COMMUNITY OPIOID OVERDOSE TRAINING

A presentation by the Westchester County Department of Health

History of Naloxone (Narcan) Training in Westchester County

- Initial focus was on training police officers. Today, there are approximately 1,000 Naloxone (Narcan) trained police officers in Westchester County.
- Since the training began in late 2014, lives have been saved by officers from the following Police Departments: Croton, White Plains, Lewisboro, Mamaroneck, Mount Pleasant, Chappaqua, Peekskill, North Salem, Buchanan, Yonkers, and Westchester County.
- In 2015, the Health Department expanded the training program to include the public in order to increase the potential to save lives.
- To date, over to 4,000 members of the community have been trained on Naloxone (Narcan) administration.
- In 2016, training expanded to include medical students.

Multi-Pronged Approach

- Requires diverse and robust collaboration among:
  - Law Enforcement
  - Public Health
  - Mental Health Community
  - Medical Professionals
  - Community Partners

Training Objectives

- Understand the opioid overdose problem in the US
- Recognize the signs and symptoms of an overdose
- Know the steps to take when encountering an opioid overdose
- Know how to properly administer Narcan
- Report use of Naloxone
- Understand the Naloxone Co-payment Assistance Program (N-CAP)
- Be aware of CDC Guidelines for Prescribing Opioids

Local Media

lohud.com The Journal News
Sunday, December 13, 2015 21A

Exchange

thinking out loud

A JOURNAL NEWS EDITORIAL

New Yorkers need access to naloxone now

Sunday, December 6, 2015

A GENERATION LOST

An addict picks up pieces of his life

DAVID ROBINSON

TEEN HEROIN USE GROWS

Sunday

Painkillers to heroin:

A GENERATION LOST

Mapping painkillers

Heroin, opioid epidemic spurs an interactive database to track prescribing habits

DAVID ROBINSON DROBINSON@LOHUD.COM

Through early January, reporters will be looking back at and following up on stories and topics that were the most popular with our readers in 2015, according to metrics on lohud.com. This story is part of that series.

COPS: HEROIN RING HID IN SLEEPY TOWN

Estimated value of seized drug was $2.3M, according to officials

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CORTLANDT – Two men targeted in what authorities say is the largest Westchester heroin bust in federal Drug Enforcement Administration history liked Cortlandt's seclusion, so they decided to move their international drug operation into town.

More than 65 pounds of heroin from Mexico, worth an estimated $2.3 million wholesale, was seized this week from a tractor-trailer parked in front of a [illegible] Drive home, bringing an abrupt end to what the DEA described as a "major trafficking operation" run from a quiet residential street.

"Members of this sophisticated and well-funded narcotics trafficking organization undoubtedly believed they were home-free when the drugs concealed inside the (trailer) axle went undetected at border crossings and in a trans-continental journey," said New York City Special Narcotics Prosecutor Bridget Brennan. "To for-

See HEROIN, Page 5A

"There is no crime in this area. It was a place you wouldn't suspect."

LESLIE ROSE
[illegible]

TANIA SAVAYAN/THE JOURNAL NEWS

The Facts

- Overdoses involving opioids killed more than 47,000 people in 2017, and 36% of those deaths involved prescription opioids.
- In 2017, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 6 times higher than in 1999.
- 130 Americans die every day from an opioid overdose
- More than 191 million opioid prescriptions were dispensed to Americans in 2017

