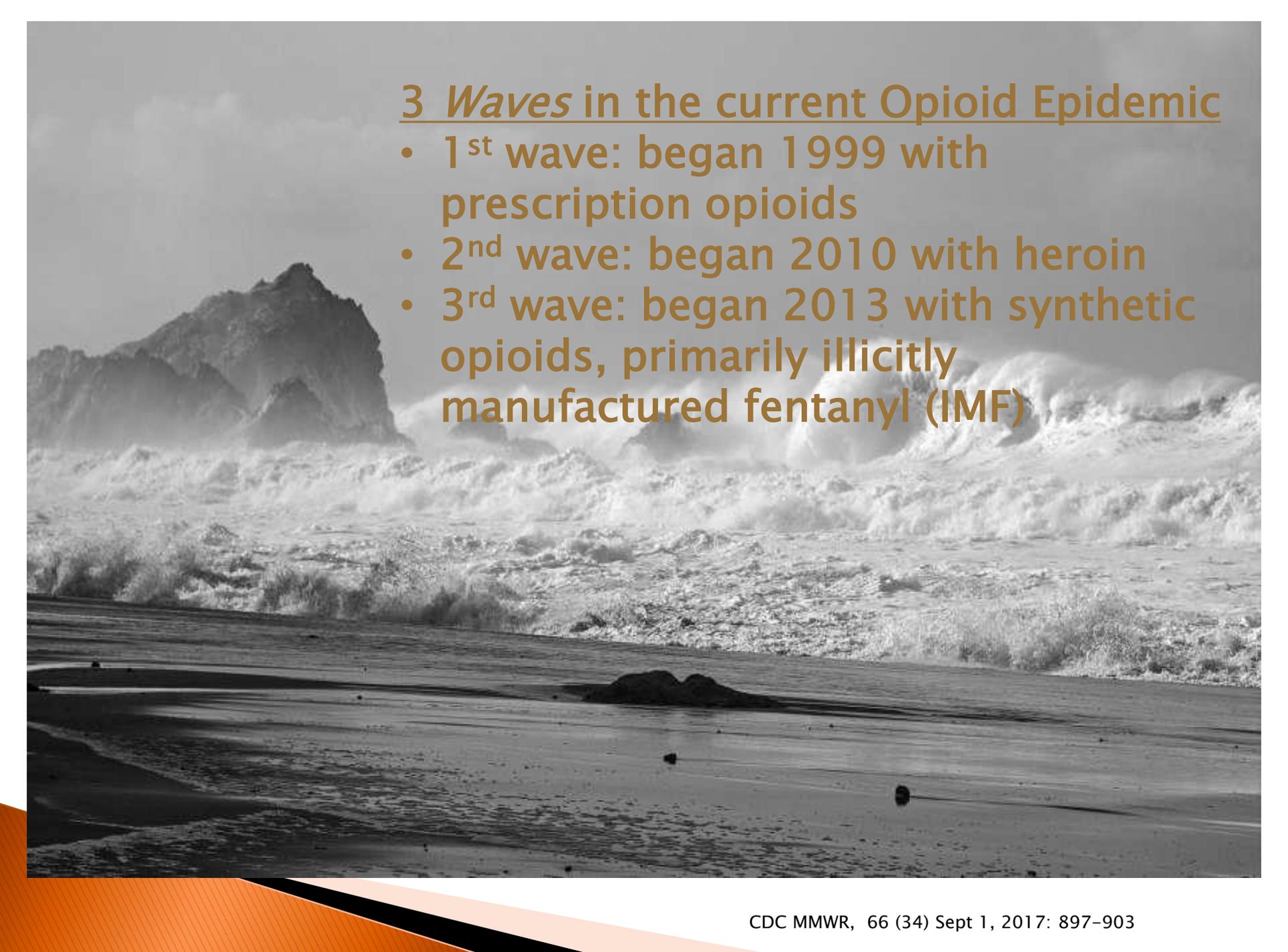


# The Opioid Epidemic & Naloxone (Narcan)

*Susan (Wolfe) Bouffard, PhD*  
*DMHAS*

## Disclosure Statement:

I have no relevant financial relationships with commercial interests now nor within the last 12 months.



