Preventing Opioid Overdose with Education and Naloxone Rescue Kits

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Association for Medical Education and Research in Substance Abuse (AMERSA)
Alexander Y. Walley Disclosures

• No financial relationships to disclose.

The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.
Educational Objectives

At the conclusion of this activity participants should be able to:

- Review the epidemiology of opioid overdose
- Describe the rationale for and scope of overdose education and naloxone distribution (OEND) programs
- Implement OEND in settings that offer medication for opioid use disorder
  - Educate patients about overdose risk reduction
  - Prescribe naloxone rescue kits
Case: 29 yo woman presents to clinic for buprenorphine treatment

- Age 18, an accomplished athlete with collegiate prospects
  - When she tore her ACL she was prescribed opioids after surgery
  - Developed an opioid use disorder by 6 months
  - Age 20, injection heroin daily, out of college

- Ages 20-26, multiple detoxification and residential programs
  - Not able to sustain >3 months without relapse

- Age 26, pregnant at her last detoxification and transferred to methadone
  - Able to stop using heroin, engage in 12 step program
  - Delivered a healthy baby, breastfed, retained custody

- Age 28, she tapered off of methadone
  - Wanted more time with the baby and to work
  - Boyfriend incarcerated for selling drugs
  - Relapsed, lost custody, now seeking treatment with buprenorphine
    - Does not want to go to the methadone clinic every day
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- Age 29-30: Good response to office-based buprenorphine treatment
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• Age 30: Hospitalized in intensive care for overdose
  ▪ Her boyfriend was released from jail and returned to stay with her
  ▪ He relapsed and overdosed on heroin on the 3rd night – likely fentanyl
    – Packed his underwear with ice, tried to rescue breathe but did not respond, so she called 911 and they were unable to save him
    – Child protection was notified about the incident and they removed her son from the home
  ▪ She stopped buprenorphine, started drinking alcohol, then relapsed to heroin/fentanyl and overdosed
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How could overdose prevention improve this case?
Overdose continues to increase and is the leading cause of accidental injury death.
Rates of Drug Overdose Deaths by State: Change from 2010 to 2015

- Opioid death rates increased by 15.6% from 2014 to 2015.
- Increase driven by synthetic opioids (illicitly-manufactured fentanyl and heroin)
- Increases in these opioid subcategories occurred overall and across all demographics and regions.

Rudd et al., 2016
Overdose deaths since 2010 are driven by heroin and fentanyl, not prescription opioids.
Fentanyl is Driving Overdose Surge

Strategies to Address Overdose

- **Prescription monitoring programs**
  - Delcher et al. DAD 2015; 150: 63-68.
- **Prescription drug safe storage and disposal**
- **Safe opioid prescribing education**
- **Medication for opioid use disorders**
  - Sordo et al. BMJ 2017; 357:j1550
- **Supervised injection facilities**
- **Overdose Education and Naloxone Distribution**
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Strategies to Address Fentanyl Overdose Deaths

Public health response to address overdoses related to illicitly made fentanyl
1. Fentanyl should be included on standard toxicology screens
2. Adapt existing harm reduction strategies, such as direct observation of anyone using illicit opioids, and ensuring bystanders are equipped with naloxone
3. Enhanced access and linkage to medication for opioid use disorders

“So, now what they [people selling illicit drugs] are doing is they’re cutting the heroin with the fentanyl to make it stronger. And the dope [heroin] is so strong with the fentanyl in it, that you get the whole dose of the fentanyl at once rather than being time-released [like the patch]. And that’s why people are dying—plain and simple. You know, they [people using illicit drugs] are doing the whole bag [of heroin mixed with fentanyl] and they don’t realize that they can’t handle it; their body can’t handle it.” — Overdose bystander

Characteristics of Fentanyl Overdose — Massachusetts, 2014–2016

Nicholas J. Somerville, MD1,2; Julie O'Donnell, PhD1,3; R. Matthew Gladden, PhD4; Jon E. Zibbell, PhD4; Traci C. Green, PhD5; Morgan Younkin, MD6; Sarah Ruiz, MSW2; Hermik Babakhanlou-Chase, MPH2; Miranda Chan, MPH2; Barry P. Callis, MSW2; Janet Kuramoto-Crawford, PhD1; Henry M. Nields, MD, PhD7; Alexander Y. Walley, MD2,5

Morbidity and Mortality Weekly Report
“The AMA has been a longtime supporter of increasing the availability of Naloxone for patients, first responders and bystanders who can help save lives and has provided resources to bolster legislative efforts to increase access to this medication in several states.”