Source: Centers for Disease Control

Deaths per 100,000 population

11
10
9
8
7
6
5
4
3
2
1
0

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015

Any Opioid

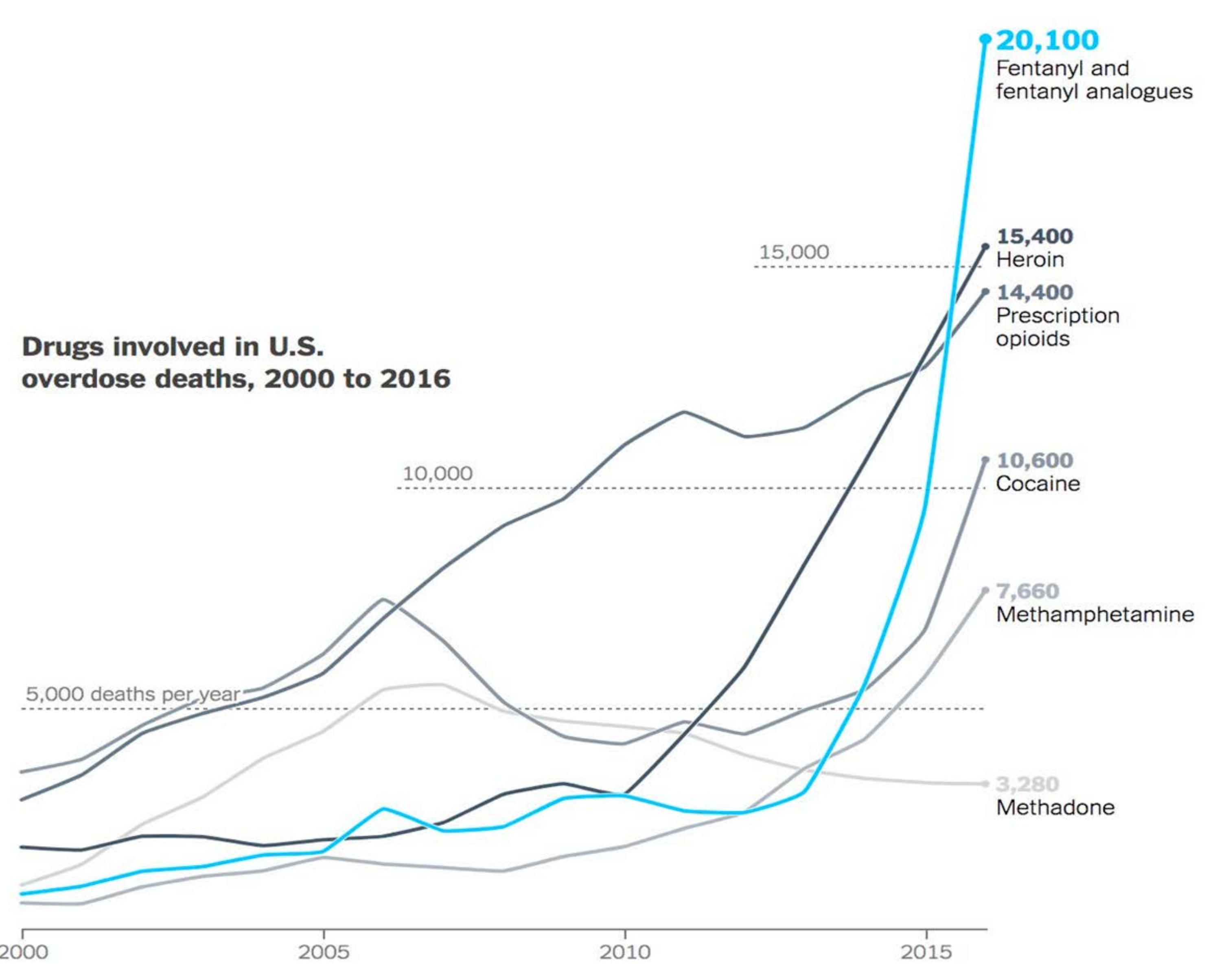
Heroin

Natural & Semi-Synthetic Opioids...