### 3 Waves in the current Opioid Epidemic

- 1<sup>st</sup> wave: began 1999 with prescription opioids
- 2<sup>nd</sup> wave: began 2010 with heroin
- 3<sup>rd</sup> wave: began 2013 with synthetic opioids, primarily illicitly manufactured fentanyl (IMF)

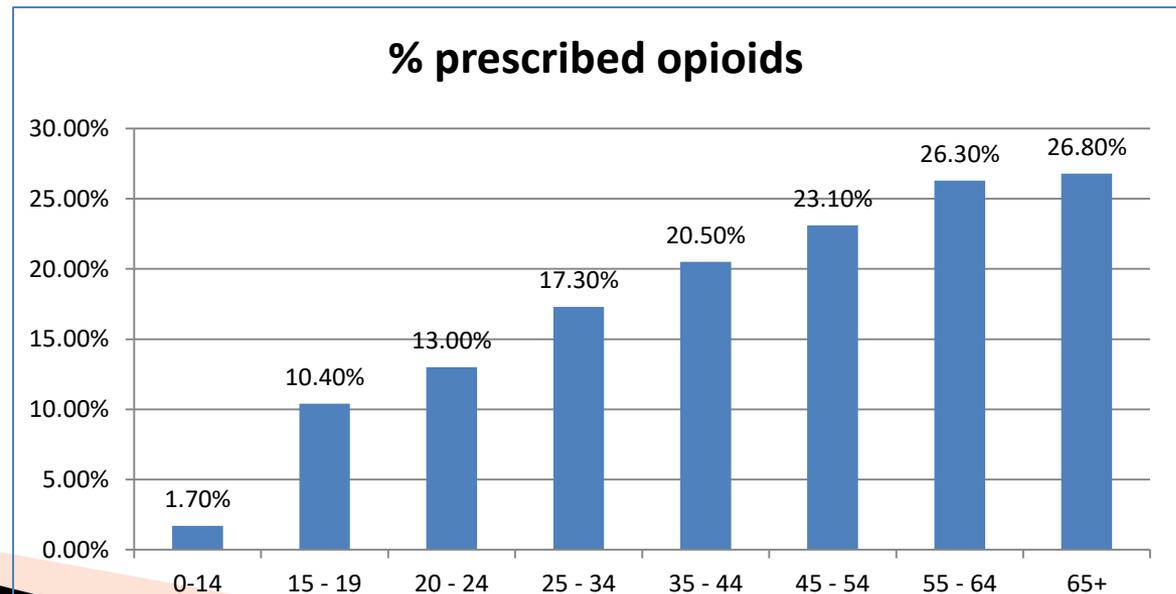
# Prescription Opioid Misuse

- People may still start with prescribed opioids, even if they transition
- Between 1999 – 2010 US prescribing of opioids nearly quadrupled
- People keep unused prescription opioids, but don't lock them up
- Most prescription opioids that are misused come from family and friends
- Lack of perceived risk of prescribed opioids



# 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes, U.S.

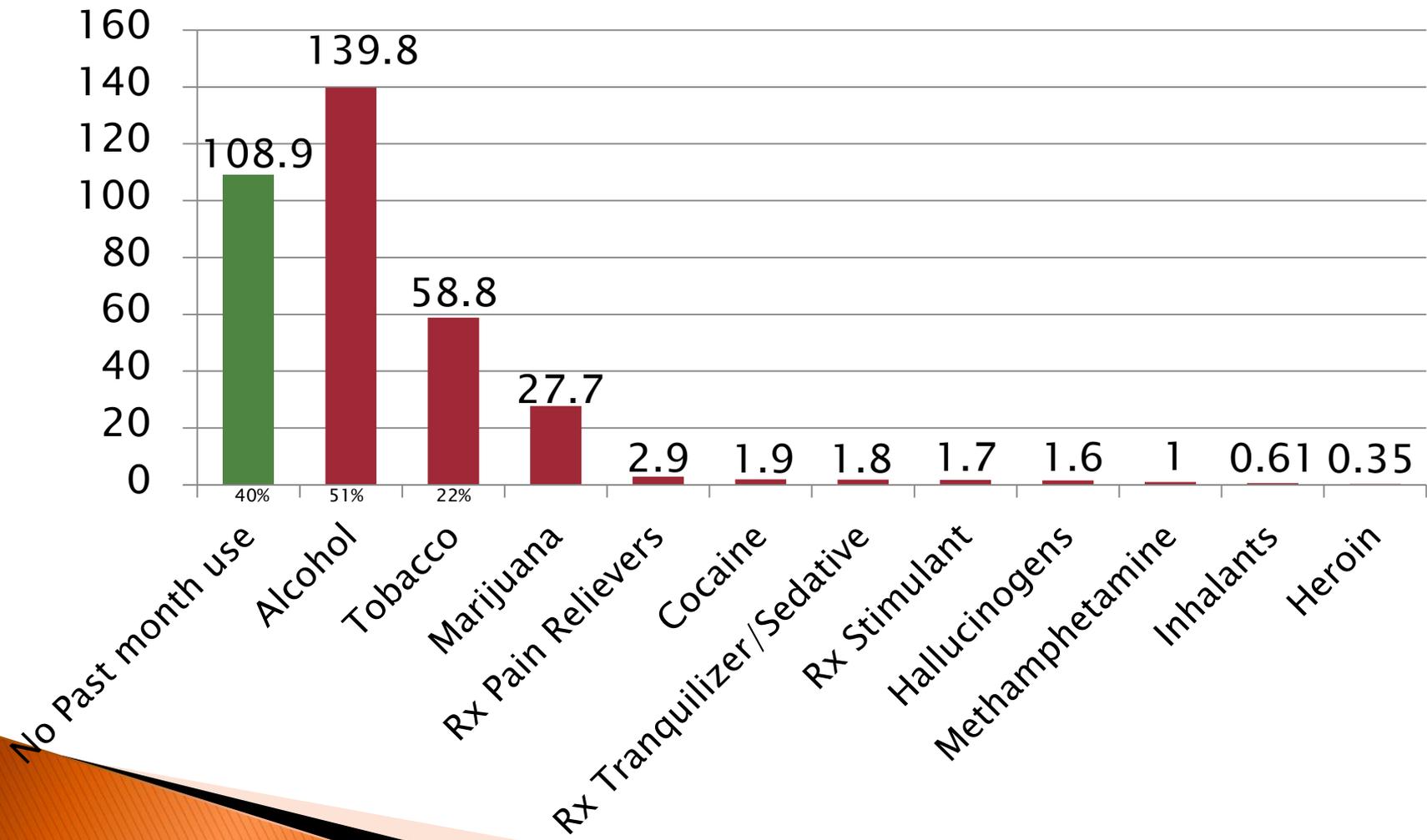
- ▶ In 2017: 191,146,822 opioid prescriptions dispensed
- ▶ 56,935,332 persons (17.4% of the US population) filled at least one opioid prescription in 2017 (avg = 3.4 prescriptions)
  - 14.8% males and 19.9% females
  - Most went to older age groups:



