

Implementing an intranasal naloxone program in a community hospital: lessons learned from what worked and what did not



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BACKGROUND

- At our community hospital, from June 2020-2021, 55% of ED IV naloxone use was due to opioid overdose
- In response, a **take-home intranasal (IN) naloxone program was launched** in 2022 in collaboration with the Florida Department of Children and Families (DCF) Overdose Prevention Program
- Goal:** expand access to free intranasal naloxone and education

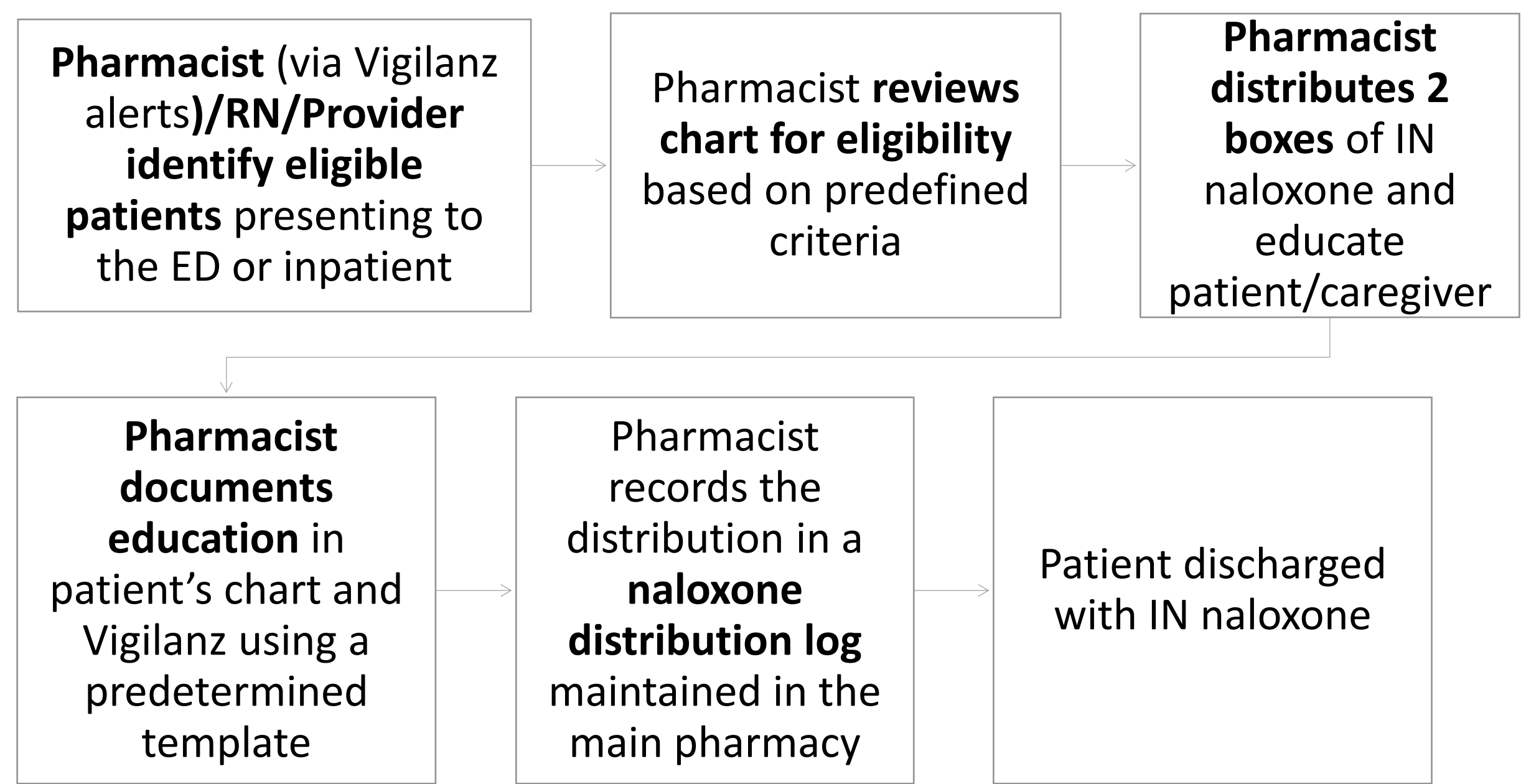
OBJECTIVES

- Describe IN naloxone kit distribution since program implementation in January 2022 through June 2026
- Evaluate pharmacy staff compliance with IN naloxone distribution
- Identify barriers and facilitators to program sustainability through pharmacist participation, intervention completion rates, and staff feedback