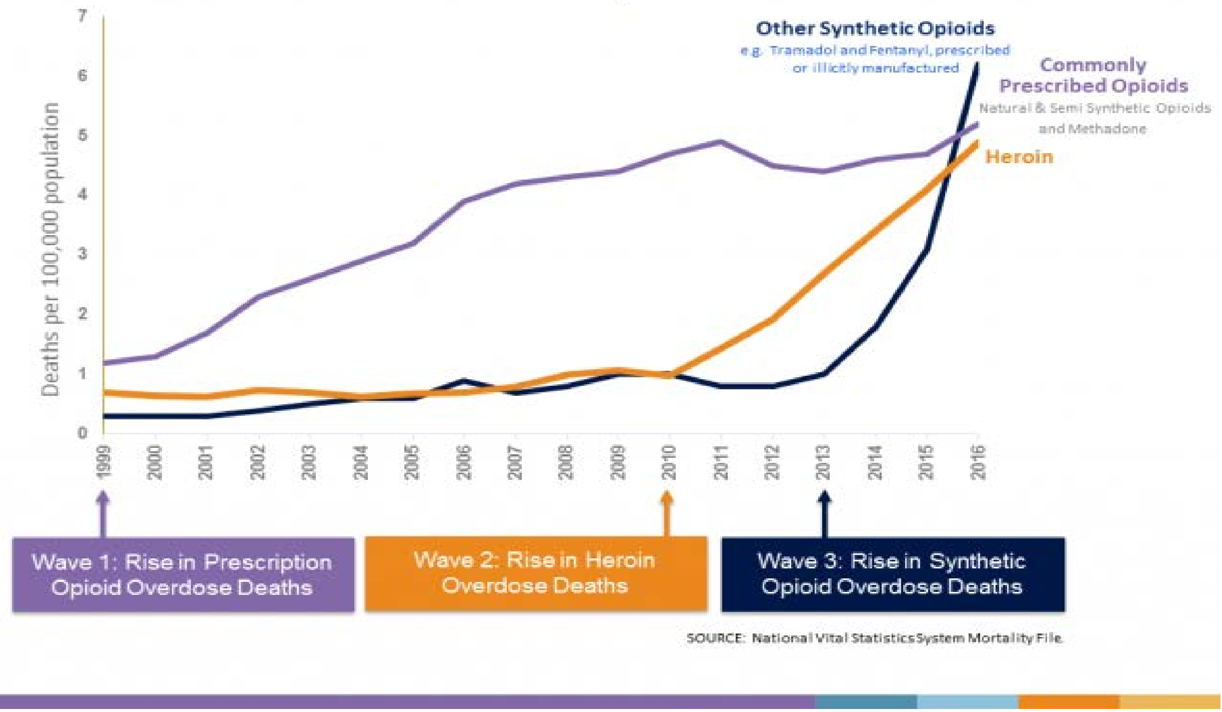
Other Synthetic Opioids
(e.g., fentanyl, tramadol)

Methadone

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.



Drugs involved in U.S. overdose deaths, 2000 to 2016
20,100
Fentanyl and fentanyl analogues
15,400
Heroin
14,400
Prescription opioids
10,600
Cocaine
7,660
Methamphetamine
3,280
Methadone
15,000
10,000
5,000 deaths per year
2000
2005
2010
2015



1.The first wave began with increased prescribing of opioids in the 1990s.

2.The second wave began in 2010, with rapid increases in overdose deaths involving heroin.

3.The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids – particularly those involving illicitly-manufactured fentanyl.

Common Opioids

- Codeine (only available in generic form)
- Fentanyl (Actiq, Duragesic, Fentora)
- Hydrocodone (Hysingla ER, Zohydro ER)
- Hydrocodone/acetaminophen (Lorcet, Lortab, Norco, Vicodin)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine (Demerol)
- Methadone (Dolophine, Methadose)
- Morphine (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR)
- Oxycodone (OxyContin, Oxecta, Roxicodone)
- Oxycodone and acetaminophen (Percocet, Endocet, Roxicet)

Heroin

- Can be injected, smoked, or inhaled by snorting or sniffing
- Associated with serious health conditions:
  - Collapsed veins
  - Infection of the heart lining and valves
  - Contractions of infectious diseases like hepatitis and HIV