## 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes, U.S., 2006 – 2017

	2006	2017	% change
Prescribing Rate of all Opioids	72.4/100 persons	58.5/100 persons	-19.1
Prescribing Rate for High-dose Opioids	11.5/100 persons	5.0/100 persons	-56.5
Days of supply per prescription: $\geq 30$	17.6	24.6	+39.8
Days of supply per prescription : $< 30$	54.7	33.9	-38.0
Avg. daily dose (MME) per prescription	59.7	45.3	-24.1
Avg. MME per prescription	828.2	873.4	+5.5
Avg. days supply per prescription	13.3	18.3	+37.4

# Past Month Substance Use among Persons 12 and Older: (in millions)



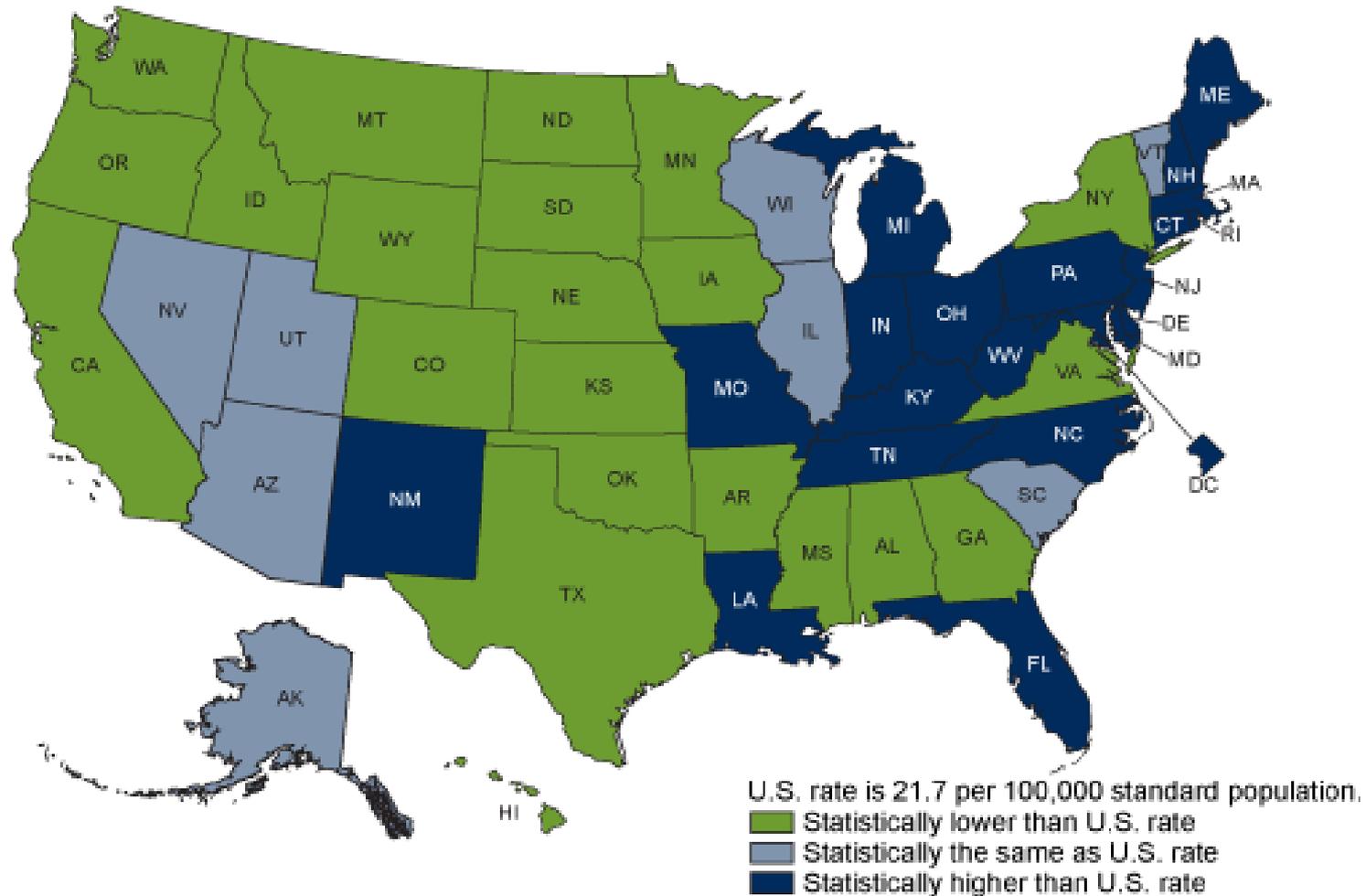
# OVERDOSES:

> 700,000 ODs in the U.S. since 1999



# Age-adjusted drug overdose death rates, by state: United States, 2017

70,237 drug overdose deaths in the US in 2017



## Age Adjusted Death Rates by State, US 2017

#1: West Virginia (57.8)  
#2: Ohio (46.3)  
#3: Pennsylvania (44.3)  
#4: Kentucky (37.2)  
#5: Delaware/New Hampshire (37.0)  
#7: Maryland (36.3)  
#8: Maine (34.4)  
#9: Massachusetts (31.8)  
#10: Rhode Island (31.0)  
#11: Connecticut (30.9)  
#12: New Jersey (30.0)  
#13: Indiana (29.4)  
#14: Michigan (27.8)  
#15: Tennessee (26.6)  
#16: Florida (25.1)  
#17: New Mexico (24.8)  
#18: Louisiana (24.5)  
#19: North Carolina (24.1)  
#20: Missouri (23.4)  
#21: Vermont (23.2)  
#22: Utah (22.3)  
#23: Arizona (22.2)

Above  
the  
National  
Average

#24: Illinois/Nevada (21.6)  
