Naloxone Leave Behind Program Training

Presenting To

Organization Name | Location

Presenter Name | Title

ARIZONA DEPARTMENT OF HEALTH SERVICES

Health and Wellness for all Arizonans

Goals for Today

- Opioid Use Disorder
- Medication Assisted Treatment
- Teach the protocol

Opioid Use Disorder

- Mild, Moderate, or severe based on number of symptoms:

- Taken in larger amounts or over longer period of time
- Unsuccessful efforts to cut down
- Spend a long time trying to get opioids
- Craving
- Use interferes with work, school, or home
- Use in dangerous settings
- Tolerance
- Withdrawal

Naloxone Leave Behind Guideline

Includes:

- Patients at risk for opioid overdose
  - History of illicit drug use or prescription for opioids
  - History of or physical exam findings consistent with IVDU (IV drug use), ie. Track marks
  - Physical environment with illicit opioids or paraphernalia, multiple or high-dose prescription opioids present
- Bystander/friend/family who is in close contact with persons at risk of opioid overdose
- Patient who overdosed on opioids, now status post reversal, but refusing transport to the Emergency Department opioids, now s/p reversal with Naloxone

EMT

- If signs of respiratory depression/arrest or Altered Mental Status, refer to Overdose Guideline.
- Provide Naloxone Kit
  - Naloxone 4mg/0.1 mL IN spray (package of 2)
  - Educational pamphlet
- Review pamphlet with opioid overdose recognition and Naloxone administration instructions
- Review list of community resources for Medication Assisted Treatment (MAT) as indicated
- Record Naloxone distribution on survey form, obtain as much or as little information as the patient/bystander will allow

Quick Summary of today:

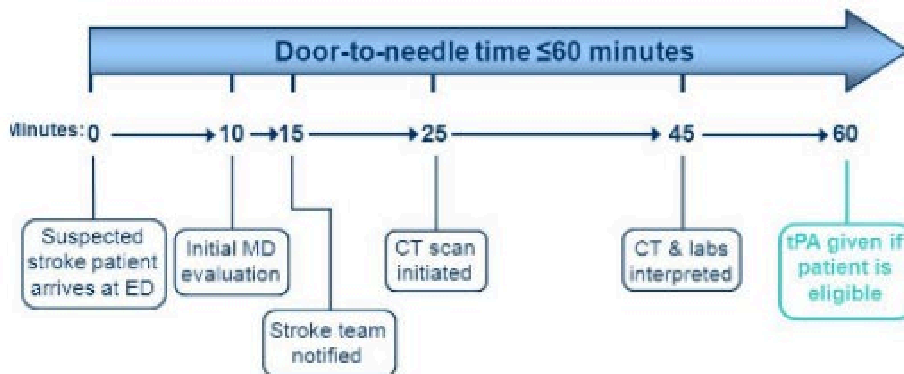
- Give a naloxone kit to anyone at risk of opioid OD
- Provide training
- Explain various options for treatment (& potentially refer)
- Document each distribution per agency policy

