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Increasing Narcan Distribution in a Primary Care Setting

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Increasing Narcan Distribution in a Primary Care Setting

Family Medicine Residency at Central Maine Medical Center, Lewiston, ME
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Problem Identification

Problem: opioid use and overdose

- Substance use identified in Maine[1], Androscoggin County[2], and Central Maine Medical Center's[3] 2022 health needs assessments

Need: increase opportunities to discuss and distribute Narcan in a primary care setting

- CDC 2022 Clinical Practice Guideline for Prescribing Opioids for Pain Recommendation 8:

  > Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.[4]

- Due to the Maine Naloxone Distribution Initiative (NMDI) that has run since 2019, Narcan is widely available to anyone who wants it[5]

AHEC Focus Areas: medical practice transformation, current and emerging health issues

Public Health Cost

Maine Overdose Statistics

- In 2020, the rate of overdose deaths (all substances) in Maine per 100,000 residents was 37.3, which is much higher than the rate of 21.5 in the U.S. overall in 2019 [1]
- Androscoggin County was higher still at 47.9 per 100,000 residents[2]
- In 2016-2018 in Androscoggin County, the rate per 10,000 of opiate poisoning hospitalizations was 1.5, the rate of ED visits was 9.7 [2]
- January-April 2023 there were 25 fatal overdoses (all drugs) in Androscoggin County[6]

Maine Narcan Statistics

- 2022: 2,639 overdose reversals reported across the state[5], 699 in Q1 of 2023 [7]
- 123,025 doses distributed in 2022 [5], 33,774 in Q1 of 2023 [7]
- Top image from Maine Drug Hub naloxone dashboard [8]

CDC estimated costs of opioid use disorder in 2017 [9]:

- Nationally: opioid use disorder $471 billion and fatal opioid overdose $550 billion
- Maine: $2,654,600,000 for OUD, $4,157,300,000 for fatal opioid overdose
- Maine OUD:
  - Cost to health care: $176,500,000
  - Lost productivity: $176,500,000
  - Reduced quality of life: $2,198,200,000
- Maine fatal opioid overdose:
  - Cost to health care: $2,000,000
  - Lost productivity: $519,500,000
  - Value of statistical life lost: $3,635,800,000
- Bottom image shows that Maine ranks among top 10 states in per capita cost of OUD and fatal overdose

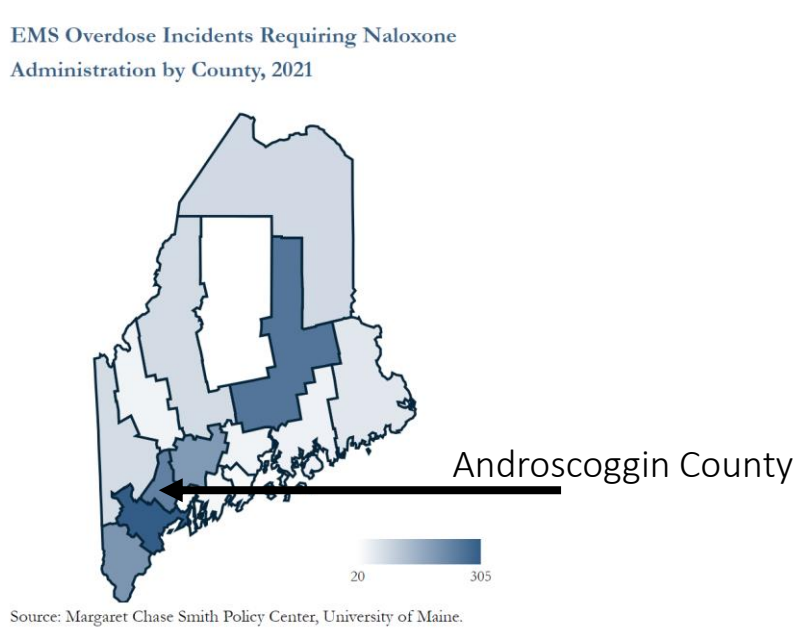
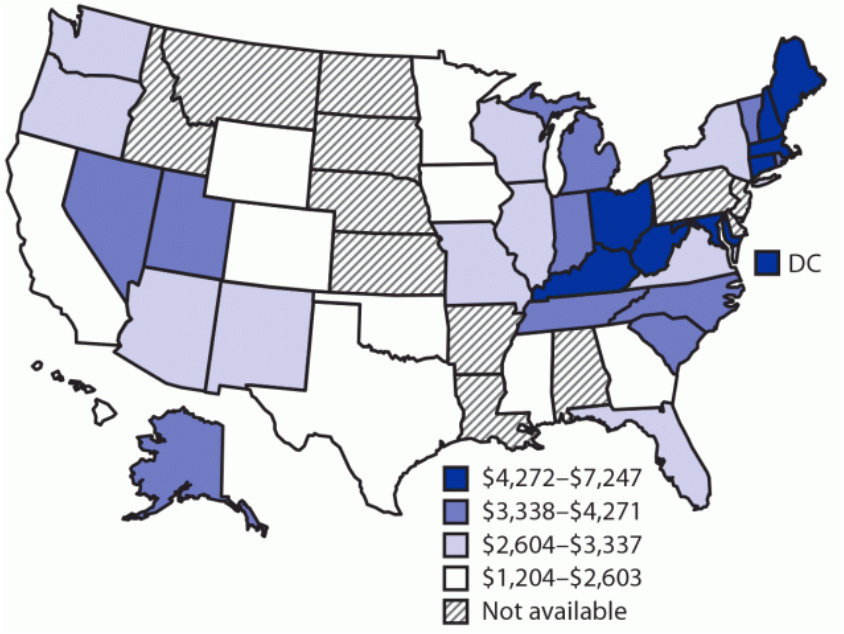