#26: Wisconsin (21.2)  
#27: South Carolina (20.5)  
#28: Alaska (20.2)  
#29: Oklahoma (20.1)  
#30: New York (19.4)  
#31: Alabama (18.0)  
#32: Virginia (17.9)  
#33: Colorado (17.6)  
#34: Arkansas (15.5)  
#35: Washington (15.2)  
#36: Georgia (14.7)  
#37: Idaho (14.4)  
#38: Hawaii (13.8)  
#39: Minnesota (13.3)  
#40: Oregon (12.4)  
#41: Mississippi/Wyoming (12.2)  
#43: Kansas (11.8)  
#44: California/Montana (11.7)  
#46: Iowa (11.5)  
#47: Texas (10.5)  
#48: North Dakota (9.2)  
#49: South Dakota (8.5)  
#50: Nebraska (8.1)

Below  
The  
National  
Average

# CT Accidental OD Deaths



- ▶ 2015: 723
- ▶ 2016: 917
- ▶ 2017: 1036
- ▶ 2018: 1018

<b>Opioids Involved</b>	<b>93%</b>	<b>US: 66%</b>
<b>Fentanyl</b>	<b>74%</b>	
<b>Heroin</b>	<b>38%</b>	
<b>Prescription Opioid</b> <small>(oxycodone, oxymorphone, hydrocodone, hydromorphone &amp; tramadol)</small>	<b>14%</b>	
<b>Total ODs involving alcohol</b>	<b>26%</b>	
<b>Total ODs involving BZDs</b>	<b>27%</b>	
<b>Total ODs involving cocaine</b>	<b>32%</b>	

# 2018 OCME data (N=1018)

## Accidental Drug Related Deaths

Males: 73%	Females: 26%
White/Non-Hispanic	76%
White/Hispanic	13%
Black/Non-Hispanic	9%
< 20	<1%
20s	16%
30s	25%
40s	23%
50s	26%
60s	10%
70+	<1%

# Typical OD Victim in CT in 2018

A non-Hispanic white male between the ages of 30 – 59 who was using opioids, probably fentanyl and other substances. On the day he overdosed, so did two other people.