METHODS

- Design:** Quality improvement project evaluating a pharmacist-led take-home IN naloxone distribution program at a single 147-bed community hospital
- Population:** Patients with opioid overdose, substance use disorder, or chronic opioid use were initially identified through a passive process; this was later enhanced with an active clinical surveillance alert (Vigilanz)
- Evaluation:** Program trends were assessed from launch (January 2022-June 2026), including a 6-month Vigilanz alert audit (November 2025–April 2026) evaluating alert appropriateness, naloxone distribution rates, and reasons for non-completion. Barriers were assessed via a 9-item Likert anonymous survey mapped to COM-B domains framework
- Analysis:** Descriptive statistics (frequencies, percentages, median, IQR)

IN Naloxone Workflow:



RESULTS

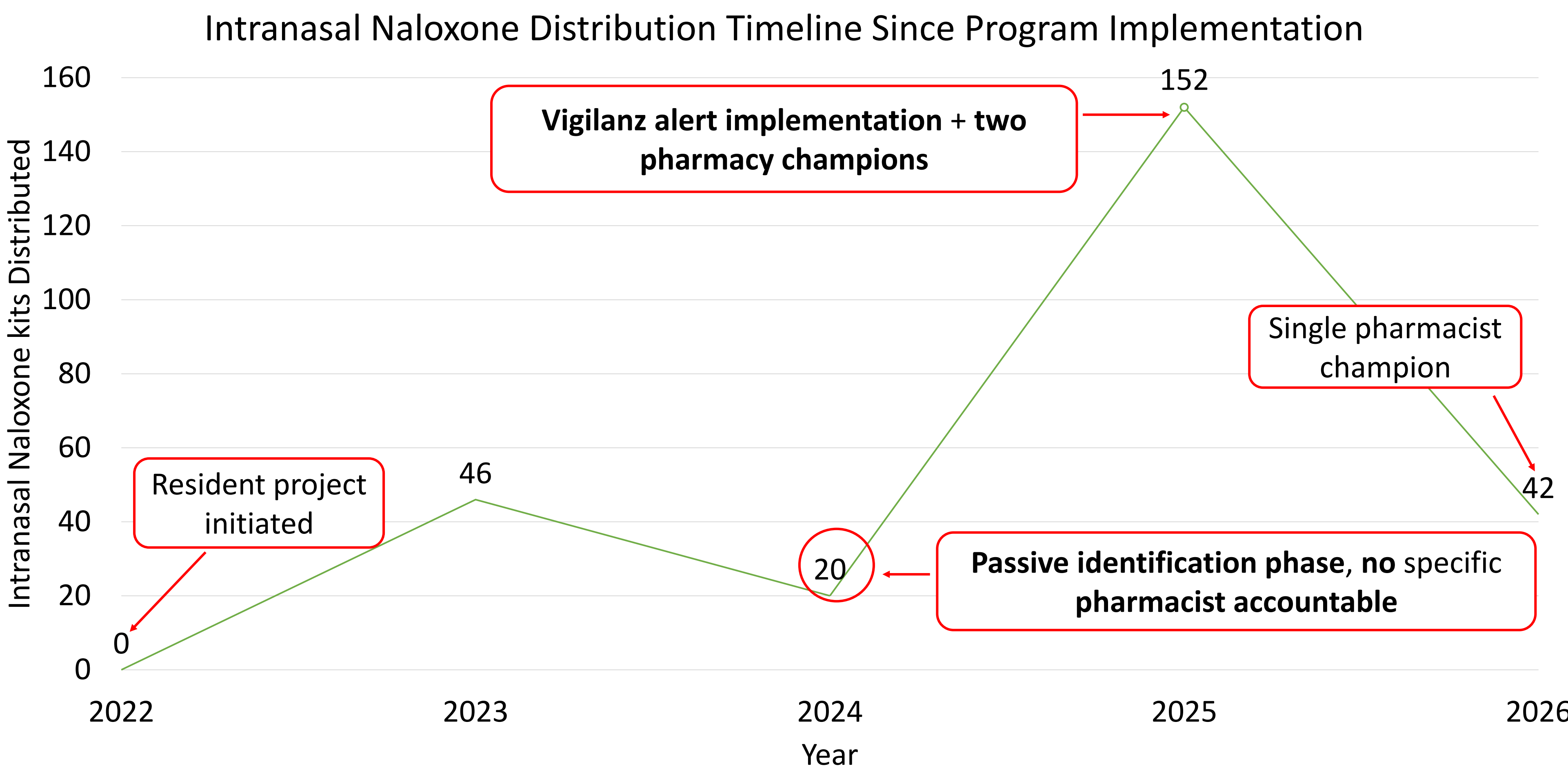


Figure 1: IN naloxone distribution program workflow improvements to enhance integration into pharmacy operations

Table 1: Outcomes in the 6-month Vigilanz Alert Audit	
Alert assessment	Results