FIGURE. Per capita combined costs* of opioid use disorder and fatal opioid overdose — United States, 2017



Bronte Roberts LCPCc, LCDC, CRC, Behavioral Health Care Manager

- Clinic lead on Narcan distribution, FMR is a Tier II distribution center
- Distribution of kits for free to any patient and anyone who comes in wanting one, but too few given out
- Also supply lock boxes for controlled substances, has never been asked for one by residents
- Kit contains: 2 boxes of Narcan (4 doses), instructions on use, safe-injection resources, recovery program resources, fentanyl test strips, etc.
- "Wanting and getting it is no issue, it's those who don't know that they should have it around who don't have it"
- Major barrier in this area is lack of providers in general, even fewer who do MAT or involved in recovery programs
- Separation between "pain patients" and OUD patients, "the ones using heroin or fentanyl have been narcaned before, they've done it to someone else, they know how to use it"
- Sees residents 1) not having enough time with patients to have this conversation and 2) not comfortable with convo (except for a few going into addiction medicine) so they refer to someone else and it's a "missed opportunity to potentially save a life"

Resident survey

- 10 responses from all three years
- Generally good comfort with having the discussion (70% said very!) none talk about overdose prevention with patients for whom they prescribe an opioid *every time*, and 30% never or rarely do
- Much higher rates of discussion with patients with OUD or seen for MAT
- All respondents would be open to more training on how to approach conversation
- Most useful interventions rated: integrated into rooming>info in waiting room=dot phrase>training during intern orientation>presentation during didactics
- "TIME! I do handout narcan from our supply in the closet, but time is a factor - if it was already in the rooms or easier to grab, I might be more inclined to hand it out. Screening question would be extremely helpful."

Medical Assistants

- Review medication list when rooming patients
- Protocol is to ask if patient has naloxone at home if prescribed an opioid
- Issue is turnover and MA's not recognizing opioid names
- Suggestion: add question of Narcan to rooming instructions like GAD-7, PHQ-9, A1c, UA, etc.