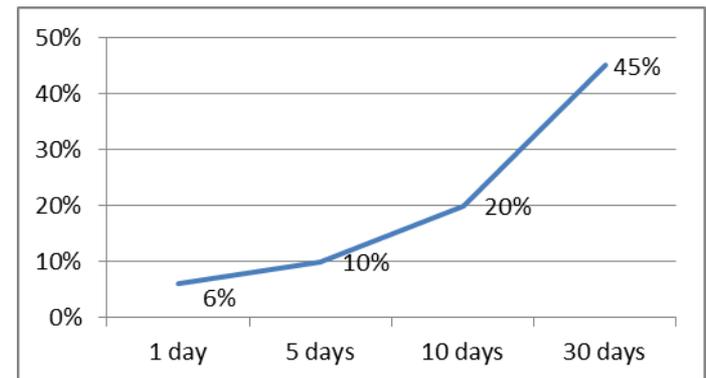
# Who is at Risk with Opioids?

- ▶ Children/Adolescents/Adults who access unsecured medications
  - ▶ Teenagers experimenting/partying
  - ▶ Seniors prescribed multiple medications who may have cognitive & medical issues
  - ▶ Chronic pain patients on long-term opioids
  - ▶ Medicaid patients prescribed more opioids
  - ▶ Young adults (18–25) who use at higher rates
- 

# Characteristics of Initial Prescription Episodes & Likelihood of Long-Term Opioid Use (CDC: MMWR Mar 17, 2017/66 (10): 265–9)

- ▶ 1.3 m patients who were 18+, cancer-free, with no history of opioid abuse with at least 1 opioid prescription between June '06 – September '15 were followed over time
- ▶ An initial prescription for 1 day of opioids resulted in a 6% chance of being on opioids at one year
- ▶ The longer the initial opioid prescription, the greater the risk of long-term use

Chance of still using opioids at one year



# Greatest Risk of Overdose

- ▶ History of Overdose
- ▶ History of Substance Use Disorder (SUD)
- ▶ Taking Opioids and Benzodiazepines (BZDs)
- ▶ ↓ Tolerance for opioids due to a break in use (incarceration, detox, hospitalization, rehab)
- ▶ On doses of opioids  $> 50$  MME/day

# CDC Guidelines for prescribing opioids for chronic pain

1. Don't start with an opioid
2. Set goals for pain and for function
3. Discuss risks/benefits & provider/patient responsibilities
4. Start with immediate release (not ER/LA)
5. Start with lowest effective dose (avoid > 90 MME)
6. Prescribe for expected duration of pain
7. Regularly assess risks & benefits
8. Assess risk factors and take steps to reduce risk
9. Check PDMP (web-based database of CS dispensed)
10. Urine drug screening
11. Don't combine Opioids and Benzodiazepines
12. Arrange for MAT (methadone/suboxone) for those who develop Opioid Use Disorder

# Naloxone Distribution Programs

- ▶ Naloxone has been around since 1971
- ▶ Naloxone Distribution Programs started in 1996
- ▶ All 50 states now have naloxone access laws
- ▶ Strategies/legislation vary by state
- ▶ Education is an expectation