Total alerts triggered from Nov-April 2026	104
Alerts meeting predefined criteria n(%)	71 (68.3%)
> Alerts acknowledged inappropriately n(%)	46 (64.7%)
Distribution Outcomes	
Patients who received IN Naloxone at discharge n(%)	18 (25.4%)
Number of pharmacist contributing to distribution	5
Patient distribution location	n=18
ED n(%)	1(5.5%)
Observation n(%)	5 (27.7%)
Inpatient n(%)	12 (66.6%)

Reasons for Alerts Acknowledged Inappropriately

- Knowledge gap/misconception 23 (50%)
- Inertia / low prioritization 10 (21.7%)
- Alert management error 10 (21.7%)
- Lack of time / Competing priorities 3 (6.5%)

Figure 3: Key facilitators to our program:

- ✓ Pharmacist champion model: 12/18 patients (66.7%)
- ✓ Clinical surveillance alert (Vigilanz)-DFC-supplies free naloxone kits-no cost barrier
- ✓ Expansion to inpatient units: 12/18 (66.7%)

Table 2: Outcomes Pharmacist Survey Findings (COM-B Assessment)	
Capability Median (IQR)	4.3 (0.66)
Opportunity Median (IQR)	2.5 (0.5)
Motivation Median (IQR)	4 (1)
*Response were measure on a 5-point Likert scale (1=strongly disagree, 5=strongly agree)	