“APhA supports the pharmacist’s role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose”


“ASAM Board of Directors
April 2010

“Naloxone has been proven to be an effective, fast-acting, inexpensive and non-addictive opioid antagonist with minimal side effects... Naloxone can be administered quickly and effectively by trained professional and lay individuals who observe the initial signs of an opioid overdose reaction.”

www.asam.org/docs/public-policy-statements/1naloxone-1-10.pdf
Naloxone Basics

Takes effect in 2 - 3 minutes

If patient is not responding in this time, a second dose may need be administered

Wears off in 30 - 90 minutes

Patients can go back into overdose if long acting opioids were taken (fentanyl patch, methadone, extended release morphine, extended release oxycodone)

Patients should avoid taking more opioids after naloxone administration so they do not go back into overdose after naloxone wears off

Patients may want to take more opioids during this time because they may feel withdrawal symptoms

Shelf-life is 12-24 months

Store at room temperature to minimize degradation
Naloxone Formulations

- Intranasal with atomizer attachment
- Auto-Injector
- Intranasal spray
- Intramuscular injection
Rationale for Overdose Education and Naloxone Rescue Kits

• Most people who use opioids do not use alone

• Known risk factors:
  ▪ Mixing substances, loss of opioid tolerance, using alone, unknown source

• Opportunity window:
  ▪ Opioid overdoses take minutes to hours and is reversible with naloxone
  ▪ Fentanyl reduces the window to seconds to minutes

• Bystanders are trainable to recognize and respond to overdoses

• Fear of public safety
Evaluations of Overdose Education and Naloxone Distribution Programs

- Feasibility
  - Piper et al. Subst Use Misuse 2008: 43; 858-70.
  - Walley et al. JSAT 2013; 44:241-7. (Methadone and detox programs)

- Increased knowledge and skills

- No increase in use, increase in drug treatment

- Reduction in overdose in communities

- Cost-effective
  - $438 (best) to $14,000 (worst) per quality-adjusted life year gained
**Objective:** Determine the impact of opioid overdose education with intranasal naloxone distribution (OEND) programs on fatal and non-fatal opioid overdose rates in Massachusetts.
Opioid Overdose Related Deaths: Massachusetts 2004 - 2006
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Number of Deaths
- No Deaths
- 1 – 5
- 6 - 15
- 16 - 30
- 30+

OEND programs

2006-07
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OEND programs
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Number of Deaths
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- 6 - 15
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OEND programs
- 2006-07
- 2007-08
- 2009
- Towns without
# Fatal Opioid Overdose Rates by OEND Implementation

<table>
<thead>
<tr>
<th>Cumulative enrollments per 100k</th>
<th>RR</th>
<th>ARR*</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute model:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No enrollment</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Low implementation: 1-100</td>
<td>0.93</td>
<td>0.73</td>
<td>0.57-0.91</td>
</tr>
<tr>
<td>High implementation: &gt; 100</td>
<td>0.82</td>
<td>0.54</td>
<td>0.39-0.76</td>
</tr>
</tbody>
</table>

* Adjusted Rate Ratios (ARR) All rate ratios adjusted for the city/town population rates of age under 18, male, race/ethnicity (hispanic, white, black, other), below poverty level, medically supervised inpatient withdrawal treatment, methadone treatment, BSAS-funded buprenorphine treatment, prescriptions to doctor shoppers, and year.

Fatal Opioid Overdose Rates by OEND Implementation

Naloxone coverage per 100K

- 0%
- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%

Opioid overdose death rate

- No coverage
- 1-100 ppl

27% reduction

Fatal Opioid Overdose Rates by OEND Implementation

Naloxone coverage per 100K

Opioid overdose death rate

46% reduction

No coverage

1-100 ppl

100+ ppl

Community Naloxone Programs, 2014

FIGURE 2. Number* and location of local drug overdose prevention programs providing naloxone to laypersons, as of June 2014, and age-adjusted rates† of drug overdose deaths§ in 2013 — United States

* Total N = 644; numbers on map indicate the total number of programs within each state.
† Per 100,000 population.
§ CDC, National Center for Health Statistics; Compressed Mortality File 1999–2013 on CDC WONDER Online Database, released January 2015.