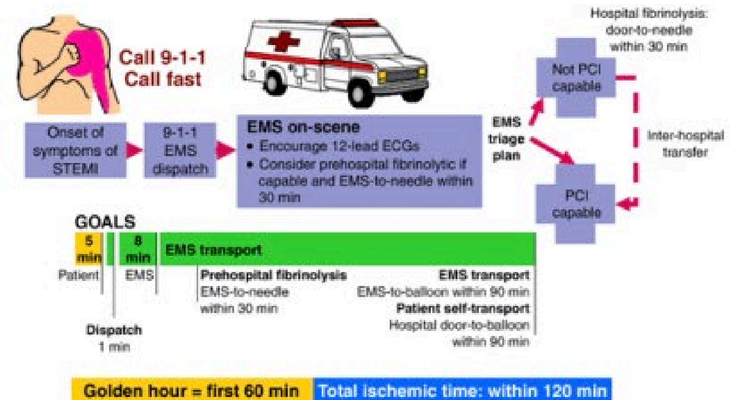
ATTENTION

Treat opioid overdose as any other emergency

PARADIGM SHIFT

Examples of Acute Emergencies

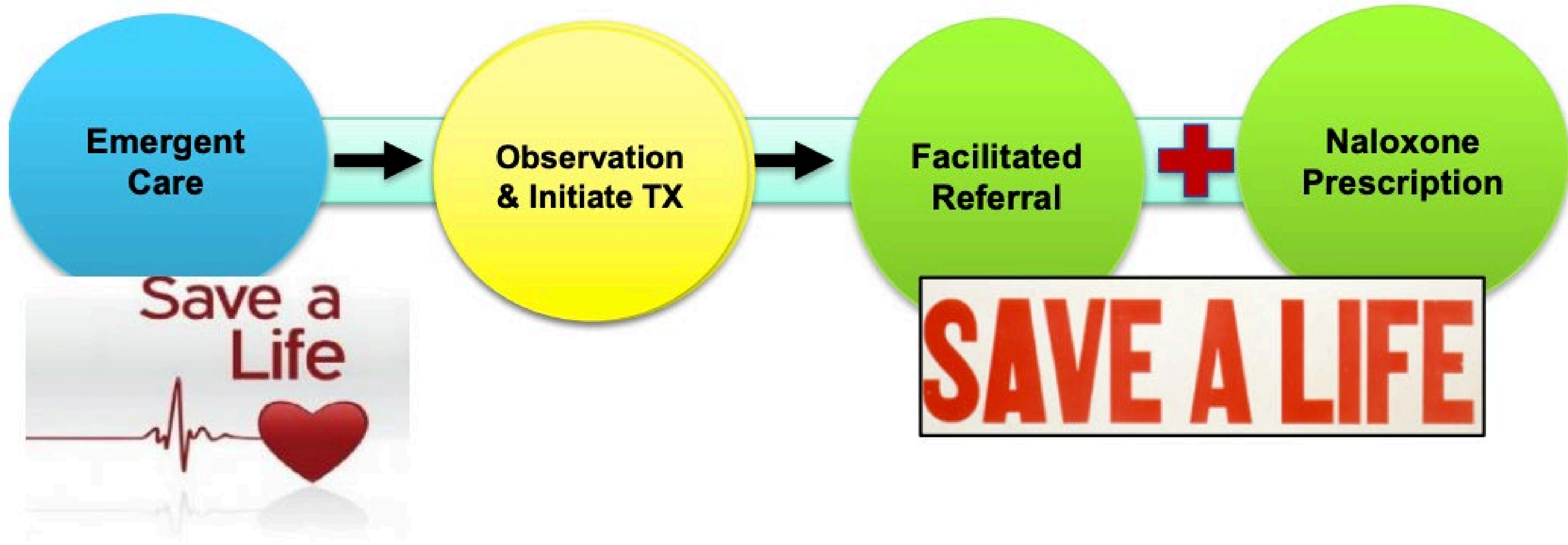




Stroke

STEMI

Overdose Emergency



Opioid Statistics

THE OPIOID EPIDEMIC BY THE NUMBERS

130+
People died every day from opioid-related drug overdoses[3] (estimated)

10.3 m
People misused prescription opioids in 2018[1]

47,600
People died from overdosing on opioids[2]

2.0 million
People had an opioid use disorder in 2018[1]

808,000
People used heroin in 2018[1]

81,000
People used heroin for the first time[1]

2 million
People misused prescription opioids for the first time[1]

15,349
Deaths attributed to overdosing on heroin (in 12-month period ending February 2019)[2]

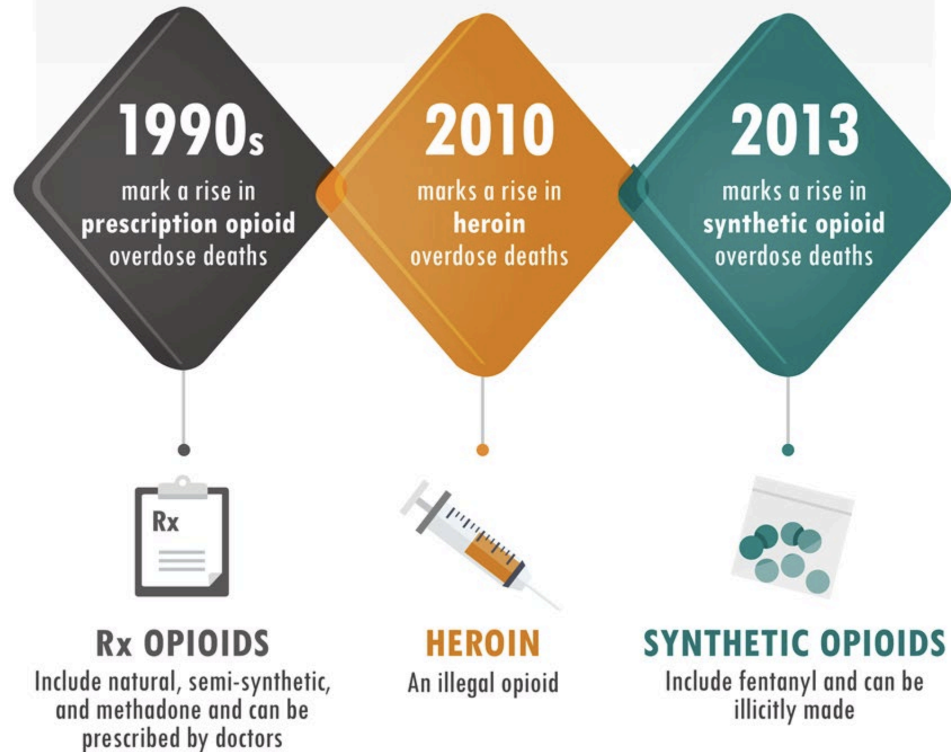
32,656
Deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending February 2019)[2]

SOURCES

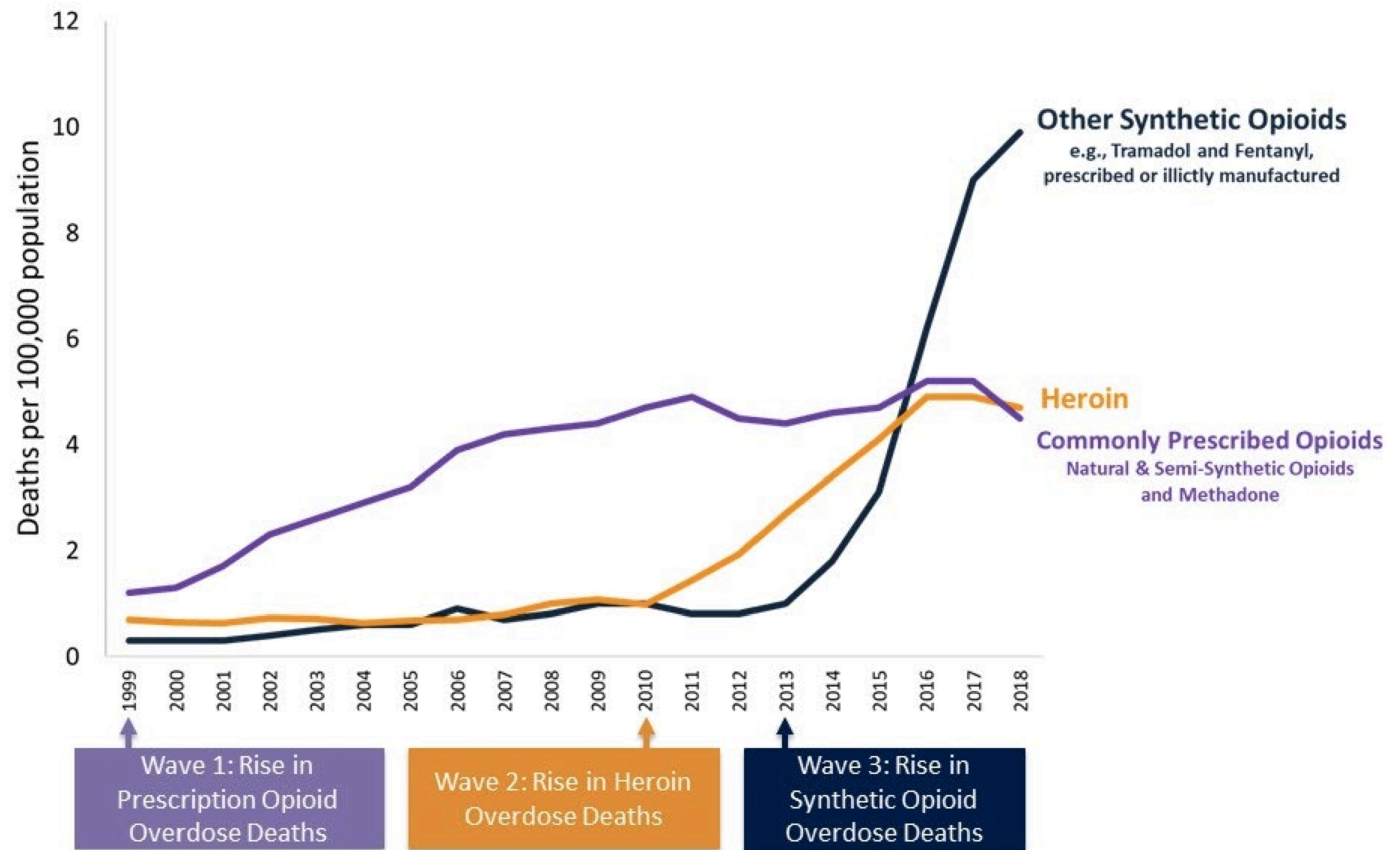
1. 2019 National Survey on Drug Use and Health. Mortality in the United States, 2018
2. NCHS Data Brief No. 329, November 2018
3. NCHS, National Vital Statistics System. Estimates for 2018 and 2019 are based on provisional data.