Fentanyl

- The most powerful opioid used in human medicine
- Often used during surgery and to treat cancer pain
- Similar to morphine but 50-100 times more potent
- Began to appear in large quantities as Illegally Manufactured Fentanyl (IMF) about 2013
- Has a rapid onset with a short duration
- Often mixed with heroin or sold as heroin
- Overdose can be reversed with Naloxone; may require multiple doses
- Chest Wall Rigidity – can not move chest wall to breathe even though you might be conscious and trying to do so
- Half life = 3.7 hours

Carfentanyl

- Analog of the synthetic opioid analgesic Fentanyl
- 100 times more potent than Fentanyl
- Used in veterinary practices on large animals such as elephants
- Involved in ODs in people using prescription opioids
- Sold as counterfeit pills resembling oxycodone

Guidelines for Prescribing Opioids

PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = "no pain", 10 = "worst you can imagine")

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = "not at all", 10 = "complete interference")

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = "not at all", 10 = "complete interference")

2 **CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE**

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calulator, go to TurnTheTideRx.org/treatment.

50 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

90 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN: www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT): store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: go.cms.gov/pecos
Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

JOIN THE MOVEMENT

of health care practitioners committed to ending the opioid crisis at TurnTheTideRx.org.

TURN THE TIDE

Opioid Overdose Prevention Efforts

- I-STOP/PMP
- Increased access to Naloxone
- N-CAP Program
- Safe medication disposal

I-STOP Prescription Management Program (2014)

PMP searches resulted in an 82% drop in the number of “doctor-shoppers”

Doctor shoppers = patients who visit multiple doctors to obtain controlled substance medications

NYS PHL Section 3331, 5. (b), (c).

- Effective July 22, 2016
- Lowers prescription limits for opioids for acute pain from 30 to 7 day supply on initial visit to doctor, with exceptions for chronic pain and other conditions
- Increases access to addiction treatment by eliminating insurance barriers
- Requires ongoing education on addiction and pain management for all physicians and prescribers

Naloxone Available at Pharmacies

- The Harm Reduction Coalition issues standing medical orders to pharmacies
- Every person dispensed Naloxone should have training in opioid overdose recognition and response
- Pharmacists need training to be better prepared to answer questions when dispensing
- The cost of a Rx is approximately $145.00

N-CAP Program

- No-cost or lower-cost Naloxone is available at pharmacies across NYS
- Up to $40 in co-payment assistance is available
- To find the nearest registered pharmacy visit, www.health.ny.gov/overdose

N-CAP

Naloxone Co-payment Assistance Program

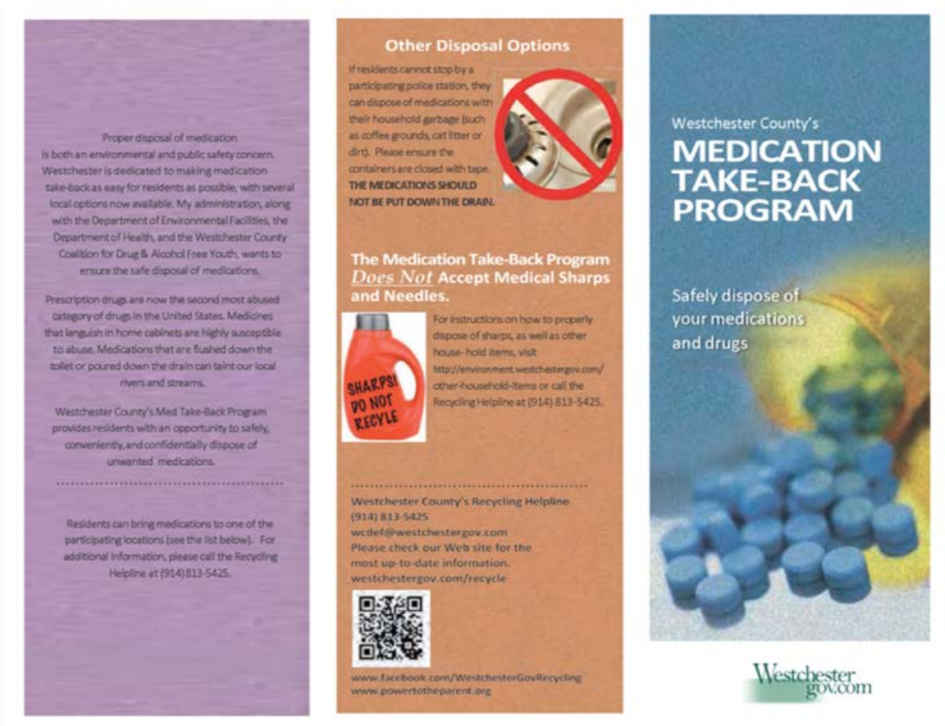
Naloxone is an emergency medicine that can stop an opioid overdose.

