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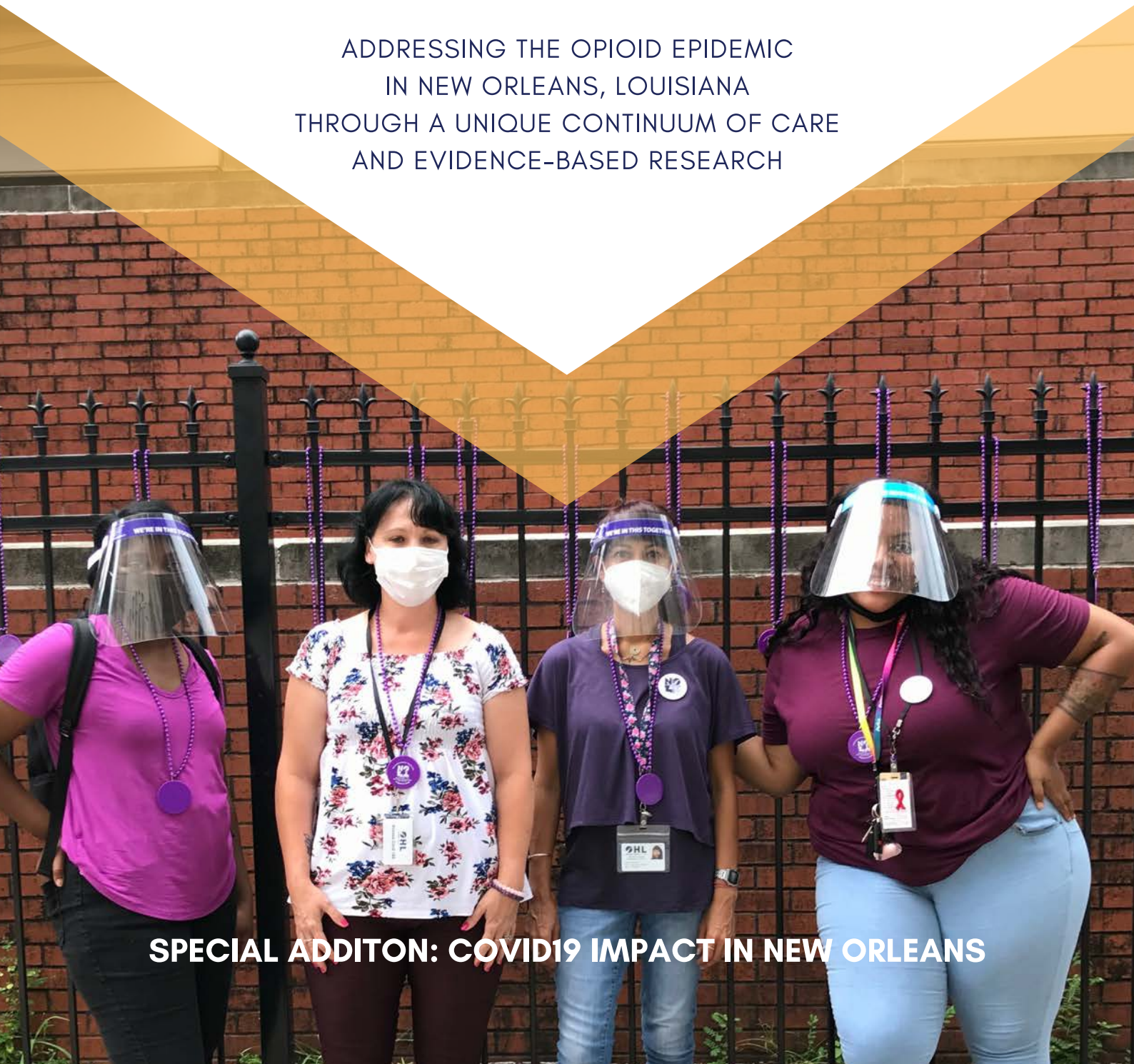
REVIVE. SURVIVE. **OVERDOSE PREVENTION**

2020 TOOLKIT

ADDRESSING THE OPIOID EPIDEMIC
IN NEW ORLEANS, LOUISIANA
THROUGH A UNIQUE CONTINUUM OF CARE
AND EVIDENCE-BASED RESEARCH



SPECIAL ADDITON: COVID19 IMPACT IN NEW ORLEANS

ABOUT OUR TOOLKIT

Throughout its multiple programs, OHL provides services to over 1,500 individuals each month. We use evidence-based practices to guide our programs and are nationally recognized as a model substance use treatment program.