Primary Care Perspective

Family Medicine Residency at Central Maine Medical Center

Community Perspective

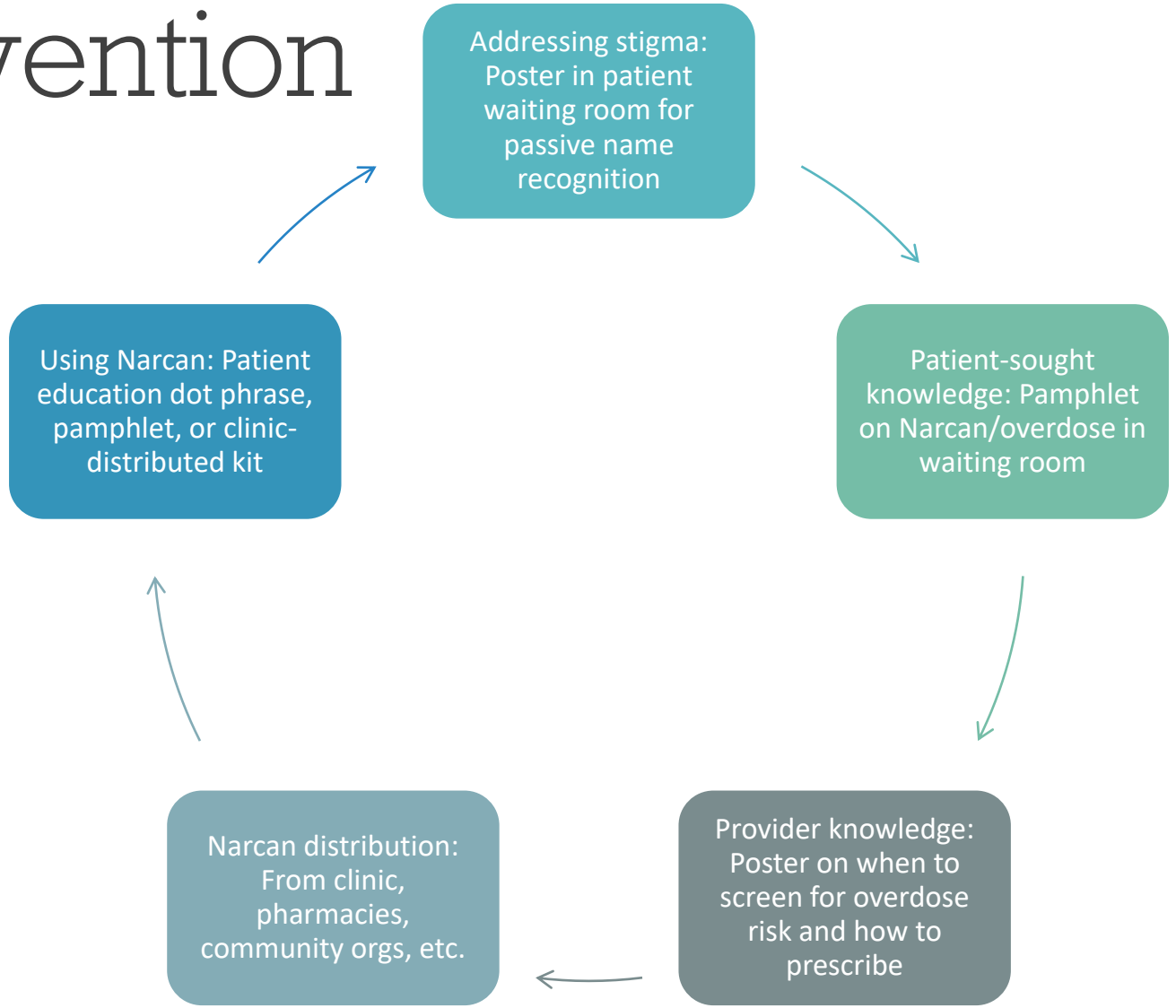
Lewiston/Auburn, Maine

David Bilodeau Androscoggin OPTIONS liaison/Team lead-SUD Community Program

- OPTIONS = Overdose Prevention Through Intensive Outreach Naloxone and Safety is a "coordinated effort of the Maine Office of Behavioral Health and other state agencies to improve the health of Mainers with substance use disorder. OPTIONS supports treatment, harm reduction and recovery, and aims to reduce the number of fatal and non-fatal drug related overdoses."[11]
- Project Support You was developed by David as a ride-along with Lewiston/Auburn Police department for opioid overdoses and allows him to independently follow-up with survivors and families to prevent recurrence and start recovery process
  - Leaves kit every time containing his phone number, recovery organizations accepting new patients (no waiting list), fentanyl test strips, and Narcan
  - Gets 80% show-up rate when patient themselves calls to make appointment when they're ready, vs 10% if he makes it for them
- Sees biggest issue for Narcan distribution as stigma
  - Public fear that places with Narcan availability will draw "users"
  - Ex: Someone has been anonymously leaving Narcan's in bus shelters and libraries, community members have called the police to have them removed and threatened to stop using these spaces because they don't want to see Narcan out in the community
- Successes: ER distribution after overdoses, Naloxboxes (grab-and-go containers), improved working relationship with LAPD, available in libraries, schools, and businesses, presence at more resource fairs
  - The over-the-counter designation has helped reduce stigma because it gets people talking but hasn't changed availability
- "With the public, you have to explain it in a way that makes sense to them. They don't see it affecting their lives, so I say 'If your granddaughter passed out in front of me, would you want me to Narcan her? Because you get marijuana laced with fentanyl and you can't tell me that she'll never smoke a joint.' And that seems to get through to them."
- Overlap with unhoused community
  - Majority of overdose calls
  - Often have used Narcan once already, see containers at scene
  - Stigma with addiction tied into stigma against unhoused folks, "people are afraid to walk into syringe exchanges even for Narcan out of fear of being seen in association with it"
- OD-ME app: people don't know about it or can't use if they don't have wifi/power