Reverse an overdose.

Carry Naloxone.

Local Prevention: Lockboxes

- Available at 39 locations
- Unwanted or unneeded prescription medications can be disposed of safely
- Medications are incinerated, keeping them:
  - off the streets
  - out of the hands of children
  - out of waste water streams
- “Pharm/Skittles” parties
- Visit our website for lockbox locations



Risk Factors for Opioid Overdose

Risk factors

- Loss of tolerance
- Mixing drugs
- Synthetic drugs
- Using alone (risk for <u>fatal</u> overdose)
- Drug strength/purity
- Depression
- History of previous overdose

Signs and Symptoms of an Opioid Overdose

- Unresponsive or minimally responsive
- Not breathing or respiratory arrest
- Slow breathing (<10 per minute)
- Snoring with gurgling
- Blue or ashen color (cyanosis)

What is Naloxone (Narcan)?

- Naloxone is a life-saving drug that can revive overdose victims
- Narcan is the brand name for the drug Naloxone
- Naloxone (Narcan) helps restore breathing to a person who is overdosing from opioid drugs such as heroin and prescription drugs such as oxycontin, oxycodone and fentanyl

How Naloxone Works

OPIOIDS BIND TO THE RECEPTORS

NALOXONE PREVENTS OPIOIDS FROM BINDING TO RECEPTORS

Naloxone temporarily holds receptors; time varies depending on the opioid.

OPIOID

OPIOID

OPIOID

OPIOID

OPIOID

OPIOID

NALOXONE

NALOXONE

NALOXONE

OPIOID RECEPTORS IN THE BRAIN

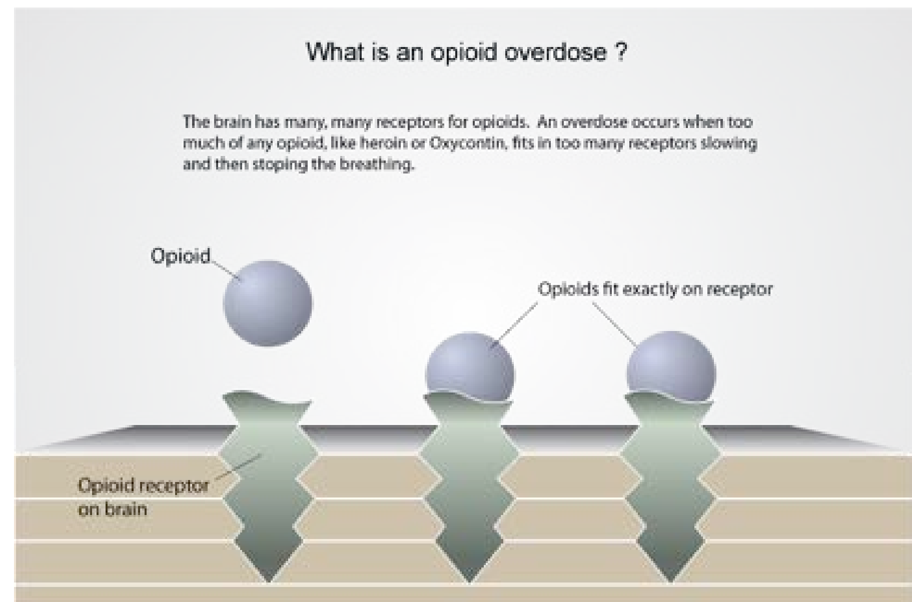
Naloxone In Action

- Wakes the person who is overdosing in 2-5 minutes
- Works for approximately 30-90 minutes
- Reverses opiate effects
- Causes sudden withdrawal – unpleasant feeling, person may become aggressive
- Not addictive
- Safe, highly effective