OHL's Prevention Department supports the agency's mission and vision by providing services directly to community members through various initiatives. We prioritize increasing access to equitable compassionate health care throughout the community through capacity building, direct services, and linkage to wraparound services.

OHL's Revive. Survive. OverDose Prevention Program (Revive. Survive. ODP) is a five-year SAMHSA funded grant designed to address and alleviate the opioid epidemic in New Orleans. With the changing health landscape of 2020 and the continuing Sars Cov-2 Pandemic, we present this year's Revive. Survive. Overdose Toolkit: Addressing the Opioid Epidemic in New Orleans, Louisiana Through a Unique Continuum of Care and Evidence Based Research; *Special Addition: COVID19 Impact in New Orleans.*
This toolkit was developed through evidence-based research; New Orleans-specific research conducted by Revive. Survive. ODP; overdose prevention trainings; community outreach; and, naloxone distribution. If you are interested in the 2019 Toolkit, please click here.

This toolkit provides a deep dive into the Revive. Survive. ODP's approach, findings, research, lessons learned, and recommendations. This year, we have also incorporated a portion of the toolkit to discuss the impact COVID19 has had on our program and community members in New Orleans, Louisiana. This portion highlights the need for flexibility and change in tactics to ensure communities continue to be served in the midst of a pandemic plaguing our most vulnerable populations.
Efforts led by Revive. Survive. ODP address and alleviate the opioid epidemic affecting our New Orleans community. We aim to:

- Increase awareness and implementation of the harm reduction approach throughout New Orleans;
- Increase access to naloxone;
- Develop naloxone distribution workflow recommendations for treatment facilities, Federally Qualified Health Centers (FQHCs), and Community Based Organizations (CBOs);
- Train prescribers, pharmacists, clients, and community members on a cursory history of the opioid epidemic, naloxone administration and access, and tools to address the needs of individuals suffering with addiction;
- Identify and serve priority populations;
- Increase access to treatment services; and,
- Facilitate citywide partnerships and capacity with pharmacists, health care providers, social service agencies, community members, and local governance.

Collectively, we can develop and strengthen our strategies, resources, tools, and data collection efforts to address the unique needs of New Orleans. Through this approach, Revive. Survive. ODP is determined to improve the overall health outcomes of all New Orleanians.

Acknowledgements

This work could not be possible without the ongoing support of our Advisory Board Members and volunteers:

Dr. Jennifer Velander

Belinda Varnando

Alison Gaye

We would also like to take this time to remember those who have been impacted by the disease of addiction.

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To reduce stigma, consider these 5 questions:

- Are you using "person first" language?
  Avoid labeling individuals as problems. Use "a person with substance use disorder" rather than "drug abuser" or "addict."
- Are you conflating substance use and substance use disorder?
  An individual who uses or has used substances in the past does not necessarily experience the symptoms associated with substance use disorder. For example, avoid that assumption that if someone has used heroin they suffer from SUD or addiction.
- Are you using technical language rather than colloquialism or words with inconsistent definitions?
  Be sure you are up to date with the most current clinical and technical language to avoid perpetuating stigmatizing language. For example, "substitution/replacement treatment" implies that one opioid is being substituted for another and perpetuates the stigma of "once an addict, always an addict." Instead, "medication-assisted treatment" (MAT) or "pharmacotherapy for opioid use disorder" is more appropriate.
- Are you using sensational or fear-based language?
  Avoid using language that sensationalizes substance use and correlated risks.
- Are you unintentionally perpetuating drug related moral panic?
  Verbiage such as "crack baby" and "junky" places blame on the individual and results in moral panic and marginalization. The fear of judgement and mistreatment by medical professionals often prevents individuals from getting the services they need. Source: SAMHSA: Words Matter: How Language Choice Can Reduce Stigma

Statements from OHL Clients to celebrate International Overdose Awareness Day:

- "What can I do to help: Talk to somebody about their problem. Recommend them to go to treatment. Carry Narcan."
- "Help people with kindness, caring enough to carry Narcan. Telling them about recovery places like Odyssey House."