Analysis and Intervention

- Multiple failures in system
  - Stigma around opioids, asking for help
  - “Pain patients” knowledge on overdose
  - Screening for risk factors for overdose
    - Clinic-specific: not able to be automatic part of rooming process
    - Provider knowledge on how to screen
  - Remembering to distribute/prescribe
  - Patient knowledge on how to use, available resources, etc.
- Two audiences:
  - Patients have to want it, or at least be amenable to talking about Narcan
  - Providers have to remember to bring it up
- Goal: target multiple parts of system, both provider and patient levels
- Interventions: Pamphlet, posters, and dot phrase at the end of the PowerPoint
  - Reminder email to residents that they can cue rooming staff to ask about Narcan at home as they run through medication list
  - All materials emailed to residents



Results

- Response to survey: “I realized I should be having these discussions a lot more”
- Resident to author: “I gave out one of the Narcan kits to that patient we saw because even though she doesn’t use opioids her partner does!”
- Attending about pamphlet: “These look great, I think patients will like them.”
- Resident on dot phrase: “That sounds really useful, it would save time pulling in different resources or writing instructions by hand. I’ll check my email for the link!”

Avenues for Evaluation of Intervention and Limitations

Evaluating interventions within the Family Medicine Residency:

- Count how many patient pamphlets get taken from waiting room
- Quantify how many patients bring up overdose or Narcan unprompted or if they have a prescription written
- Track number of Narcan kits given out by clinic (ongoing already by Bronte), and see if number increases from pre- to post-intervention
- Post-survey for residents after a few weeks of materials posted to see if frequency of conversations increased

Evaluation of distribution within Lewiston:

- Track number of Narcan kits given out by various organizations (ongoing by David)
- Number of lives saved vs fatal overdoses (ongoing at county level by Dept of Health)
- Number and variety of orgs amenable to having Narcan on hand

Limitations

- Stigma around mental health, addiction, opioids, unhoused community is difficult to measure through surveys
- Provider limitations on implementation: time, attention, memory constraints (not checking email for materials, placement within clinics/hospitals that have different distribution methods)
- All interventions require attention by patient or provider, which can vary with person, place, and time, no intervention was made automatic within system
- Collected data has low power for true comparison (ex: having only ten respondents to survey prohibited statistical analysis)

Future Directions

Within the Family Medicine Residency or other outpatient clinic:

- Narcan available in waiting room (David's suggestion)
- Asked by MA's at every visit for a patient with a prescribed opioid (requires MA training but reduces burden on providers to research med list ahead of time)
- Narcan prescribed, kit given, or accidental overdose conversation documented with every new opioid prescription *automatically*
- Dedicated intern education for comfort on when and how to have overdose prevention conversation
- Better quantification of number of kits given out and to whom – not a clipboard in a back room

In Lewiston or local community:

- Availability of Narcan or overdose-prevention kits in public spaces like police stations, public libraries, willing businesses, resource fairs, medical offices, etc. (improving in Lewiston!)
- Conversations about overdose prevention in public spaces to help end stigma (resource fairs, fliers)
- Integration of social worker or case manager into police responses to overdoses to ensure resource distribution and enable follow-up (it's been a success in Lewiston!)
- Patients surviving overdose discharged from emergency departments with Narcan in-hand (like at CMMC)
- Increase awareness of OD-ME app (overdose recognition and step-by-step rescue actions)