• Routinely used by EMS (larger doses)
• No harm if an opioid is not present
• No potential for abuse/addiction

What Happens During an Opioid Overdose?

- Opioids repress the urge to breathe
- Carbon dioxide levels increase
- Oxygen levels decrease
- Process takes time
- There is time to respond, but not time to waste



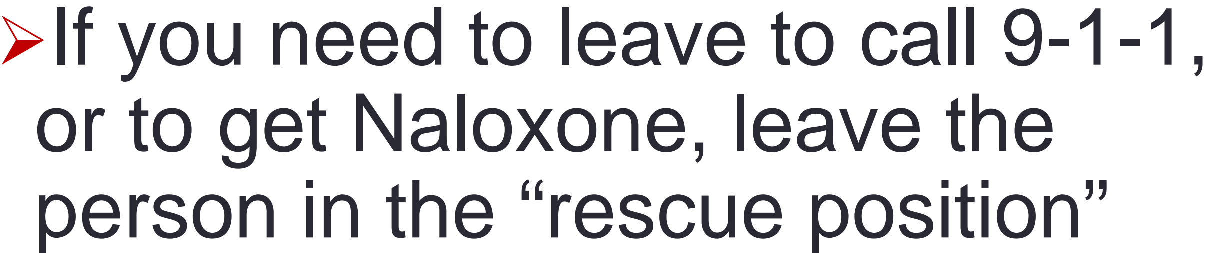
Steps To Responding To An Overdose

Sternal Rub

If the person is passed out and appears to be overdosing:

- Shake them and shout at them to wake up.
- If no response, grind your knuckles into their chest bone (sternal rub) for 5-10 seconds
- If the person still does not respond, give the person Naloxone and call 9-1-1— whichever is quickest to do first

Steps To Responding To An Overdose…continued



➢ If you need to leave to call 9-1-1, or to get Naloxone, leave the person in the “rescue position”

Rescue Position

- lying on their left side, with their top arm and top leg crossed over their body
- this lowers the chance they will choke on their own vomit

Call 9-1-1

Call 9-1-1 Right Away!

Tell the 9-1-1 dispatcher:

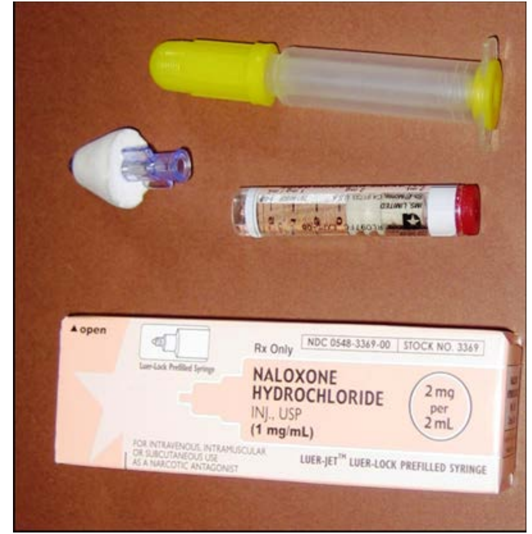
"I think someone has overdosed."

- Tell the dispatcher you are going to administer Naloxone
- Give the address and location
- Stay with the person until help arrives

Resuscitation

- Naloxone is **not a substitute for CPR**.
- If the person does not appear to be breathing or is gasping, they need CPR.