Abstinence: in the context of substance use disorder, abstinence refers to refraining from alcohol or drug use.

Acute Pain: is an expected physiologic experience to harmful stimuli that can become pathologic, is normally sudden in onset, time limited, and motivates behaviors to avoid actual or potential tissue injuries.

Addiction: a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Agonist: a substance that acts on or binds to a neuronal receptor to produce effects like those of a reference drug.

Antagonist: a substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of an agonist that produces specific physiological or behavioral effects mediated by that receptor.

Analog: drugs that are similar in chemical structure or pharmacological effect to another drug but are not identical. The number of fentanyl analogs contribute to the increasing number of fentanyl related fatalities.

Benzodiazepines: sedatives used to treat anxiety, insomnia, and other conditions. Combining benzodiazepines with opioids increases a person's risk of overdose and death.

Biopsychosocial: refers to a medical problem or intervention that combines biological, psychological, and social elements.

Buprenorphine: a partial opioid agonist that is used to treat opioid addiction as well as acute and chronic pain; exhibits agonist effects at mu and delta opioid receptors and antagonist effects at kappa opioid receptors. Component of Suboxone (buprenorphine/naloxone), a medication used for MAT.

Chronic Pain: pain that occurs on at least half the days for six months or more.

Delirium: an acute organic cerebral syndrome characterized by concurrent disturbances of consciousness, attention, perception, orientation, thinking, memory, psychomotor behavior, emotion, and sleep-wake cycles. Delirium tremens may occur during alcohol-induced withdrawal.

Dependence: a cluster of physiological, behavioral and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value.

Depressant: any agent that suppresses, inhibits, or decreases some aspects of central nervous system activity.

Detoxification (Detox): also referred to as a managed withdrawal or supported withdrawal, detox is the supported cessation of a psychoactive substance.

Disparity: in the context of health, is a health difference that is closely linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people that have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.

Extended-release/long acting opioids: slower-acting medication with a longer duration of pain-relieving action.

Fentanyl: a synthetic opioid significantly more potent than morphine or heroin. Evidence of fentanyl has been found in a growing number of overdose fatalities, either mixed with another substance or by itself.

Harm Reduction: is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Heroin: an opioid drug synthesized from morphine.

Illicit Drug: the use of a variety of drugs that are prohibited by law. This includes illicitly produced and distributed substances as well as prescription medications consumed by someone other than the prescribed.

Immediate-release opioids: Faster-acting medication with a shorter duration of pain-relieving action.

Integrated Health Care: a model that includes the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

Medication-Assisted Treatment (MAT): combines behavioral therapy and medications to treat substance use disorders such as opioid addiction. Methadone, buprenorphine/naloxone (Suboxone) and naltrexone (Naltrexone) are some medications used in MAT.

Methadone: a long-acting opioid agonist medication used in MAT for opioid addiction, often taken as an oral solution in specially designated clinics referred to as Opioid Treatment Programs (OTPs).

Naloxone: generic name for opioid-overdose reversal medication, also known by the brand name NARCAN. This medication is safe, has no addictive potential, and is appropriate for layperson use. It can be administered as a nasal spray, intramuscular injection, or an auto injector.

Naltrexone: an opioid antagonist medication uses in MAT that helps prevent opioid cravings.

Neonatal Abstinence Syndrome: a group of behavioral and physical conditions, or withdrawal syndromes that occurs in newborns exposed to certain substances, including opioids in the womb during pregnancy.