## Implementing Overdose Prevention in Addiction Treatment Settings

<table>
<thead>
<tr>
<th>Model</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff provide OEND on-site</td>
<td>Good access to OEND</td>
<td>Patients may not disclose risk</td>
</tr>
<tr>
<td></td>
<td>Opioid overdose prevention integrated</td>
<td></td>
</tr>
<tr>
<td>Outside staff provide OEND on-site</td>
<td>Opioid overdose prevention integrated</td>
<td>Community OEND program needed</td>
</tr>
<tr>
<td></td>
<td>Interagency cooperation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low burden on staff</td>
<td></td>
</tr>
<tr>
<td>OE provided onsite, naloxone received off-site</td>
<td>Opioid overdose prevention integrated</td>
<td>Increased patient burden to get naloxone</td>
</tr>
<tr>
<td></td>
<td>Interagency cooperation</td>
<td></td>
</tr>
<tr>
<td>Outside staff recruit near methadone maintenance treatment (MMT) or detoxification</td>
<td>Confidential access to opioid overdose prevention</td>
<td>Opioid overdose prevention not re-enforced in treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not all patients reached</td>
</tr>
</tbody>
</table>

**Don’t forget the staff:** Among 29 MMT and 93 detoxification staff who received OEND, 38% and 45% respectively reported witnessing an overdose in their lifetime.

Other Venues and Models

- Buprenorphine and naltrexone treatment
- First responder – police and fire
- Emergency Department (ED) SBIRT
- Post-incarceration
- Prescription naloxone
  - [Prescribetoprevent.org](Prescribetoprevent.org)
Overdose Prevention for Patients

- Review medications – Communicate with other prescribers
- Take a substance use history
- Check the prescription monitoring program

Overdose history

Ask your patients:
- How do you protect yourself against overdose?
- How do you keep your medications safe at home?

And their loved ones:
- What is your plan if you witness an overdose in the future?
- Have you received training to prevent, recognize, or respond to an overdose?
Overdose Prevention for Patients

What they need to know

• Prevention - the risks:
  ▪ Mixing substances
  ▪ Abstinence - low tolerance
  ▪ Using alone
  ▪ Unknown source
  ▪ Chronic medical disease
  ▪ Long acting opioids last longer

• Recognition
  ▪ Unresponsive to sternal rub with slowed or absent breathing
  ▪ Blue lips, pinpoint pupils

• Response - What to do
  ▪ Call for help
  ▪ Rescue breathe
  ▪ Deliver naloxone and wait 3 minutes
  ▪ Stay until help arrives

Patient education videos and materials at prescribetoprevent.org
How to Respond in an Overdose

Steps to teach patients, family, friends, caregivers

1. Recognize overdose
2. Call 911 for help
3. Administer naloxone as soon as it is available
4. Rescue breathe/chest compressions per rescuer’s level of training
5. Stay until help arrives

Place in recovery position if breathing

Multi-step nasal spray
Intramuscular injection
Auto-injector (EVZIO®)
Single-step nasal spray (NARCAN®)
**Updated Opioid Associated Life Threatening Emergency (ADULT) Algorithm**
Objective: To evaluate the feasibility and effect of implementing naloxone prescription to patients prescribed opioids for chronic pain at 6 safety-net primary care clinics

Results

- 38% of 1985 patients receiving long term opioids co-prescribed naloxone rescue kits
- Patients with higher opioid doses and previous opioid-related ED visits were more likely to be prescribed naloxone kits
- Opioid-related ED visits were reduced by 47% at 6 months and 63% at 12 months among those who were co-prescribed naloxone, compared with those who were not
- No change was detected in the net prescribed opioid doses for patients who were co-prescribed naloxone

Innovations: Models for Pharmacy Naloxone

Prescriber writes prescription
Patient fills at pharmacy

Setting: clinic with insured patients
Pharmacies alerted to prescribing plans
May need to have atomizers on-site if intranasal formulation
Informational brochure, patient fills

Pharmacy provides naloxone directly to customer

Without prescriber contact under a standing order
Training needed
Passive or active models: Naloxone co-prescription
Universal offer, may require clear policy direction

Pharmacy provides naloxone to patients in treatment center/clinic

Without prescriber or pharmacy contact under a standing order, distribution model
Patient training done on-site at clinic, facilitates facility-level compliance and sustainability

Are you or someone you know at risk of overdose from an opioid prescription or illicit drug?

Ask your pharmacist how you can get a naloxone rescue kit. It could be a lifesaver.

Naloxone is a special medication that can stop an overdose. Opioid pain medications or drugs such as heroin can slow breathing and cause overdose. Naloxone is safe and effective, and comes in a nasal spray. Talk to your pharmacist to learn more. You could save a life.
And, always call 911 when faced with a potential overdose situation.

Learn more at prescribetoprevent.org

A message from the Massachusetts Pharmacists Association and the University of Massachusetts Medical School
Offer Naloxone to Everyone…..