HHS.GOV/OPIOIDS

Shift in Opioid Overdose Deaths



Synthetic Opioids & Opioid overdose deaths



DRUG OVERDOSES

KILL MORE

THAN CARS, GUNS, AND FALLING.

Falling **28,360 deaths**

Guns **32,351 deaths**

Traffic accidents **33,692 deaths**

Drug overdoses **41,340 deaths**

(16,917 from opioid pain medicine)

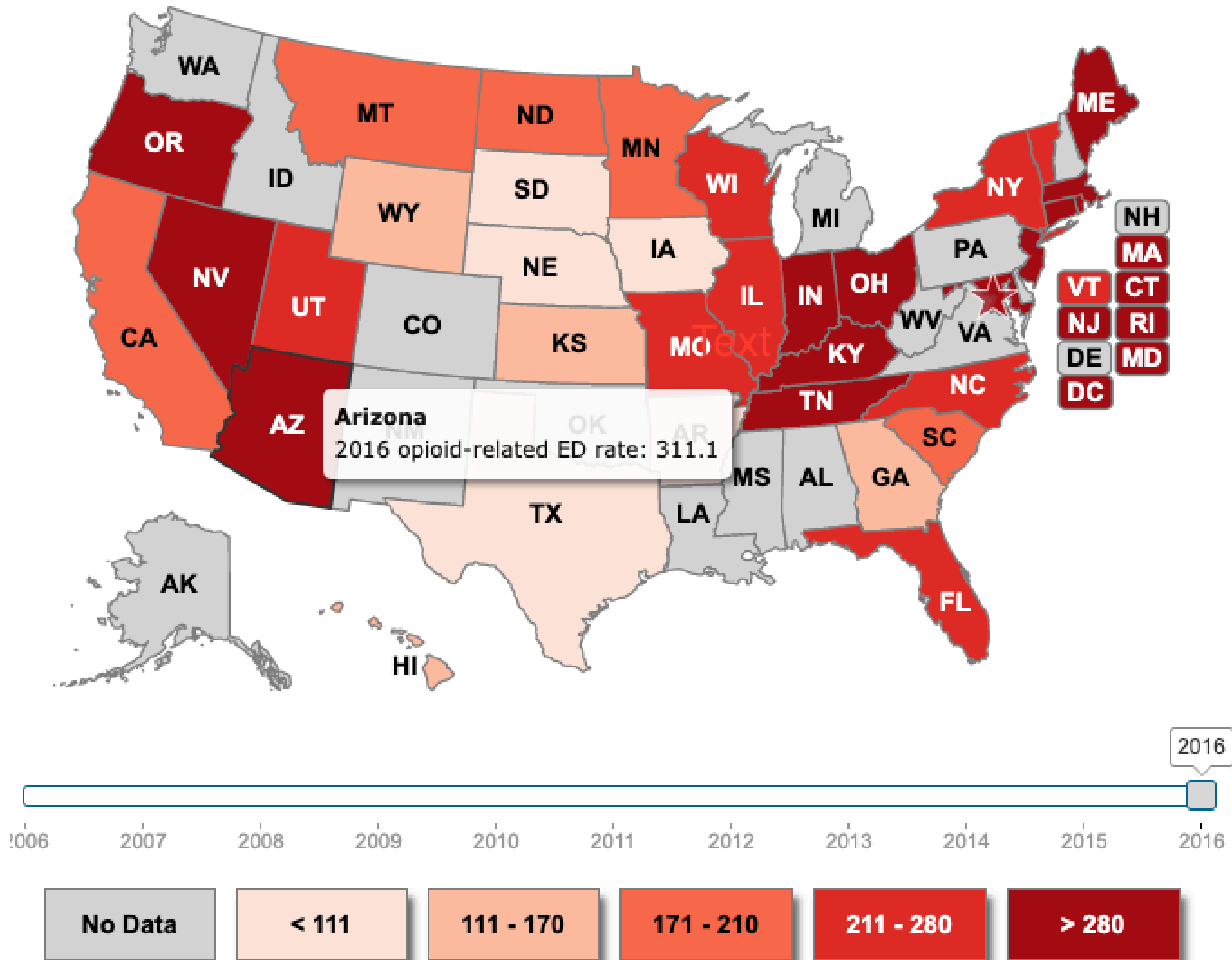
Source: CDC Wide-ranging OnLine Data for Epidemiologic Research (WONDER) on Mortality: http://wonder.cdc.gov/mortsql.html (2011)

Why EMS?