Nonmedical use: taking a medication prescribed to another or taking prescribed medication for an unauthorized amount, frequency, duration of time or indication.

Non-opioid therapy: methods of managing pain that do not involve opioids. These methods can include but are not limited to, acetaminophen (Tylenol) or ibuprofen (Advil), cognitive behavioral therapy, physical therapy, acupuncture, meditation, exercise, medications for depression or for seizures, or interventional therapies (injections).

Opioid: a natural, synthetic, or semi-synthetic chemical that interacts with opioid receptors on nerve cells in the body and brain and reduce the intensity of pain signals and feelings of pain.

Opioid Use Disorder: An addictive disorder that includes physical and psychological reliance on opioids.

Opiate: refers to specifically natural opioids such as heroin, morphine, and codeine.

Overdose: the use of any drug in such an amount that acute adverse physical or mental effects are produced. Overdoses may result in lasting detrimental effects or death.

Peer Support Specialist: a person willing to self-identify as having a serious mental health condition or addictive disorder with lived, personal experiences. Specific training and/or specialized certification is typically provided to these individuals. The role of a peer support specialist is to support others in the recovery process.

Polysubstance Use: the use of more than one drug at once (Example: opioids and benzodiazepines).

Psychosocial Intervention: any non-pharmacological intervention carried out in a therapeutic context at an individual, family, or group level. Psychosocial interventions can be structured, professionally administered interventions such as cognitive behavioral therapy or insight-oriented psychotherapy. They can also be non-professional interventions such as self-help groups, financial support, legal support, employment assistance, information and outreach.

Physical Dependence: adaptation to a drug that produces tolerance and symptoms of physical withdrawal when the drug is stopped.

Rebound Toxicity: the re-emergence of respiratory depression and other features of opioid overdose following the temporary reversal of opioid overdose symptoms with an opioid antagonist such as naloxone.

Recovery: a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Individuals with severe and chronic substance use disorder can, with help, overcome their substance use disorder and regain health and social functioning.

Relapse/Recurrence: a return to substance use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. The Stages of Change Model identifies relapse as a normal progress in the cycle of change.

Suboxone: a medication used to treat opioid addiction. It is a mixed opioid agonist antagonist composed of buprenorphine and naloxone.

Substance Abuse and Mental Health Services Administration (SAMHSA): the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health (mental illness and addiction) of the nation.

Substance Use Disorder (SUD): a medical illness caused by repeated use of a substance or substances causing clinically significant impairments in health, social function, and control over subsequent substance use. Substance use disorders are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Moderate to severe substance use disorders are commonly referred to as addiction.

Stigma: is defined as an attribute, behavior, or condition that is socially discrediting. It is influenced through the understanding of cause and controllability being either internal or external. The misconception that addiction is a choice and an individual has caused it or can control it has resulted in significant stigma surrounding substance use disorder. As a result, individuals with addiction are less likely than those with other medical conditions, to receive treatment, remain engaged in treatment, or receive adequate services unrelated to addiction. The resulting health disparities illustrate the need for improvements in practice and services.

Syringe Service Programs (SSPs): also known as needle-exchange programs, work to reduce the spread of infectious diseases such as Hepatitis C and HIV by removing used injection equipment from circulation. Research shows that through wrap around services and referrals to addiction treatment, SSPs reduce the number of active injection drug users in their area.

Tolerance: a symptom of physical dependence in which higher doses of a drug are required to produce the same effect achieved previously. Opioids are known for producing physiologic tolerance.

Transtheoretical Model of Change/Stages of Change Model: The Transtheoretical model posits that health behavior change involves progress through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and recurrence. Ten processes of change have been identified for producing progress, along with decisional balance, self-efficacy, and temptations.

Trauma: results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Although many individuals report a single specific traumatic event, others, especially those seeking mental health or addiction treatment services, have been exposed to multiple or chronic traumatic events.

Trauma Informed Approach: a trauma-informed approach to the delivery of health services includes an understanding of trauma and an awareness of the impact it can have across settings,

services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic.