# Naloxone (Narcan): IM & IN

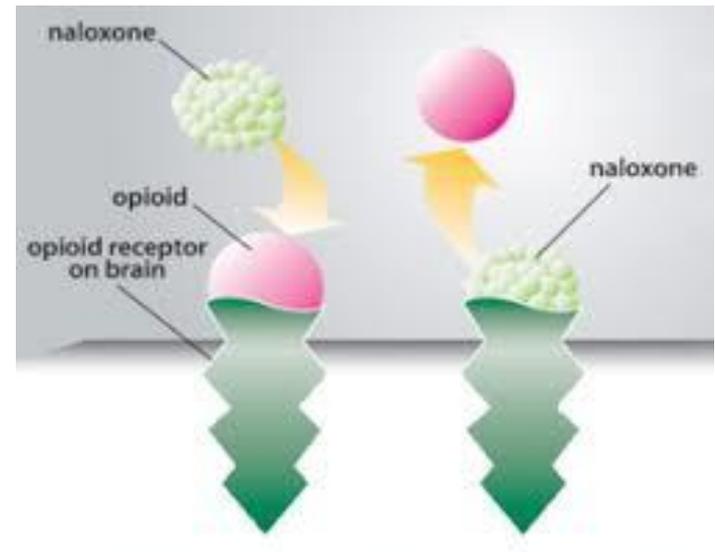


# Naloxone (Narcan)

- ▶ Prescription medication
  - ▶ Safe medication
  - ▶ Only has an effect if the person has opioids in their system
  - ▶ You cannot get high from it, it has no abuse potential/street value, and if you are dependent, it causes withdrawal
  - ▶ Its only function is opioid overdose reversal
- 

# How does Narcan Work?

- ▶ In an opioid overdose, the automatic drive to breathe is diminished
- ▶ Narcan “steals the spot” of the opioid in the brain receptor site for 30 – 90 minutes – so breathing resumes while the Narcan lasts
- ▶ Works on any opioid



# Standard Training on Naloxone (Narcan)

- ▶ Identifying an Opioid Overdose
- ▶ Naloxone (Narcan) administration
- ▶ Calling 911
- ▶ Resuscitative efforts
- ▶ Recovery Position



# Identifying an Opioid Overdose

- ▶ Unresponsive or minimally responsive
  - ▶ Blue or gray face, especially fingernails and lips
  - ▶ Shallow breathing with rate less than 10 breaths per minute or not breathing at all
  - ▶ Pinpoint pupils
  - ▶ Loud, uneven snoring or gurgling noises
  
  - ▶ Other evidence: known opioid user, track marks, syringes, pills or pill bottles, information from bystanders
- 

# Try to rouse them

- ▶ Call their name and shake them
- ▶ Check for a pain response: rub hard up and down on the person's sternum with your knuckles
- ▶ **IF NO RESPONSE: Administer Naloxone and CALL 911**

# Intramuscular Administration



- Clean with alcohol wipe
- Inject into muscle (shoulder or thigh) at 90°
- Push in plunger



# Intranasal Naloxone Device



- Pull off plastic caps, screw spray device onto syringe
- Pull plastic cap off the vial and screw into bottom of syringe
- Spray half of vial up one nostril and half up the other

# Auto-Injector Naloxone Device



**Talks you through the process.**

# Narcan Nasal Spray

- ▶ With one hand under their neck, tilt their head back
- ▶ With the other hand, insert the device into one nostril until top of fingers touch bottom of nose
- ▶ Press firmly on the plunger & spray into nose



recently purchased by  
Emergent Biosolutions



# Call 911

- ▶ Provide as much information as possible, including about the person's breathing
- ▶ Describe exactly where the person is located
- ▶ They may provide instructions

# Resuscitation

## ▶ Rescue Breathing

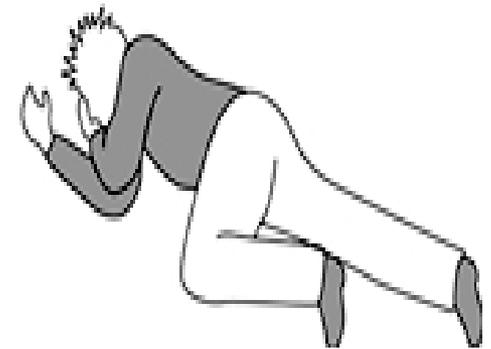
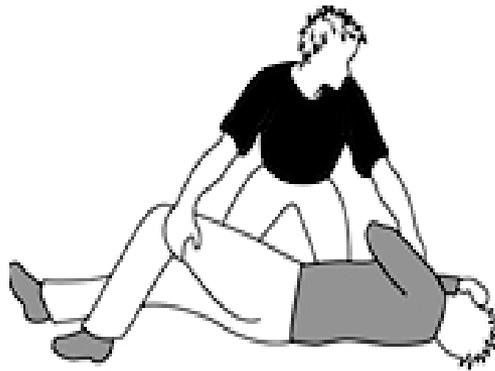
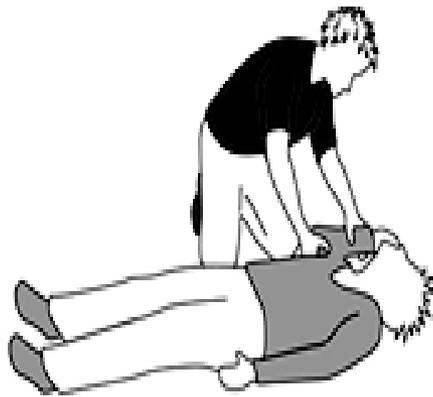
- ▶ AHA Guidelines (1 / 2018) for suspected Opioid OD:
  - if not breathing normally, but has pulse – provide rescue breaths every 5–6 seconds
  - if no pulse – provide CPR and administer naloxone (and use mobile phone to call 911 & put on speaker)