- Because that's where the patients are!
  - Opioid overdoses
  - Seeking treatment for their addiction
  - Unrelated medical complaint, but history of opioid prescription or illicit use
- Addiction is a disease with a high mortality, and we have a treatment.
  - Let's treat it like any other medical condition
- Addiction is a cyclical disease.
  - If we meet a patient who is interested in treatment, it is best to engage with them in that narrow window/moment
- Prehospital Initiation of treatment for opioid use/addiction reduces their acute risk of OD

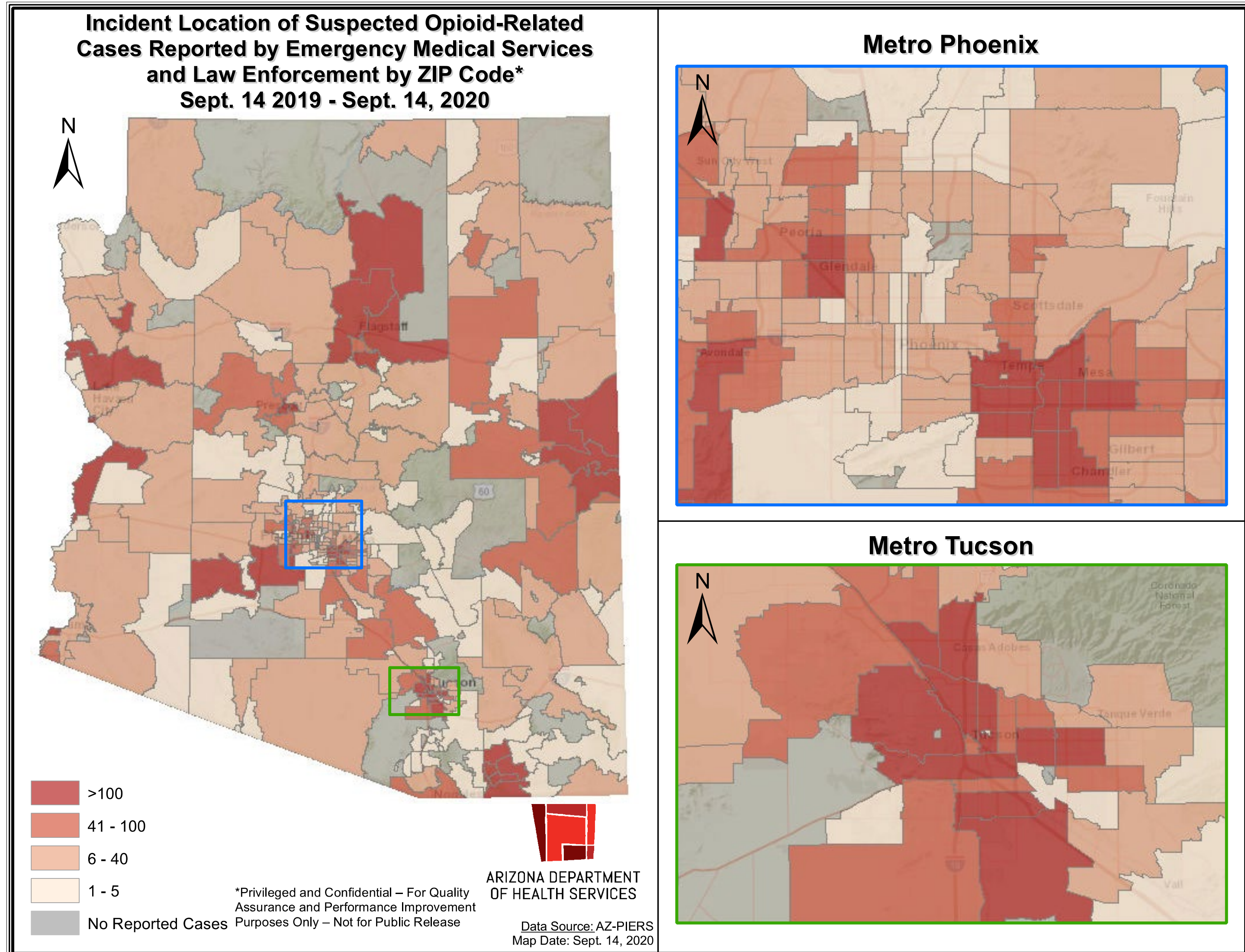
Rate of Opioid-Related ED Visits per 100,000 Population

2016 National rate: 243.5



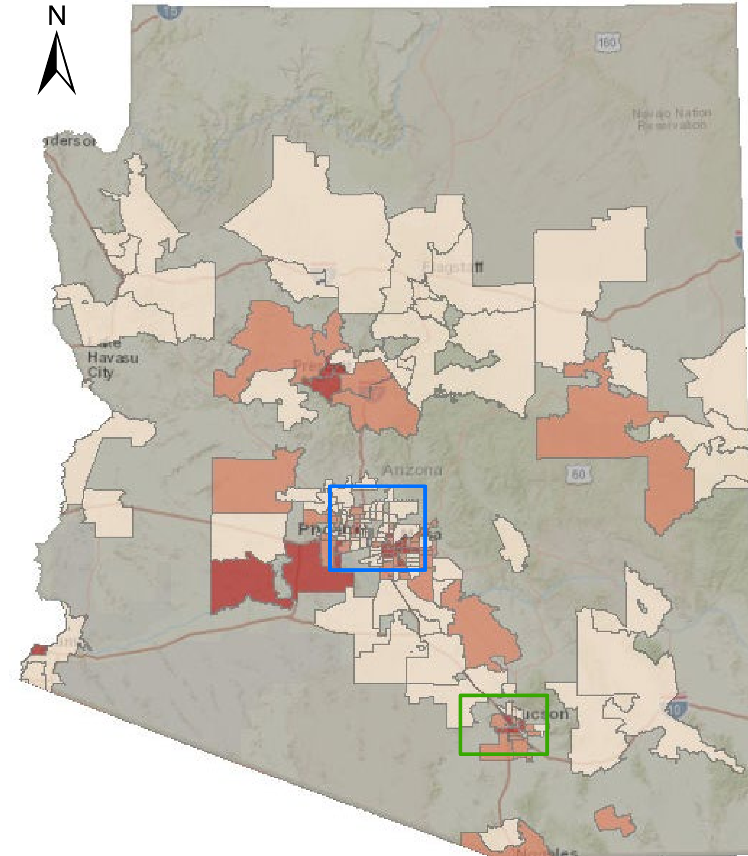
Emergency department visits exclude those for patients admitted to the hospital.
States are classified into five categories which were defined based on an equal grouping of States in 2015.
Data Notes & Methods and Data Export options are available within the data exploration tool.