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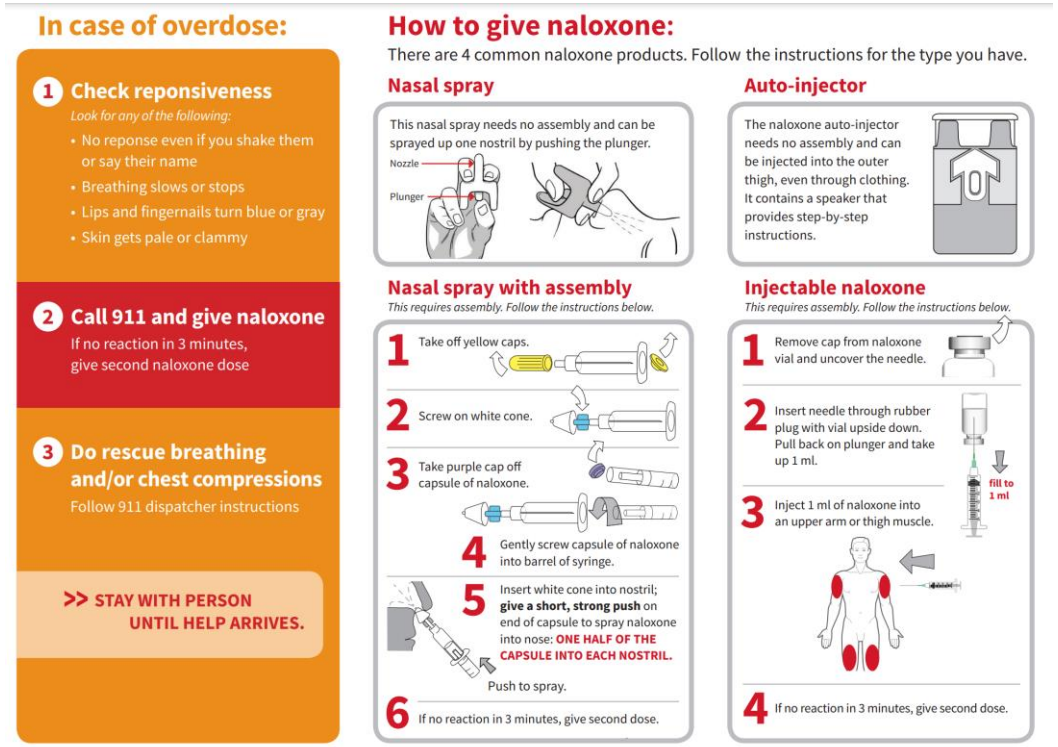
Resident Survey Questions

1) What year are you in your training?
2) When you prescribe an opioid, how often do you have a discussion with your patient about overdose or naloxone? (for next three: never, occassionally, half the time, most times, every time)
3) When you see a patient who is currently using non-prescribed opioids, how often do you have a discussion with your patient about overdose or naloxone?
4) When you see a patient that is seen for MAT (with you or someone else), how often do you have a discussion with your patient about overdose or naloxone?
5) How comfortable do you feel having discussions about opioid overdose prevention? (not at all, somewhat, very, or depends on the patient/context)
6) Would you like more training on identifying when to have these conversations? (Y/N/maybe)
7) Would you like more training on identifying how to approach these conversations? (Y/N/maybe)
8) What tools would be most helpful to increase your comfort or frequency with which you have these conversations? Options: presentation during resident education, creation of a “dot phrase” for patient education printout, integrating “naloxone at home” screening question into intake process, dedicated training during intern orientation, info on naloxone in waiting room, other
9) General written feedback

Credit to Boston Medical Center for this poster, their logo is cut off, found at prescribetoprevent.org[12]

Two placed in waiting room at FMR



In case of overdose:

1 Check reponsiveness

Look for any of the following:

- No reponse even if you shake them or say their name
- Breathing slows or stops
- Lips and fingernails turn blue or gray
- Skin gets pale or clammy

2 Call 911 and give naloxone

If no reaction in 3 minutes, give second naloxone dose

3 Do rescue breathing and/or chest compressions

Follow 911 dispatcher instructions

>> STAY WITH PERSON UNTIL HELP ARRIVES.

How to give naloxone:

There are 4 common naloxone products. Follow the instructions for the type you have.