Withdrawal: a group of symptoms of variable clustering and degree of severity that occur on cessation or reduction of the use of a psychoactive substance that has been taken repeatedly. Depending on the substance and level of physiological dependence, withdrawal can be fatal. Opioid withdrawal is not typically fatal. The following are common opioid withdrawal symptoms: stress, anxiety, depression, and flu like symptoms including nausea, vomiting, sneezing, and cramping.

Commonly Used Acronyms

Adverse Childhood Experiences	ACEs
Center for Disease Control and Prevention	CDC
Centers for Medicare and Medicaid Services	CMS
Drug Enforcement Administration	DEA
Federally Qualified Health Center	FQHC
Food and Drug Administration	FDA
Illicitly Manufactured Fentanyl	IMF
Intensive Outpatient Program	IOP
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual	LGBTQIA+ (often a **plus** sign meant to cover anyone else who's not included)
Louisiana Department of Health	LDH
Louisiana Public Health Institute	LPHI
Medication Assisted Treatment	MAT
Metropolitan Human Services District	MHSD
National Institute of Health	NIH
Neonatal Abstinence Syndrome	NAS
Neonatal Opioid Withdrawal Syndrome	NOWS
New Orleans Health Department	NOHD
New Orleans Syringe Access Program	NOSAP
Odyssey House Louisiana	OHL
Office of Behavioral Health	OBH
Office of National Drug Control Policy	Office of National Drug Control Policy
Office of Public Health	OPH
Opioid Related Diagnoses	ORD
Opioid Treatment Program	OTP
Opioid Use Disorder	OUD
Orleans Parish Sheriff's Office	OPSO
People Who Use Drugs/ People Who Inject Drugs	PWUD/PWID

Prescription Drug Monitoring Program	PMDP
Screening, Brief Intervention, and Referral Treatment	SBIRT
Substance Abuse and Mental Health Services Administration	SAMHSA
Substance Use Disorder	SUD
U.S. Department of Health and Human Services	HHS
World Health Organization	WHO

REVIVE. SURVIVE. OVERDOSE PREVENTION: THREE YEAR OVERVIEW

OHL's Revive. Survive. OverDose Prevention is a five-year SAHMSA funded program. We aim to address and alleviate the opioid epidemic in New Orleans by the development and implementation of a unique multi-faceted program providing comprehensive quality care supporting the unique needs of the New Orleans community.

The team is comprised of three full time staff: Director: Helena Likaj, MPH; Project Coordinator: Annette Johnson, MPH; and Outreach Coordinator: Christopher Stella, JD.
The team is supported by Policy and Research Group Evaluators Carolyn Kelly and Teresa Smith, as well as various essential volunteers including students from Tulane's School of Medicine, OHL clients, and OHL graduates.

In year 3, October 1, 2019 -September 30, 2020, we developed, implemented, managed and strengthened our various approaches, ensuring that we are best meeting the needs of our community and the infrastructures throughout agencies are as well. We are intentional in applying a health equity lens, using culturally humble, easily digestible, visually appealing community-centered approaches in our body of work. This body of work includes trainings, naloxone distribution, outreach, and linkage to care.

As the rest of the world, the Revive. Survive. OverDose Prevention team's work was and is dramatically impacted by the COVID-19 pandemic. The team expeditiously adjusted our tactics to ensure that our efforts continued, and so that our most vulnerable populations continued to be prioritized in a manner that ensured the safety of staff and community members. Throughout this toolkit we discuss the efforts that continued in keeping with previous years, but also highlight how we adapted thoroughly and quickly to innovate and operationalize during a global pandemic. It is essential to understand the importance of flexibility and remaining client centered as we continue to move forward in this new and uncertain landscape.