Formulations



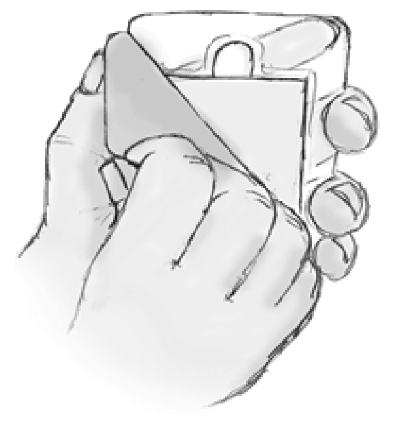
Adapt (Narcan) Device

How to use the Adapt (Narcan) Device

- Requires no assembly
- Device should remain in its blister pack until ready to use
  - DO NOT PRACTICE WITH DEVICE
  - The entire dose is released when the plunger is pushed
- Contains 4 mg/0.1ml of naloxone
  - This dose is 40 times more concentrated than the previously used multi-step nasal spray (Amphastar) with twice as much naloxone in 1/20 the amount of water

How to Give Narcan

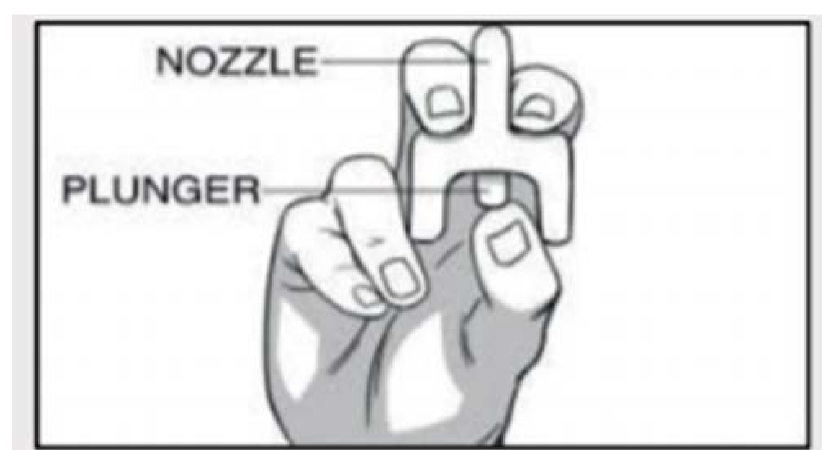
Step 1: Peel back the package to remove the device. Hold the device with your thumb on the bottom of the plunger and 2 fingers on the nozzle. Do NOT press the plunger.



Step 2: Place and hold the tip of the nozzle in either nostril until your fingers touch the bottom of the person's nose.