# How do the different formulations of naloxone compare?

- ▶ All formulations are in the standard dose range (0.4– 2.0 mg) except Narcan Nasal Spray (4.0 mg)
- ▶ CT Medicaid and most commercial insurance will cover (may be co-pay/deductible)
- ▶ Cost varies considerably, but for 2 doses out of pocket:
  - \$60–\$100
  - \$75 “public interest organization” or \$120–150
  - Started \$800



# Rescue Position



# Afterwards

- ▶ People usually revive in 2 – 3 minutes, feeling dazed and/or confused and not realizing that they've overdosed
  - ▶ They might be in withdrawal (about 1% are agitated)
  - ▶ If the person doesn't respond to the Naloxone within 2–3 minutes, give a second dose
  - ▶ The person could re-overdose based on how much they used and how long the Naloxone lasts; don't let them use more opioids
  - ▶ They should be monitored for at least one hour
- 

# CT Narcan Legislation

- ▶ PA 11–210: Good Sam Law; ↑ calls to 911
- ▶ PA 12–159: Naloxone can be prescribed to anyone, but only prescribers protected
- ▶ PA 14–61: Person administering protected
- ▶ PA 15–198: Certified pharmacists can prescribe/dispense; CMEs; checking PDMP
- ▶ PA 16–43: 7 day limit on opioid prescribing; PDMP entries by next business day & weekly for veterinarians; expanded definition of “authorized agents” that can check the PDMP

# CT Narcan Legislation: PA 17-131

- ▶ **More Opportunity to Dispose of Controlled Substances (CS)**
  - DCP can take custody of/destroy excess/unwanted
  - Nursing Homes/OP Surgery Centers can dispose with 2+ leaders
  - Home Health Agency RNs can dispose
- ▶ **Electronic Transmission of CS Prescriptions**
  - Exceptions: technical/electronic lack/problem, prescriber anticipates harmful delay/negative impact on patient care, or an out of state pharmacy is dispensing
- ▶ **Revised limit on Prescribing Opioids to Minors**
  - From 7 to 5 days with same exceptions/documentation as before
  - Risks to be discussed with patient: addiction/OD, mixing with alcohol/Benzodiazepines (BZDs), reason for opioid
- ▶ ASAM Criteria for Substance Use Treatment Admissions
- ▶ Each municipality will have at least one 1<sup>st</sup> responder trained/equipped with naloxone
- ▶ DCP can share CPMRS info with other state agencies
- ▶ Mandatory Insurance Coverage of Inpatient Detox
- ▶ Voluntary Non-Opioid Directive Form
- ▶ DPH will post info on how prescribers can prescribe Suboxone
- ▶ ADPC assignments

# CT Narcan Legislation: PA 18-166

- ▶ Study feasibility of drug courts
- ▶ Persons with unwanted CS may return them to prescriber;
- ▶ Emergency: prescribers can prescribe/dispense/administer 72 hours of CS to themselves/family/household relatives
- ▶ Agreements between prescribers & organizations wanting to distribute/train on naloxone; staff must be trained 1<sup>st</sup>; agreement must cover: storage, handling, labeling, recalls & recordkeeping
- ▶ ADPC will create workgroup to look at data and investigate other strategies for responding to the opioid crisis

# PA 19 – 191 An Act Addressing Opioid Use

- ▶ Consultation offered when picking up Rxs \*
- ▶ Pharmacy techs can access PDMP for pharmacist
- ▶ Drug wholesaler/manufacturers will report to DCP\*:
  - Suspicious orders (atypical size, frequency or pattern)
  - Possible diversion
- ▶ Can't deny life insurance just for narcan Rx\*
- ▶ 12+ wks Rx for opioids for pain must have treatment agreement/care plan in medical record\*:
  - Treatment goals
  - Risks of opioid use
  - Urine drug screening
  - Expectations (what would discontinue the Rx)
  - Non-opioid treatment options

\*Effective 10/1/19

# PA 19 – 191 An Act Addressing Opioid Use

- ▶ By 1 / 1 / 20, colleges/universities will have naloxone policy that:
  - Identifies medical/public safety professional responsible for purchase, storage & distribution on each campus
  - Specifies location on each campus
  - Ensures students & staff know location & can access
  - Requires maintenance consistent with manufacturer's guidelines
  - Requires a call to 911 or local EMS when naloxone used, unless medical treatment already provided
  - Must be approved by DCP before implementing and posting on the college/university website

