared to physicians alone.

22 Effectiveness of Opt-Out HIV Testing in the Emergency Department: A RE-AIM-Informed Evaluation of Linkage to Care

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Background: Since 2023, the Emergency Department (ED) at St. Joseph's Hospital and Medical Center in Phoenix, AZ has provided free opt-out HIV testing through Gilead's FOCUS Program to patients aged 18 years and older who receive bloodwork in the ED, with linkage-to-care (LTC) services offered for both newly and previously diagnosed patients. Program workflow is evaluated using an implementation science framework to improve delivery and address barriers to integration. This presentation builds on prior evaluation efforts and focuses on program effectiveness related to LTC.

Methods: The RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance) was used to analyze quantitative and qualitative program data from 2025, including the number of eligible patients tested and the number of HIV-diagnosed patients linked to care. Effectiveness was assessed through qualitative content analysis of electronic health record chart reviews, systematically coding LTC actions and documented barriers and facilitators at the individual, programmatic, and structural levels for patients with confirmed HIV diagnoses.

Results: In 2025, 9,754 ED patients were tested and 97 were confirmed HIV-positive. Among these patients, 38 were already engaged in care, 22 were successfully linked to care, and 37 were lost to follow-up, declined LTC, or had pending appointments. Key facilitators to LTC included family support, access to transportation, insurance coverage, and acceptance of HIV diagnosis. Identified barriers included delays in confirmatory test results limiting bedside navigation, unreliable contact information, and socio-structural factors

such as housing instability.

Conclusion: Using the RE-AIM framework allowed for systematic assessment of program effectiveness and identification of actionable opportunities to strengthen LTC processes. Findings highlight multi-level barriers and facilitators that inform program implementation and maintenance and are relevant to other EDs implementing opt-out HIV testing among vulnerable populations.

23 Evaluating Emergency Department Naltrexone Initiation Using a Large Multicenter Database

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Background: Alcohol Use Disorder (AUD) is the most commonly diagnosed substance use disorder in the US. While previous studies have demonstrated the benefits of naltrexone for AUD, data are limited on the patients who receive treatment as well as the outcomes following naltrexone initiation (NI) in Emergency Departments (EDs). The objectives of this study are to assess and compare characteristics and 1-year outcomes of patients prescribed naltrexone for AUD in EDs versus patients prescribed in ambulatory clinics (ACs).

Methods: The TriNetX US database was queried to establish 2 cohorts between 2007 and 2023: patients who were diagnosed with AUD who had received naltrexone initiation in an ED versus initiation in an AC. We excluded patients with a history of opioid use disorder. We compared the demographics of the ED and AC cohorts in the 5 years before NI. After propensity score matching, the prevalence of the following alcohol-related negative 1-year outcomes was assessed: cirrhosis, acute pancreatitis, alcoholic liver disease, and alcoholic gastritis.

Results: Each cohort contained 6,235 patients. As compared to the AC cohort, the ED cohort was significantly more likely to be younger, homeless, male, and Black or Hispanic. In the 5 years before NI, the ED cohort was more likely to have experienced depression, elevated AST/ALT, gastritis, pancreatitis, and cirrhosis. The ED cohort experienced greater risk of observed outcomes one year post NI with an odds ratio (OR) of 4.86 (95% CI: 3.33,7.08) for alcoholic gastritis, an OR of 3.42 (95% CI: 2.63,4.46) for acute pancreatitis, an OR of 2.13 (95% CI: 1.56,2.90) for liver cirrhosis, and an OR of 2.40 (95% CI: 1.89,3.04) for alcoholic liver disease.

Conclusion: Findings suggest patients who received NI in the ED had a higher prevalence of comorbidities than those who received NI in the AC. The ED group also had more negative health outcomes 1 year post-NI than those in the AC. Results suggest NI may occur later in the course of illness

for the ED cohort, highlighting the necessity of intervening sooner for patients with a higher risk of comorbidities. The ED cohort being more likely to be Black/Latino is consistent with previous findings and may be related to systemic barriers to medical treatment these groups have historically faced. Systemic barriers to treatment, whether socioeconomic or racial inequity, warrant further research.