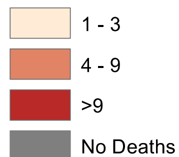
Current Opioid Overdoses – last 12 months



Current Opioid Overdose Deaths – last 12 months

Incident Location of Suspected Out-of-Hospital Opioid-Related Deaths Reported by Emergency Medical Services & Law Enforcement by ZIP Code*
Sept.14, 2019 - Sept.14, 2020



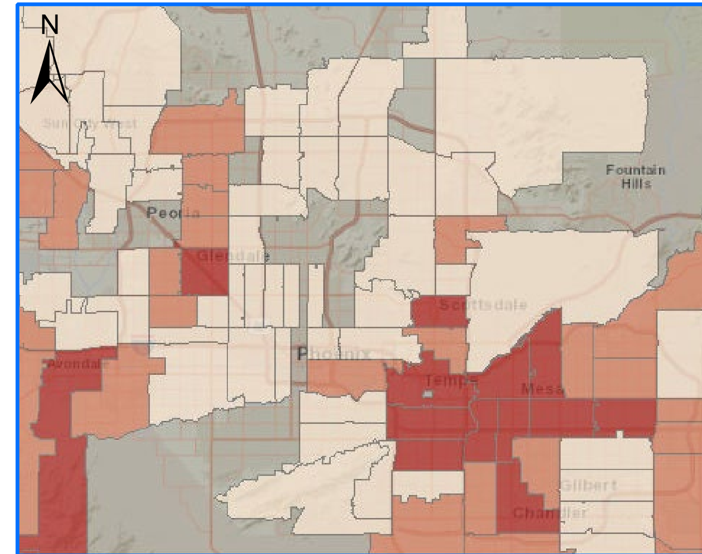


*Privileged and Confidential – For Quality Assurance and Performance Improvement Purposes Only – Not for Public Release

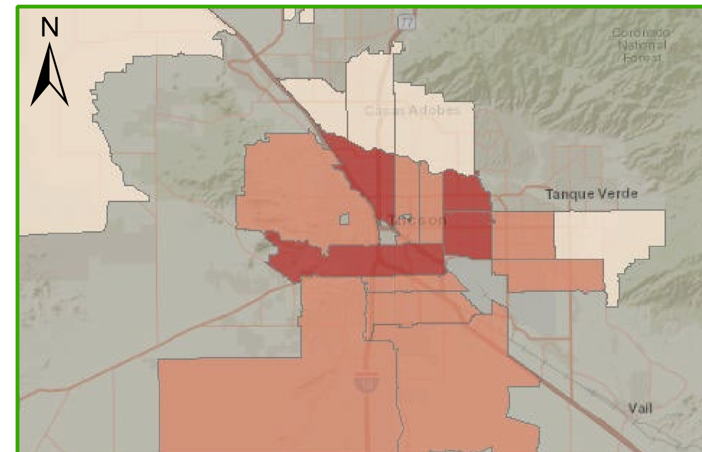
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS
Map Date: Sept.14, 2020

Metro Phoenix



Metro Tucson



Missed opportunity?

- Accidental/non-intentional overdose
- Dying at home (using alone in private space = dangerous)
- Many patients have an encounter with the healthcare system before they die, why not intervene then?

Missed opportunity?

- Washington:
  - Matched all fatal OD's in 2018 to EMS data
  - Found that 40% of decedents had at least one encounter with EMS in the year prior to fatal OD
  - Majority of their chief complaints were related to drugs or etoh
- North Carolina:
  - A similar retrospective study
  - Nearly 1/3 of individuals who died from accidental opioid OD used EMS in the year before their death

EMS reversal = Poor prognostic factor

- Boston: 10% estimated one-year mortality
  - MA study: 10% of pt's who were administered Narcan by EMS died w/in the year
  - Weiner SG, Baker O, Bernson D, Schuur JD. 402 One-Year Mortality of Opioid Overdose Victims Who Received Naloxone by Emergency Medical Services. *A*. 2017;70(4):S158. doi:10.1016/j.annemergmed.2017.07.281
- North Carolina: 13-fold increase in one-year mortality compared to the general population
  - Retrospective cohort study of 3,085 patients
  - One-year mortality was 12% in those who responded

HARM REDUCTION

Meet patients where they are

Practical strategies

Reduce negative consequences associated with drug use

https://harmreduction.org/about-us/principles-of-harm-reduction/

Harm Reduction

- Drug use & recovery exist along a complex continuum
- Drug-related harm cannot be assumed
- Harm reduction does not aim to minimize real harm related to substance use
- People who use drugs are more than their drug use

Harm Reduction as Empowerment

- Empower people to make decisions about their health
  - Give people options
  - Acknowledge difference in experience
  - Take a realistic approach
  - Utilize low-barrier services
  - Understand that individuals are experts on their own lives

Examples

- Buddy system (not using alone)
- Syringe access program
- Take-home naloxone/Narcan
- Fentanyl testing strips
- Low barrier medications for addiction treatment (MAT)
- Wound care
- Supervised consumption sites

What is Stigma?