# PA 19 – 191 An Act Addressing Opioid Use

- ▶ By 1 / 1 / 20, DMHAS will report on:
  - Review of in-home treatment/recovery services for OUD (especially MAT for Medicaid recipients who went to the ED with OUD and/or suspected opioid OD and are at ongoing risk)
  - The protocol for police detaining a person suspected of an opioid OD
  - Implications of involuntarily transporting a person suspected of an opioid OD to the ED and referring them to a Recovery Coach

# PA 19 – 191 An Act Addressing Opioid Use

- ▶ Substance Use Programs treating OUD, at the time of admission, will\*:
  - Educate client on naloxone & its administration
  - Provide naloxone/prescription for naloxone if they have prescriber services
  - Educate family members/significant others on naloxone and its administration
- ▶ Hospitals & EMS will report opioid ODs to DPH\*
- ▶ By 1 / 1 / 20, hospitals treating patients for nonfatal opioid OD will conduct MH screening/assessment and share results with the patient
- ▶ By 1 / 1 / 20, DPH will share OD data with respective health department where OD occurred

\*effective 10/1/19

# Storage and Expiration

- ▶ Store in moderate temperatures
  - ▶ Out of direct sunlight
  - ▶ Not in refrigerator
  - ▶ Generally expires after 12 – 24 months
- 

# Security & Disposal

- ▶ Medication lock boxes
- ▶ Medication drop boxes
- ▶ DEA take back days
- ▶ Pharmacy disposal bags



# NORA

- ▶ A free tool from the CT Department of Public Health
  - ▶ A progressive website, rather than an app per se, for desktop or phone use
  - ▶ go to [www.norasaves.com](http://www.norasaves.com) to add to your phone (instructions also on the website)
  - ▶ Covers everything you need to know, including how to access narcan, how to administer it, legislation, submitting data, etc.
- 

# NORA = Naloxone & Overdose Response App

nora

NALOXONE + OVERDOSE RESPONSE APP



Signs of an Overdose



Overdose Response



How to Give Naloxone



I Gave Naloxone

## Your Legal Protections

Naloxone and Where to Find It

Prevent Opioid Overdose

What are Opioids?



[DRUGFREECT.ORG](http://DRUGFREECT.ORG)



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# Change the Script, Live Loud & DrugFreeCT.org

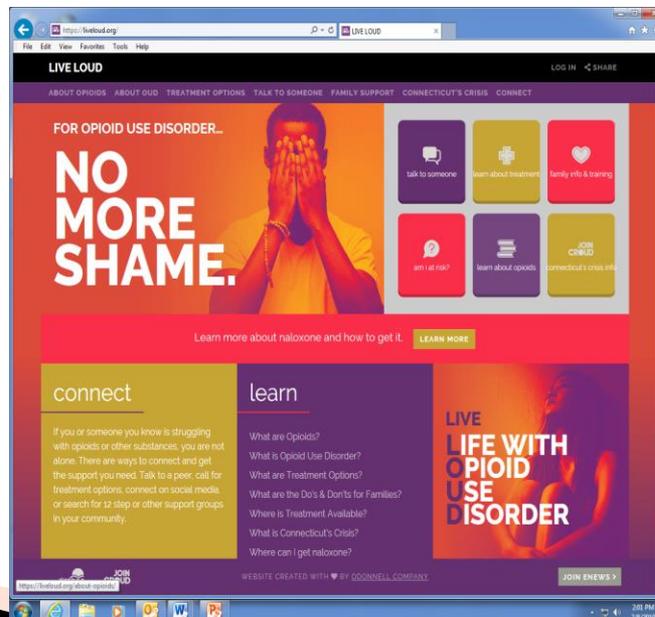
Raise awareness of risks of prescription drugs



Info about opioids, treatment connections, recovery supports & harm reduction

drugfreeCT.org

Covers the continuum, scope of the crisis, storage/disposal, OD prevention & treatment/recovery supports



# Other Resources

- ▶ DMHAS website:  
<http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=509650>
- ▶ Prescribe to Prevent. org
- ▶ DMHAS help for opioid use: 1-800-563-4086
- ▶ Naloxone Prescribing Pharmacists:  
<https://data.ct.gov/Health-and-Human-Services/Naloxone-Prescribing-Pharmacists/qjtc-pbhi>
- ▶ Susan (Wolfe) Bouffard, PhD
  - [susan.bouffard@ct.gov](mailto:susan.bouffard@ct.gov)
  - 860-418-6993

# Questions / Discussion