24 Is Housing Stability Associated with Telehealth Utilization among Emergency Department Patients?

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Background: Housing instability is a major social determinant of health and is associated with increased reliance on emergency healthcare. Emergency departments (ED) often serve as an entry point to healthcare for people experiencing homelessness (PEH). Telehealth use has expanded rapidly since the COVID-19 pandemic. The majority of PEH own a mobile phone; many PEH perceive mobile health to be supportive and increase healthcare accessibility. However, telehealth use may be limited by a lack of awareness, inconsistent internet access, and limited access to charging. This study describes the relationship between telehealth utilization and housing stability.

Methods: This is a cross-sectional study conducted during Summer 2024, Spring 2025, and Summer 2025 in an urban safety-net ED. Patients were included if ≥ 18 years old and spoke English or Spanish. They were excluded if altered, critically ill, intoxicated, in law enforcement custody, or on a psychiatric hold. Research associates systematically sampled patients who visited the ED using standardized questions. Telehealth use was defined as accessing healthcare via phone or video call. Housing stability was defined as having a steady place to live (AHC-HRSN). Questions were adapted from a previously tested survey instrument. Chi-square analysis and logistic regression were performed.

Results: Of the 1,164 included patients, 39% used telehealth, 14% reported housing instability, and 89% owned a smartphone. Telehealth utilization was higher in individuals with stable housing (41% v 28%, $p = 0.001$), who own a smartphone (41% v 30%, $p = 0.018$), and with education at the college level or above (47% v 36%, $p = 0.001$). After adjusting for smartphone ownership, health literacy, age, and education, people with stable housing (OR: 1.65, 95% CI 1.13-2.42) and higher education (OR: 1.45, 95% CI 1.09-1.91) had statistically significantly greater odds of telehealth use. Smartphone ownership, age, and health literacy did not have significant associations with telehealth use.

Conclusion: Housing stability and higher education

level are associated with higher rates of telehealth utilization. Innovative and culturally tailored resources may be needed to increase telehealth use for individuals who are affected by social risk factors, specifically housing instability. Limitations include self-reported data from a single site.

25 Patient Outcomes Following Prehospital Naloxone Administration in San Francisco

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Background: Naloxone (NLX) is available to laypersons and an effective public health intervention. In 2024, San Francisco, CA recorded 638 opioid-related deaths, showing the opioid crisis and need to expand bystander NLX access. As NLX is often administered before EMS arrival, understanding prehospital use patterns and transport dispositions is critical. This study quantifies the effects of these interventions on the EMS system.

Methods: The Toxicology Investigators Consortium (ToxIC) Real-World Examination of Naloxone for Drug Overdose Reversal (RENDOR) project is an ongoing multisite observational study where EMS providers collect prehospital data on opioid overdose cases, including demographics, scene type, NLX administrator/dose/route, transport disposition, and provision of leave-behind NLX. Patients were grouped by administrator: Pre-EMS only (family/friend/stranger, police (PD), non-transport fire, and community/social services (C/SS) staff), EMS only, and Pre-EMS + EMS. EMS encounters from 6/2024-12/2025 were included.

Results: Among San Francisco cases ($n = 350$), 79.1% ($n = 277$) were male, and the mean age differed by group ($p = 0.010$): EMS-only recipients were older (45.5 y) than pre-EMS-only (40 y) and pre-EMS + EMS (41.7 y). Most overdoses were on streets/sidewalks ($n = 264$, 75.4%), with pre-EMS responders giving NLX 73% ($n = 193$) of these cases. EMS-only responses were more common in private residences ($n = 24$, 54.5%; $p = 0.001$). IN NLX was predominant among pre-EMS responders ($n = 184$, 93.9%) compared to IN + IM/IV/IO ($n = 4$, 2.0%). EMS used IN in 44.2% ($n = 46$), similar to IM/IV/IO use ($n = 38$, 36.5%), and more often than IN + IM/IV/IO ($n = 19$, 18.3%). Among pre-EMS administrators, bystanders accounted for 87.8% ($n = 216$), with smaller contributions from PD ($n = 10$, 4.1%) and C/SS providers ($n = 20$, 8.1%). Most patients were transported ($n = 253$, 72.3%), while 25.1% ($n = 88$) refused/eloped. On-scene deaths were rare ($n = 6$, 1.7%). No significant difference in transport outcomes was not found for patients