Trainings:
Using information made available in our various toolkits, the Revive. Survive. ODP team developed several trainings for specific audiences. The need for trainings was made apparent in the Revive. Survive. ODP's 2018 needs assessment, therefore unique trainings were developed for high risk populations, community service providers, pharmacists, prescribers, and general community members. Topics discussed include but are not limited to:

- Opioid Epidemic Rates
- Naloxone Administration
- Local Laws and Regulations around Naloxone Access and Administration
- Stigma Surrounding Substance Use and Language
- Incorporating Trauma Informed Care
- Incorporating Harm Reduction Principles

- Reviewing OHL's Prescribing and Co Prescribing Protocols
- Various Activities: centered on open dialogue and leaving with skills/tools to be implemented
  outside training
- Understanding of Addiction and Treatment Options

To ensure our trainings are made available to all New Orleanians, the Revive. Survive. ODP team promoted trainings to various entities via social media, flyering, distribution via email chains, and held meetings with various stakeholders. We continue to receive great interest from partners at various local agencies, direct service providers, colleges, and community members to attend our trainings.

All trainings were previously held in person, however due to COVID19, we quickly shifted our approach, and began hosting many of our trainings via video conference applications with community members and partner agencies. While video conferencing is a great tool for various populations, we recognize that many of our community members we train via street outreach do not have access to video conference platforms. Therefore, to ensure we provide services in an equitable manner, we continue to work with various partner agencies to provide in person trainings and developed a COVID19 heightened risk mitigation plan. For example, for all training conducted in-person we require that all staff wear proper PPE, individuals trained wear a mask, and both adhere to social

Image: Flyer distributed on social media, listservs, and partner agencies to promote online training due to COVID19

distancing recommendations.

From October 1, 2019 to September 30, 2020 the Revive. Survive. ODP team provided trainings to various entities including but not limited to:

- OHL Detox Clients weekly
- OHL Residential Clients biweekly
- Currently incarcerated individuals at Orleans Parish Sheriff Office weekly
  - Which has halted due to COVID19
- Low Barrier Shelter Residents monthly
- General community trainings monthly
- Individuals accessing resources at Crescent Care's New Orleans Syringe Service Program weekly
  - Which has halted due to COVID19
- Due to COVID19, The City of New Orleans has implemented a hotel housing program for those experiencing homelessness, which the Revive. Survive. OverDose Prevention team quickly partnered to ensure we provided various services to this priority population

From October 1, 2019 to September 30, 2020 we have trained:

- 1699 OHL Clients Trained, of which 950 were unique individuals who had never attended this training before.
  - Double the rate from last year trainings of 864 OHL Clients trained.
- 800+ Community Members Trained at Low Barrier Shelter Orleans Parish Sheriff Office, New Orleans Syringe Access Program, General Community trainings, and Community Service Providers
  - Half the rate from last year's training of 1,356 Community Members. This drastic decrease is significantly associated with the COVID19 pandemic.
- 148 Pharmacists and Pharmacy students
  - Last year's number of pharmacist and pharmacy students trained was 17.
- 180 Prescribers and Nursing students
  - Last year's number of prescriber and nursing students trained was 3.

Below you will find characteristics of individuals trained by the Revive. Survive. ODP Team from Year One to Year Three:

Background Characteristics of Trainees

Characteristic	All Trainees	In Receipt of Naloxone
Personal experience with opioid epidemic	***n* = 6,188** [1]	***n* = 1,834**
Have used opioids for non-medical reasons	69.7%	79.8%
Have been to the emergency room for opioid overdose	25.5%	29.6%
Have been hospitalized for opioid overdose	16.8%	18.9%

[1] Of the individuals who completed enrollment forms, 70 selected one or more personal experiences with opioids, but also responded *These do not apply to me*. These responses were marked as inconsistent and omitted from results. The 459 individuals who selected only *These do not apply to me* are also excluded from the sample.