- Stereotype: a negative belief about a group (dangerousness, laziness, moral weakness)
- Prejudice: Agreement with belief + negative emotional reaction (fear, anger)
- Discrimination: Behavior response to prejudice (avoidance, withhold access to basic needs/help)

Understanding the impact of stigma on people with mental illness, Corrigan and Watson, 2002

Stigma permeates every aspect of a marginalized person's life – relationships, health care, housing, employment, and education.

Stigma: Alcohol vs Opioids

According to the National Institute of Health……

- Alcohol-Related Deaths: » In 2015, It was determined that an estimated 88,000 people (approximately 62,000 men and 26,000 women) die from alcohol-related causes annually, making alcohol the third leading preventable cause of death in the United States.
- In 2014, alcohol-impaired driving fatalities accounted for 9,967 deaths (31 percent of overall driving fatalities).
- 696,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking.
- 97,000 students between the ages of 18 and 24 report experiencing alcohol-related sexual assault or date rape.

So what is the difference?

- Criminalization and Acceptable Harm
- As a society, we have decided the harms associated with alcohol are acceptable. That the benefits outweigh the harms, even though it is more dangerous than many other drugs. With Opioids, we have stigmatized not only the drug itself, but it’s users as well.

OEND = Opioid Education & Naloxone Distribution

Opioid Education &
Naloxone Distribution

Organizations who Support increased naloxone access

- World Health Organization
- American Medical Association
- American Public Health Association
- National Association of Boards of Pharmacy

- 2010: nearly 200 community-based naloxone distribution programs were in operation.
  - 50,000+ lay people were trained
  - Participants reported reversing more than 10,000 OD's
- In Canada, take-home naloxone kits are available at most pharmacies without a prescription and many provinces offer it for free

Centers for Disease Control and Prevention. Community-based opioid overdose prevention programs providing naloxone - United States, 2010. MMWR Morb Mortal Wkly Rep 2012;61(6):101-5.

Clark AK, Wilder CM, Winstanley EL. A systematic review of community opioid overdose prevention and naloxone distribution programs. J Addict Med 2014;8(3):153-63.

- Effectively train people how to recognize an OD and give naloxone
- Participants more likely to reduce opioid use and enter treatment
- Reduce fatal OD's
- May be particularly effective in populations that may delay calling 911 due to fear of arrest

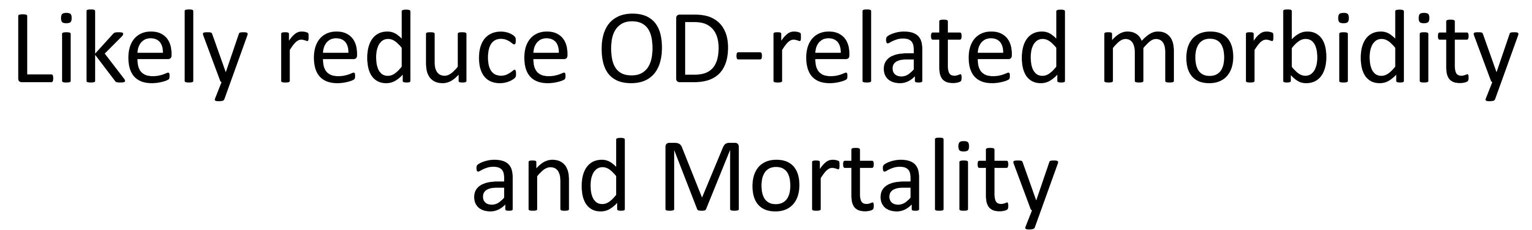
Mueller, S.R. et al. A Review of Opioid Overdose Prevention and Naloxone Prescribing: Implications for Translating Community Programming into Clinical Practice. Subst Abus. 2015 Apr-Jun; 36(2): 240–253.

Is the training enough?

- A single training session increases knowledge of appropriate OD response (Wagner 2010)
- Even a very brief education session is likely sufficient (Behar 2015)
- Even those without formal training are probably fine
  - No significant difference in rescue behaviors or reversal rates between naloxone administered by people who had received formal training vs those who had not (Doe 2014)

Increased Access to Naloxone is not associated with increased drug use or risky behavior

- SF study: heroin users who received OEND reported a statistically significant decrease in heroin injection 6 months after intervention (Seal et al, 2005)
- LA study: A majority of individuals trained in OD prevention reported that their drug use decreased after the training (Wagner 2010)
- MA: OEND did not lead opioid users to increase their overall opioid use (Doe-Simkins et al, 2014)



Likely reduce OD-related morbidity and Mortality

- MA study: Communities with higher access to naloxone and OD training had significantly lower opioid overdose death rates than those did not (Walley et al 2013)
- NC: Striking decrease in OD deaths after a comprehensive prevention program was initiated (Albert et al, 2011)
- Chicago: Reduction in heroin deaths may be partly attributable to a naloxone distribution program in that city (Maxwell et al 2006)
- UK: The distribution of take-home naloxone decreased OD deaths by around 6.6% (Langham et al)

Liability?

- Some prescribers worried that prescribing naloxone may increase their risk of civil liability (Beletsky et al., 2007; Burris et al., 2009)
  - Burris et al's Legal review:
    - Every tort claimant must establish that he or she suffered an **injury** actually caused by the **negligenc**e of the defendant health-care provider.
      - Negligence?
        - » Naloxone has long been the standard of care for reversing opiate overdose.
        - » It would be virtually impossible for a plaintiff to get a claim that it was not to a jury, let alone to prevail.
      - Harm/Injury?
        - » No – naloxone is extremely safe. Similar to other acute medical problems, the provider is not responsible for causing the medical emergency.

Naloxone Standing Order

July 2, 2021

Subject: Naloxone Leave Behind Program

Dear Arizona EMS Agencies:

Arizona law permits EMS agencies who have responded to an individual experiencing an opioid-related overdose ("at-risk person") to leave behind pre-packaged, intranasal naloxone (Narcan®) if the EMCT believes that it can be used in the future by the at risk person, family members, or friends to reverse an opioid overdose. The naloxone leave behind kit should include instructions on when and how it should be administered.