- Any opioid prescription
- Any opioid/benzodiazepine rx combination
- Any disease/opioid combination
- Any methadone
- Any buprenorphine
- Any naltrexone for opioids
- Transitions of care

- Friends and family of those at risk
- Syringe buyer request
- Addiction treatment
- Correctional institution
- Behavioral health

Orienting patients to greater opioid safety: models of community pharmacy-based naloxone

Traci C. Green, Emily F. Dauria, Jeffrey Bratberg, Corey S. Davis, and Alexander Y. Walley
Practical Barriers to Prescribing Naloxone

1. Prescriber knowledge and comfort
2. How to write the prescription?
3. Does the pharmacy stock rescue kits?
   - Work with your pharmacy to get it stocked
4. Who pays for it?
   - Work with your pharmacy to see if they will cover it
   - Advocate with insurance (e.g. Medicaid) to get naloxone on formulary
Legal Barriers to Prescription Model

“Prescribing naloxone in the USA is fully consistent with state and federal laws regulating drug prescribing. The risks of malpractice liability are consistent with those generally associated with providing healthcare, and can be further minimized by following simple guidelines presented.”

- Only prescribe to a person who is at risk for overdose
- Ensure that the patient is properly instructed in the administration and risks of naloxone

Does your state permit prescribing to people NOT at risk of overdose?
Does your state have a Good Samaritan law?
- Go to pdaps.org – to find out

Example of Overdose-Naloxone Law: Good Samaritan, limited liability for patients/prescribers and 3rd party prescribing

Good Samaritan provision:
• Protects people who overdose or seek help for someone overdosing from being charged or prosecuted for drug possession
  ▪ Protection does not extend to trafficking or distribution charges

Patient protection:
• A person acting in good faith may receive a naloxone prescription, possess naloxone and administer naloxone to an individual appearing to experience an opioid-related overdose.

Prescriber protection:
• Naloxone or other opioid antagonist may lawfully be prescribed and dispensed to a person at risk of experiencing an opioid-related overdose or a family member, friend or other person in a position to assist a person at risk of experiencing an opioid-related overdose. For purposes of this chapter and chapter 112, any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.

Massachusetts - Passed in August 2012:
An Act Relative to Sentencing and Improving Law Enforcement Tools
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  - Overdose prevention education and rescue kit part of her taper and discharge plan
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- Age 30: Continues in her recovery despite BF’s relapse and overdose
  - Her boyfriend had been released from jail and returned to stay with her
  - He relapsed and overdose on heroin on the 3rd night,
    - She called 911, started rescue breathing, and administered one dose of nasal naloxone. He was transported, observed and transferred to a residential program for formerly incarcerated with drug problems
    - Police and EMS praised her for her response: “It saved his life”
  - She called her buprenorphine program counselor and went to group counseling that week where she received support
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*And she lived happily everafter!!!*
Helpful Websites

- For prescribers and pharmacists
  - Prescribetoprevent.org
- News + research on overdose prevention
  - Overdosepreventionalliance.org
- International overdose prevention efforts
  - Naloxoneinfo.org
- Opioid overdose prevention education
  - Stopoverdose.org
- Family support
  - Learn2Cope.com
  - http://pdaps.org/
- Project manual
- 2013 National Drug Control Strategy
  - www.whitehouse.gov/ondcp/2013-national-drug-control-strategy
- ASAM 2010 Policy Statement
  - www.asam.org/docs/publicy-policy-statements/1naloxone-1-10.pdf
- SAMHSA Toolkit
- SAMHSA Letter to prescribers
• Factors associated with opioid overdose: a 10-year retrospective study of patients in a large integrated health care system.
• The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.
References

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References

PCSS Mentor Program

• PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.

• PCSS mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medication-assisted treatment.

• 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.

• No cost.

For more information visit: pcssNOW.org/clinical-coaching
PCSS Discussion Forum

Have a clinical question?

Ask a Colleague
A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now
PCSS-MAT is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with the: Addiction Technology Transfer Center (ATTC); American Academy of Family Physicians (AAFP); American Academy of Neurology (AAN); American Academy of Pain Medicine (AAPM); American Academy of Pediatrics (AAP); American College of Emergency Physicians (ACEP); American College of Physicians (ACP); American Dental Association (ADA); American Medical Association (AMA); American Osteopathic Academy of Addiction Medicine (AOAAM); American Psychiatric Association (APA); American Psychiatric Nurses Association (APNA); American Society of Addiction Medicine (ASAM); American Society for Pain Management Nursing (ASPMN); Association for Medical Education and Research in Substance Abuse (AMERSA); International Nurses Society on Addictions (IntNSA); National Association of Community Health Centers (NACHC); National Association of Drug Court Professionals (NADCP), and the Southeast Consortium for Substance Abuse Training (SECSAT).

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