Have experienced an opioid overdose	40.5%	49.1%
Have witnessed an opioid overdose	65.7%	76.3%
Have family or friends at risk of opioid overdose	62.3%	70.9%
Work with individuals at risk of opioid overdose	26.6%	24.4%
Age	***n* = 6,188**	***n* = 3,108**
Mean age	39.0	39.0
Gender	***n* = 3,630**	***n* = 2,026**
Man	60.7%	64.4%
Woman	38.1%	34.2%
Transgender individual	0.7%	0.8%
Other	0.6%	0.7%
Sex at birth	***n* = 6,170**	***n* = 3,094**
Male	66.4%	67.8%
Female	33.6%	32.2%
Identify as LGBTQIA+	***n* = 2,806**	***n* = 1,615**
Yes	13.4%	14.6%
Race[2]	***n* = 6,020**	***n* = 3,051**
Black	40.6%	33.4%
White	51.6%	57.8%
Other	7.8%	8.8%
Hispanic/Latino	5.1%	5.9%
Health insurance status	***n* = 5,802**	***n* = 2,752**
Medicaid or Medicare	68.8%	72.5%
Military	0.6%	0.4%
Private	9.6%	3.7%
No insurance	20.9%	23.3%
Multiple types listed	0.1%	0.1%
Residence	***n* = 6,144**	***n* = 3,062**
Orleans Parish	58.8%	61.9%

Employment Characteristics of Trainees

Characteristic	All Trainees	In Receipt of Naloxone
Employed[3]	***n* = 2,221**	***n* = 1,007**
Yes	39.6%	27.4%
First responders	**2.7% (*n* = 61)**	**0.8% (*n* = 8)**
Police officer	8.2%	12.5%
Firefighter	8.2%	25.0%

[2] Trainees are asked to indicate their race and whether or not they are Hispanic or Latino; therefore, race and ethnicity categories are not mutually exclusive and may not sum to 100%. Out of all trainees, 6,020 respondents indicated their race; 5,598 indicated whether they were Hispanic or Latino. Out of those that received naloxone, 3,051 respondents indicated their race; 2,811 indicated whether they were Hispanic or Latino.

[3] The number of individuals considered *employed* includes 236 individuals who responded to more specific employment questions, but did not respond to the question, "Are you currently employed?"

Emergency medical technician	13.1%	25.0%
Medical personnel at school or institution	67.2%	12.5%
Multiple responses	3.3%	25.0%
Healthcare professionals	**12.9% (*n* = 286)**	**0.9% (*n* = 10)**
Physician	1.4%	0.0%
Physician assistant	0.3%	0.0%
Nursing profession	26.6%	10.0%
Pharmacist	3.8%	0.0%
Pharmacy staff member	12.2%	10.0%
Other	55.6%	80.0%
Licensed to prescribe medication[4]	8.6%	7.4%
Licensed pharmacist[5]	4.1%	4.3%
Direct service providers	**23.8% (*n* = 528)**	**19.9% (*n* = 200)**
Public service	17.0%	11.0%
Non-profit services	15.5%	11.5%
Education	3.2%	2.5%
Housing	3.0%	2.5%
Hospitality	2.5%	2.5%
Food and/or beverage	13.6%	22.5%
Retail	6.8%	3.0%
Construction	3.6%	8.5%
Student	2.3%	0.0%
Other	23.3%	29.5%
Multiple responses	9.1%	6.5%

In addition to feedback, the Revive. Survive. ODP team wanted to ensure that we were measuring the effectiveness of our trainings; therefore, we have developed pretests and posttests that are administered to attendees before and after each training. Below are our findings from trainings conducted from October 1, 2019 to September 30, 2020:

We have seen statistically significant change in:

- Clients' self-reported knowledge of opioids generally, as well as treatments, and laws; naloxone and its use; and, opioid overdose (including symptoms, prevention, and response/treatment methods)

Outreach:

[4] The characteristic *Licensed to prescribe medication* is reported as a percentage of the total number of individuals that report being currently employed as a healthcare provider. However, one individual reported being licensed to prescribe medication, but did not report being currently employed as a healthcare provider.

[5] The characteristic *Licensed pharmacist* is reported as a percentage of the total number of individuals that report being currently employed as a healthcare provider. However, two individuals report being a licensed pharmacist, but did not report being currently employed as a healthcare provider.