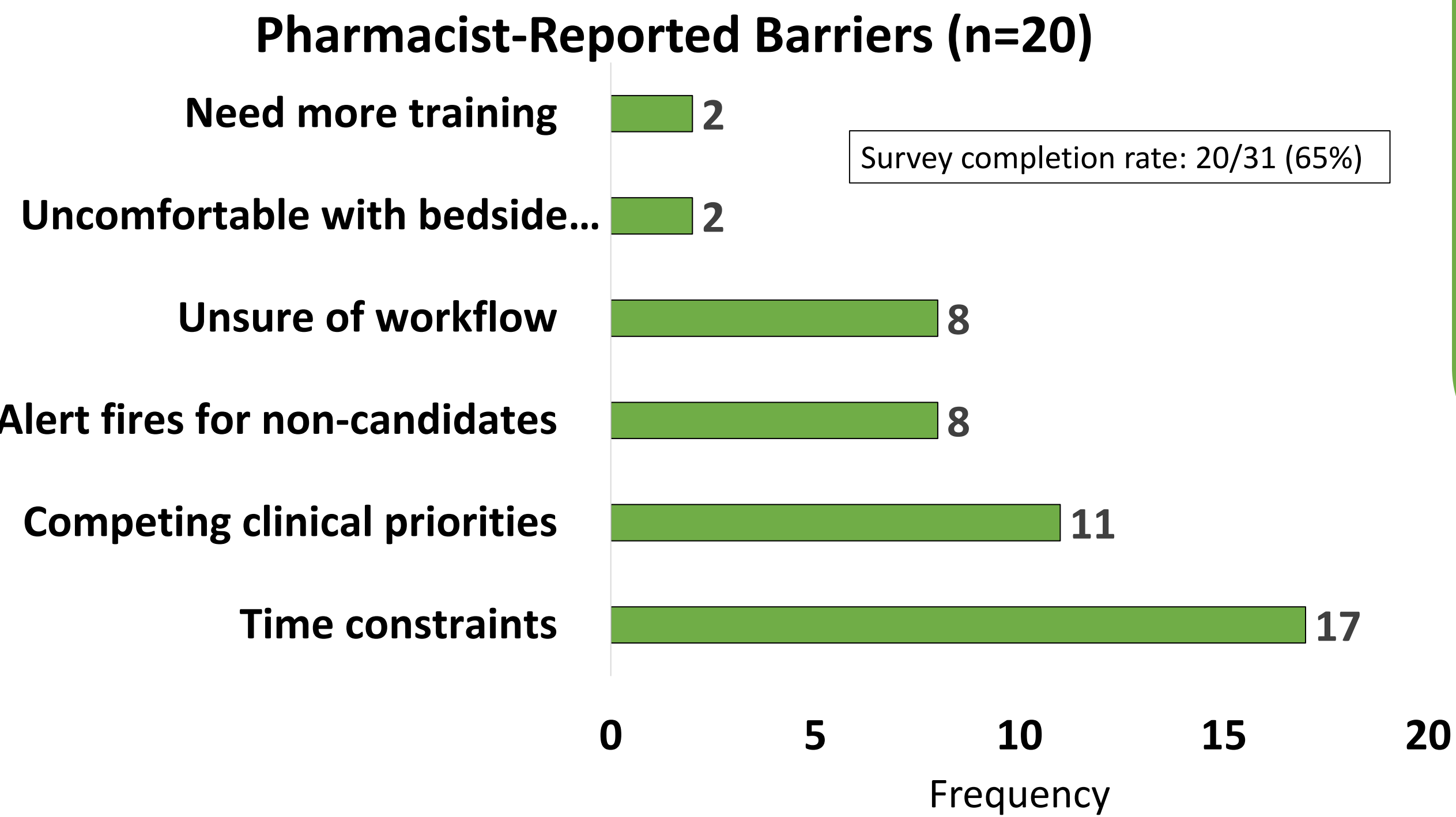


Figure 2: Self-reported barriers to naloxone distribution

Vigilanz alerts increased IN naloxone distribution, but highlighted knowledge gaps as a key barrier

DISCUSSION

- A gap exists between self-perceived capability and actual performance. Pharmacists rated capability highly (median 4.3/5), yet knowledge gaps and misconceptions such as requiring positive toxicology or a prescription accounted for 50% of missed distribution opportunities.
- Opportunity barriers were most prominent, with time constraints (median 2.5/5) and low alert specificity (68.3%) contributing to alert fatigue.
- The pharmacist champion model enabled growth but created fragility; one pharmacist accounted for 66.7% of distributions, while inappropriate alert closure contributed to 21.7% of missed opportunities.
- Cross-training and targeted Vigilanz re-education are expected to increase engagement, expand participation, and improve program success
- Program success may be further enhanced by improving access to IN naloxone kits in the ED Pyxis.

LIMITATIONS

- Small sample size
- Self reported survey data (social desirability bias)
- Classification bias
- Alert audit limited to 6 months
- Lack of patient level outcome data

CONCLUSION

- Pharmacist-led IN naloxone distribution is feasible in a community hospital setting, with 260 kits distributed since implementation
- The primary barrier to staff compliance is a knowledge gap between self-perceived capability and actual practice
- Targeted education (case based) is the highest yield intervention for future direction

REFERENCES

- Evaluating the use of parenteral naloxone in the emergency department of a community hospital. *Hospital Pharmacy*, 58(2), 148–151. (2022)
- Applying the capability, opportunity, motivation, and behavior model to identify opportunities to increase pharmacist comfort dispensing naloxone in Texas: A structural equation modeling approach. *International Journal of Drug Policy*, 83, 102827. (2020)

DISCLOSURES

- All authors of this presentation have nothing to disclose.