A.R.S. § 36-2266 is written broadly and allows the administrative medical director of an EMS agency to write a protocol for a naloxone leave behind program for patients or family members who may be at high risk for overdose. This is at the discretion of, and requires the approval from, the agency's administrative medical director.

An EMS agency that is interested in implementing a naloxone leave behind program, but does not have administrative medical direction, may approach the Department for assistance if they qualify under A.R.S. § 36-2202(K).

Sincerely,

Rachel Zenuk Garcia, Chief
Bureau Chief
Bureau of EMS & Trauma System
Arizona Department of Health Services

Gail Bradley, M.D., FACEP, FAEMS
Medical Director
Bureau of EMS and Trauma System
Arizona Department of Health Services

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

Bureau of Emergency Medical Services and Trauma System
150 North 18th Avenue, Suite 540, Phoenix, AZ 85007-3247 P | 602-364-3150 F | 602-364-3568 W | azhealth.gov

Naloxone Leave Behind Program - SAMPLE POLICY

1. In the event that a patient overdoses on an opioid, personnel should immediately treat the patient and stabilize them.
2. After stabilizing the patient, encourage them to seek additional medical treatment at a hospital, and inform them of the potential risks of not obtaining additional treatment at the hospital.
3. A Naloxone Leave Behind Kit may be offered to an at risk person, friend, or family member in the event of an opioid overdose, after the patient is treated, stabilized and either refuses transport or is transported to the hospital. Naloxone Leave Behind Kit may also be offered to bystander/friend/family who is in close contact with persons at risk of opioid overdose. Patients at risk for opioid overdose include:
   a. History of illicit drug use or prescription for opioids
   b. History of or physical exam findings consistent with IVDU (IV drug use), ie. Track marks
   c. Physical environment with illicit opioids or paraphernalia, multiple or high-dose prescription opioids present
4. Naloxone Leave Behind Kit
   a. Commercially prepared Naloxone (Narcan®) 4mg/0.1mL nasal spray.
   b. Instructions on when and how to administer the Naloxone Leave Behind Kit.
   c. Contact information for the Arizona Opioid Assistance and Referral (OAR) Line and other resources available in your community.
5. A Naloxone Leave Behind Kit may be distributed on each call in which it is indicated to be left.
6. Documentation per agency policy indicating when naloxone (Narcan®) was left behind.

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

150 North 18th Avenue, Suite 500, Phoenix, AZ 85007-3247 P | 602-542-1025 F | 602-542-1062 W | azhealth.gov
Health and Wellness for all Arizonans

So What Does This Mean?

Naloxone Leave Behind Guideline

Includes:

- Patients at risk for opioid overdose
    - History of illicit drug use or prescription for opioids
    - History of or physical exam findings consistent with IVDU (IV drug use), ie. Track marks
    - Physical environment with illicit opioids or paraphernalia, multiple or high-dose prescription opioids present
- Bystander/friend/family who is in close contact with persons at risk of opioid overdose
- Patient who overdosed on opioids, now status post reversal, but refusing transport to the Emergency Department opioids, now s/p reversal with Naloxone

EMT

- If signs of respiratory depression/arrest or Altered Mental Status, refer to Overdose Guideline.
- Provide Naloxone Kit
    - Naloxone 4mg/0.1 mL IN spray (package of 2)
    - Educational pamphlet
- Review pamphlet with opioid overdose recognition and Naloxone administration instructions
- Review list of community resources for Medication Assisted Treatment (MAT) as indicated
- Record Naloxone distribution on survey form, obtain as much or as little information as the patient/bystander will allow

Our Naloxone kits

- Provide Naloxone Kit
  - Naloxone 4mg/0.1 mL IN spray (package of 2)
  - Educational pamphlet

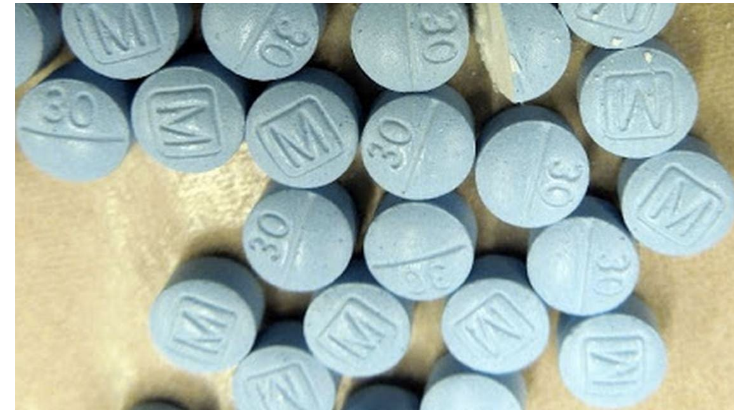
Naloxone Administration

Inclusion criteria:
Who can we leave naloxone with?

- Patients who:
  - Overdosed on opioids
  - Are at risk of overdosing on opioids
- Bystanders who are in close contact with persons at risk of opioid overdose

Patients at risk for OD:

- Mixing drugs (eg, benzo's and oxycodone)
- Reduced tolerance
  - Rehab/detox/jail/prison/hospitalization
    - Death most likely in first 28 days after leaving inpatient treatment
- Increased dependence
- New/different supply
- New route (IV instead of pills)
- Using alone or injection by partner



When giving someone a kit:

- Give them the kit:
  - Naloxone IN spray
  - Naloxone educational pamphlet
- Provide training on how to recognize an OD and what to do
- Instruct them on how to administer the Naloxone
- Explain various options for treatment as indicated (see pamphlet)

Example Agency-specific education pamphlet

PEEL

PLACE

PRESS

Suspect an Overdose?

1. Peel back the package to remove the device. Hold the device with your thumb on the bottom of the red plunger and two fingers on the nozzle.
2. Place and hold the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose.
3. Press the red plunger firmly to release the dose into the patient's nose.
4. After you administer the dose, call 911 and perform rescue breathing
5. If your friend wakes up, they make feel very sick. Don't let them use again, even if they want do, otherwise they may overdose again. They may be at risk of overdosing after the naloxone wears off.