Nasal spray

This nasal spray needs no assembly and can be sprayed up one nostril by pushing the plunger.

Nozzle

Plunger

Auto-injector

The naloxone auto-injector needs no assembly and can be injected into the outer thigh, even through clothing. It contains a speaker that provides step-by-step instructions.

Nasal spray with assembly

This requires assembly. Follow the instructions below.

1. Take off yellow caps.
2. Screw on white cone.
3. Take purple cap off capsule of naloxone.
4. Gently screw capsule of naloxone into barrel of syringe.
5. Insert white cone into nostril; **give a short, strong push** on end of capsule to spray naloxone into nose: **ONE HALF OF THE CAPSULE INTO EACH NOSTRIL.** Push to spray.
6. If no reaction in 3 minutes, give second dose.

Injectable naloxone

This requires assembly. Follow the instructions below.

1. Remove cap from naloxone vial and uncover the needle.
2. Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.

fill to 1 ml

3. Inject 1 ml of naloxone into an upper arm or thigh muscle.
4. If no reaction in 3 minutes, give second dose.

What is an opioid overdose?

Opioids can cause bad reactions that make your breathing slow or even stop. This can happen if your body can't handle the opioids that you take that day.

TO AVOID AN ACCIDENTAL OPIOID OVERDOSE:

- Try not to mix your opioids with alcohol, benzodiazepines (Xanax, Ativan, Klonopin, Valium), or medicines that make you sleepy.
- Be extra careful if you miss or change doses, feel ill, or start new medications.

Now that you have naloxone...

Tell someone where it is and how to use it.

Common opioids include:

GENERIC	BRAND NAME
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morphine	MSContin, Kadian, Embeda, Avinza
Codeine	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic, Actiq
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

* Heroin is also an opioid.

For patient education, videos and additional materials, please visit **www.prescribetoprevent.org**

Opioid safety and how to use naloxone

A GUIDE FOR PATIENTS AND CAREGIVERS

Pamphlet Placed in Waiting Room

Credit to San Francisco Dept of Health, found at prescribetoprevent.org, 10 copies and team given link to print more[12]

Information for Prescribers

From Prescribe to Prevent, printout placed on central bulletin board within the FMR[13]

INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS: Prescribing Naloxone

Naloxone is the antidote for an opioid overdose. It has been used for decades to reverse respiratory depression associated with toxic exposure to opioids. Naloxone is not a controlled substance and can be prescribed by anyone with a medical license. Take-home naloxone can be prescribed to patients at risk of an opioid overdose. Some reasons for prescribing naloxone are:

1. Receiving emergency medical care involving opioid intoxication or overdose
2. Suspected history of substance abuse or nonmedical opioid use
3. Starting methadone or buprenorphine for addiction
4. Higher-dose (>50 mg morphine equivalent/day) opioid prescription
5. Receiving any opioid prescription for pain plus:
   a. Rotated from one opioid to another because of possible incomplete cross-tolerance
   b. Smoking, COPD, emphysema, asthma, sleep apnea, respiratory infection, other respiratory illness
   c. Renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS
   d. Known or suspected concurrent alcohol use
   e. Concurrent benzodiazepine or other sedative prescription
   f. Concurrent antidepressant prescription
6. Patients who may have difficulty accessing emergency medical services (distance, remoteness)
7. Voluntary request from patient or caregiver

Two naloxone formulations are available. Intra-muscular injection is cheaper but may be less attractive because it involves using a needle syringe. (IM syringes aren't widely used to inject controlled substances.) Intra-nasal (IN) spray is of comparabale effectiveness, but may be more difficult to obtain at a pharmacy. Check with pharmacist to see whether IM or IN is more feasible.

Billing for Clinical Encounter to Prescribe Naloxone

Most private health insurance, Medicare and Medicaid cover naloxone, but it varies by state.

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10
Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior.* 1982;7(4):363-371.

Screening, Brief Intervention & Referral to Treatment

SBIRT can be used to bill time for counseling a patient. Complete the DAST-10 and counsel patient on how to recognize overdose and how to administer naloxone, using the following sheets. Refer to drug treatment program if appropriate.

Billing codes

Commercial insurance: CPT 99408 (15 to 30 mins.)
Medicare: G0396 (15 to 30 mins.)
Medicaid: H0050 (per 15 mins.)