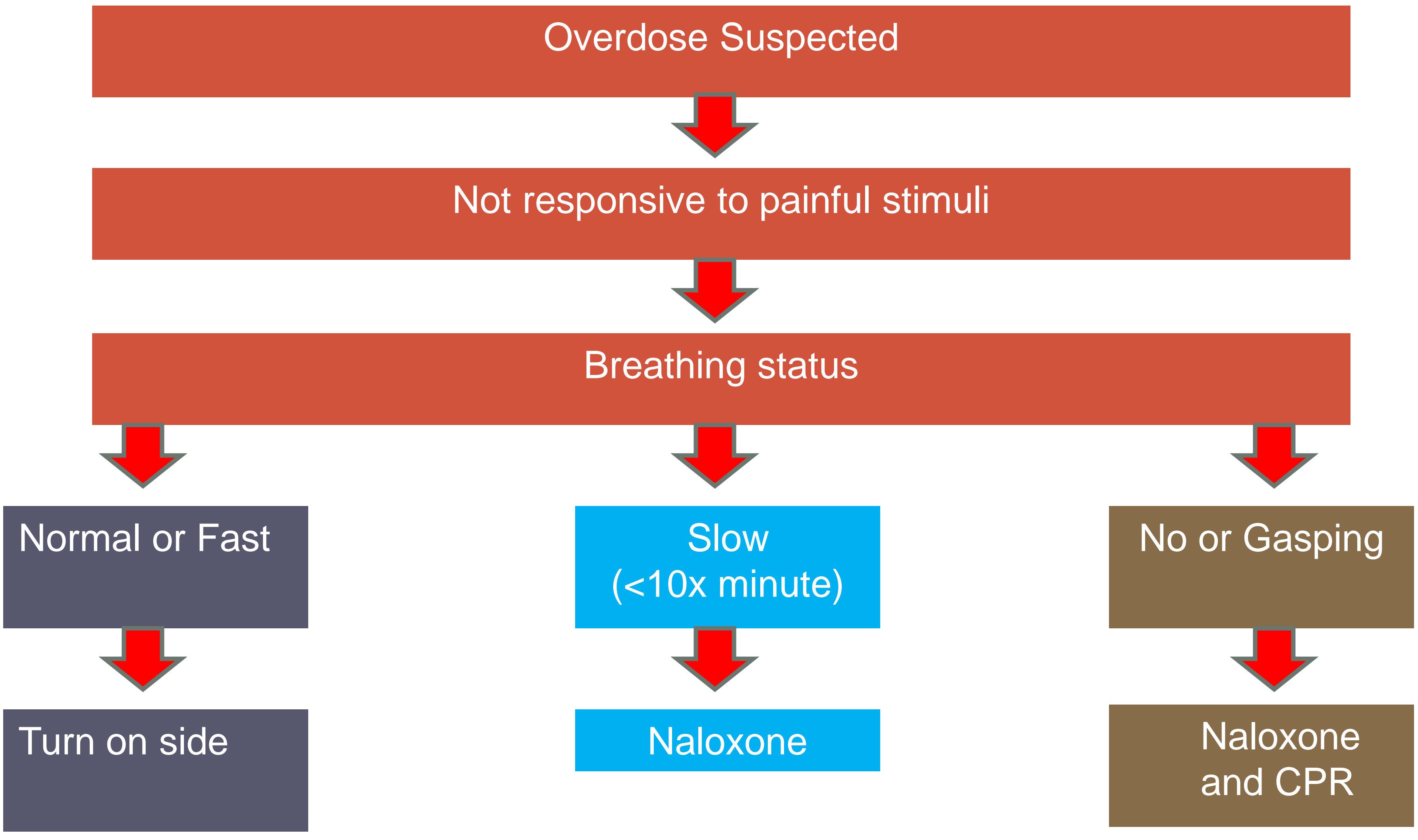
How to Give Narcan

Step 3: Press. Once the tip is in the nostril, press the plunger firmly to release the dose into the person's nose.



Step 4: **Repeat.** After 2-3 minutes if there is no or minimal response, repeat with second device into other nostril.

Recap…When to Use Naloxone



Drug Abuse Prevention & Treatment

- Remember, Naloxone does **NOT** prevent opioid overdoses. It prevents opioid overdose deaths.

- Drug treatment and counseling resources are needed to prevent overdoses.

PHL Section 3309, 10 NYCRR 80.138

- Effective since April 2006
- Protects non-medical person from liability when using Naloxone in settings of overdose
- Allows the medical provider to write a prescription to give Naloxone for “secondary administration” (the person being trained can use it on someone else)
- Recent amendment to law allows for ‘standing orders’ or non-patient specific prescriptions originating from a physician or physician’s assistant

This certifies that

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has been trained in opioid overdose prevention including the use of injectable/intranasal naloxone for the purpose of preventing death from an opioid overdose. This practice is legal under New York State Public Health Law Section 3309 and under 10 N.Y.C.R.R. Section 80.138

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NYS/Westchester County Approved Opioid Overdose Prevention Program

For more information:

Visit us at: www.westchestergov.com/health

Like us at: facebook.com/wchealthdept

Follow us at: twitter.com/wchealthdept

For drug treatment and counseling resources, visit the Department of Community Mental Health at: www.westchestergov.com/mentalhealth