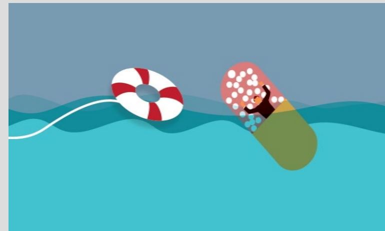
What puts you at risk of an OD?

When you take more opioids than your body can handle, you stop breathing and your brain stops functioning, leading to death. This occurs when:

- Your tolerance is lowered, due to recently getting out of detox, treatment, or jail
- You are using dope/pills that are stronger than you are used to, i.e. new cut, new dealer, higher mg
- Your immune system is weakened because you are sick or recently got over being sick
- You recently started injecting
- You are mixing opioids with benzos (Xanax/Valium, etc.) or alcohol – this is very dangerous!

To prevent overdose, don't use alone, start low and go slow, don't lock your door, and make sure those around you have naloxone.

Example Agency-specific education Pamphlet



Treatment

There is treatment that WORKS. Some referrals in Peoria/Phoenix are:

OAR
Opioid Assistance & Referral Line
(888) 688-4222
www.azdhs.gov/oarline

Treatment

COMMUNITY MEDICAL SERVICES
Methadone, Suboxone, Vivitrol
10689 N 99th Ave, Peoria 85345
(623) 233-1333
www.communitymedicalservices.org

INTENSIVE TREATMENT SYSTEMS
24/7 Walk-ins Welcome
Methadone, Suboxone, Vivitrol
4136 N 75th Ave, Ste. 116
Phoenix 85033
(855) 245-6350
www.itsofaz.com

RECOVERY INNOVATIONS
24/7 Walk-ins Welcome
Mental Health Services
11361 N 99th Ave, Ste 402, Peoria 85345
(602) 636-1212
www.riinternational.com/crisis-services

Opioid Use Disorder

Signs of an Opioid Overdose: BLUE

BREATHING: Breathing is shallow, gurgling, erratic, or completely absent

LIPS: Lips and fingertips are blue, due to decreased oxygen throughout the body

UNRESPONSIVE: The victim will not respond to verbal or physical stimuli

EYES: Pupils are pinpoint

Bystander training

- Identify opioid OD
  - BLUE: Breathing is slowed, Lips are blue, Unresponsive, Eyes have pinpoint pupils

SIGNS OF AN OPIOID OVERDOSE. B.L.U.E.

BREATHING — Breathing during an overdose is shallow, gurgling, erratic, or completely absent.

LIPS — Lips and fingertips are blue, due to decreased oxygen throughout the body.

UNRESPONSIVE — The victim will not respond to verbal or physical stimulation.

EYES — Pupils are pinpoint, as the opioids constrict the pupils to an unusally small size.

Bystander training

- Identify opioid OD
  - BLUE: Breathing is slowed, Lips are blue, Unresponsive, Eyes have pinpoint pupils
- Assess scene safety
- Verbal/Tactile simulation (try to wake the patient)
- Call 911
- Administer intranasal Naloxone
  - If the patient does not respond within 3 minutes, repeat the dose
- Recovery position/CPR if no improvement
- Stay with the patient until EMS/Police arrive
  - Good Samaritan laws protect you
- Learn about treatment options and ways to reduce risk (harm reduction)

Good Samaritan Law

Call 911

SPWAZ.ORG

You cannot be charged for possession if you call 911 for an overdose, and neither can the overdose victim.

The most commonly cited reason for not calling for help is fear of arrest or punishment by law enforcement.

In early 2018, Arizona Revised Statute (ARS) 13-3423 was amended.

WHO DOES IT HELP?
Anyone who is at risk for overdose or anyone who cares about someone who could overdose

If someone is experiencing a drug-related overdose or someone calls 911 in a drug-related overdose, both parties can no longer be charged for the possession or use of a controlled substance or paraphernalia.

You can still be charged with intent to sell if there are greater than these amounts in your possession:
HEROIN: 1 gram

REFERRALS!

Who Needs Referrals for treatment?

- Patients with illicit opioid use (heroin, fentanyl, M30's, etc)
- Patients who verbalize desire to stop using opioids
- Patients who have overdosed (intentional and unintentional)
- Patients who are using their medications, but not as prescribed (ie. Taking more than prescribed amount daily)

- Who does not need a referral for treatment???
  - Patients with chronic underlying illness on long-term opioids
    - Cancer patients
    - Patients with end-stage MS, ALS, spina bifida . . .

MAT = Medication for Addiction Treatment

- Methadone
- Buprenorphine (Suboxone/Subutex/Sublocade)
- Naltrexone (Vivitrol)

MAT HAS BEEN SHOW TO...

Improve patient survival

Increase retention in treatment

Decrease illicit opiate use and other criminal activity among people with substance use disorders

Increase patients' ability to gain and maintain employment

Improve birth outcomes among women who have substance use disorders and are pregnant

Treatment Options

OAR

Opioid Assistance & Referral Line

(888) 688-4222

www.azdhs.gov/oarline

COMMUNITY MEDICAL SERVICES

Methadone, Suboxone, Vivitrol

www.communitymedicalservices.org

(855) 203-6352

Add resources in your jurisdiction here:

Documentation per your agency's policy

Summary

- Give a naloxone kit to anyone at risk of opioid OD
- Provide training
- Explain various options for treatment as indicated
- Documentation per your agency’s policy

To request free naloxone from ADHS, Office of Injury Prevention (for law enforcement, local health departments, and community organizations):

-Fill out this form: https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/order-naloxone.pdf

-Submit form to azopioid@azdhs.gov

Naloxone Leave Behind Guideline

Includes:

- Patients at risk for opioid overdose
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    - History of or physical exam findings consistent with IVDU (IV drug use), ie. Track marks
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Questions?

THANK YOU

Presenter Name | Title

presentersemail@azdhs.gov | 602-542-1025

azhealth.gov