Pharmacist: Dispensing Naloxone

Many outpatient pharmacies do not stock naloxone but it can be easily ordered from major distributors. The nasal atomizer can be ordered from the manufacturer LMA (1-800-788-7999), but isn't usually covered by insurance ($3 each). It may take 24 hours to set up an account with LMA, and the minimum order size is 25.

PrescribeToPrevent.com v12.1

Dot Phrase - .narcanedu

You have been identified as possibly at-risk for overdosing on opioids
Opioids include heroin as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora) and hydromorphone (Dilaudid, Exalgo).

You are being provided a prescription for an antidote to opioids called **Narcan** (also known as Naloxone)

- Narcan can reverse the effect of opioids if a person *cannot* be awoken from a sleep or if they are breathing very slowly or not at all
- Narcan only lasts a brief time – a person can continue to suffer from the effects of an overdose even after receiving Narcan
- While it is not effective against overdose of other substances like alcohol, benzodiazepines (ex: Xanax), or xylazine, Narcan is not harmful if given to someone who doesn't need it
- You can play a part in preventing accidental overdose in yourself or others by keeping Narcan on hand, just like an EpiPen
- ***If you suspect that someone has overdosed, call 911 immediately after giving Narcan***

If you overdose on opioids, someone else needs to give you Narcan

- You should talk to family and friends about Narcan
- You should keep Narcan in a location easy to find
- You should keep the instructions about giving Narcan next to the medication

Administration information is available from the manufacturers in this video https://youtu.be/KEOq6fUWNtA and step-by-step instructions come with the medication or are attached at the end of this printout.

Where can you get Narcan?

- Available for free at the Family Medicine Residency clinic, just ask!
- As a prescription or over the counter in nearly all pharmacies (Walgreens, CVS, etc.), free with many insurance plans including MaineCare
- Get Maine Naloxone website https://getmainenaloxone.org/
- Maine Access Points https://www.maineaccesspoints.org/naloxone to order online and for training, call or text (207) 370-9445 for free naloxone
- Tri-County CommUNITY Recovery at 1155 Lisbon Street, Lewiston, (888) 304-4673
- Church of Safe Injection at 195 Main Street, Lewiston, (207) 241-2537

How do you lower the risk of opioid overdose?

- **Do not use illegal drugs or misuse prescription drugs.**
- **Do not mix drugs:** Mixing drugs together and mixing drugs with alcohol can cause an overdose.
- **Your tolerance can change:** Tolerance is how much drug your body can handle. If you take a break from a drug, your tolerance falls. This means that when you start again, your body cannot handle as much drug as before. Starting opioids again after a break (like illness, jail, hospital, rehab) increases the risk of overdose.
- **Other health problems increase your risk of an overdose:** If you have health problems like asthma, liver problems, kidney problems, or HIV/AIDS, your body cannot handle the effects of opioids. Medical problems make your risk of overdose higher.

Where can you get help with opioid addiction?

- Ask your provider if you or a loved one want more information on opioids, overdose prevention, or treatment for addiction
- Tri-County CommUNITY Recovery at 1155 Lisbon Street, Lewiston (888) 304-4673
- Church of Safe Injection at 195 Main Street, Lewiston (207) 241-2537 for needle exchange and Narcan
- Never Use Alone hotline 1-800-484-3731
- Maine Crisis Hotline (888) 568-1112 or 711
- General information 211 or out of state at (877) 463-6207 to find resources
- Eyes Open for ME www.eyesopenforme.org or 1-800-974-0062
- Narcotics Anonymous www.namaine.org or 1 (833) 436-6166
- OPTIONS program https://knowyouroptions.me/ for information on naloxone distribution and substance use
- OD-ME app on apple or android developed by the University of Maine and is a great tool for overdose rescue education
- Maine Access Points https://www.maineaccesspoints.org/naloxone, call or text (207) 370-9445 for more information
- Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov/
- Seeking Drug Abuse Treatment: Know What To Ask. NIDA. https://www.drugabuse.gov/sites/default/files/treatmentbrochure_web.pdf

To be included in end-of-visit patient education printout. Emailed to new interns and rising PGY2's and 3's, copy example posted in two places within the FMR. Pamphlet on prior slide attached at end.

Taken from the American College of Emergency Physician's and filled in with Androscoggin County and Maine-specific info[14]