In Year 3, the Revive. Survive. OverDose Prevention team continued to prioritize outreach. Building rapport with community members is a critical component of OHL's Prevention Department. Therefore, it was vital that we continued to integrate Revive. Survive. ODP's team into established efforts and expanded our efforts to best serve our community. Daily, staff members were in the field conducting active outreach, flyering, and hosting events. While in the field, staff continued to distribute literature and resources; continued to meet individuals where they are; continued to provide comprehensive care to individuals including naloxone access information and trainings; referrals to Odyssey House of Louisiana and other substance use disorder treatment programs, as we recognize our services may not best meet the needs of all individuals; Medicaid enrollment; continued to refer clients to our Federally Qualified Health Center, for general wellness; and conducted HIV and Hepatitis C testing. All staff and volunteers were trained by the Director to conduct active, non-biased, compassionate outreach. Trainings are regularly conducted for staff, with the purpose of ensuring staff comprehend and lead by example in utilizing Harm Reduction principles, Trauma Informed Care, and the Stages of Change.

The moment a staff member enters the community, the opportunity to build a meaningful relationship with the residents begins. We are mindful that, when interacting with one community member, we are also interacting with this individual's social network. We must ensure that we are equipped to meet the needs of this individual, and that our constant presence aids in delivering the various services we offer. Building rapport with our community members is essential as we can support them in having their needs met, and we are also capable of ensuring their treatment with the agency is a positive experience. In building rapport within the community, we also gain valuable insight regarding the issues impacting individuals in the community that will support and guide the development and implementation of our program. For instance, once we have built meaningful relationships with our community members, we are able to receive feedback on our resources, our approach, and geographical and demographic areas we should conduct outreach.

Due to COVID19, many of our various outreach efforts had to come to a pause. However, as the city was adjusting their efforts to serve our most vulnerable populations, the Revive. Survive. OverDose prevention team ensured that we were working in tandem with the city to ensure our community needs were being met. This included Revive. Survive. OverDose Prevention team quickly jumping into action the moment the city established multiple hotel housing units for those experiencing homelessness. All Revive. Survive. Overdose Prevention staff jumped in to provide trainings, naloxone distribution, and linkage to wraparound services including referrals to our treatment programs and FQHC to staff and clients of the hotel housing for those experiencing homelessness. Additionally, as the city moved into phase 2 of COVID, a risk mitigation plan was developed and distributed to staff to ensure the safety of staff, clients, and community members remained priority as we began providing outreach efforts in the community.

Below you will find a few of our various experiences while conducting outreach in the field and the impact it has had with our community members:

- “A community member was in Armstrong Park on two separate occasions and always brings naloxone with her when she leaves home. On both occasions, she came across an individual overdosing. She called 911 and administered naloxone and was able to revive both individuals! The individuals left in the ambulance and she did not know them personally, but hears they are doing okay.”
- “Community Member was alone when he injected a substance intravenously and felt as though he was starting to feel faint and his breathing greatly slowed. He quickly administered a vial of naloxone provided by OHL at Midtown Hotel Initiative 3 days prior and immediately felt his breathing return to normal and no longer felt faint. He did not choose to call 911.”
- “A Community Member was with a friend that was experiencing an overdose. The friend refused her offer to call 911, but she remembered that she had received naloxone from OHL Midtown Hotel Initiative. She was able to quickly administer the naloxone to her friend and "bring him back.”

The Revive. Survive. OverDose Prevention team has established partnerships with agencies to distribute various Revive. Survive. OverDose Prevention resources that support linkage to care. This includes but is not limited to the development of a language guide to ensure individuals are using non-stigmatizing language to community members and clients, a daily email that is sent out to stakeholders regarding bed availability to our treatment facilities with a referral resource linked, as well as a New Orleans specific one pager including various Opioid programs throughout the city distributed by EMS, Police Department, Fire Department, and Probation & Parole along with other stakeholders.

Image: Staff members providing various services to community members, including naloxone training, on International Opioid OverDose Awareness Day 2020

From October 1, 2019 to September 30 ,2020 OHL’s Prevention Department, including efforts from Revive. Survive. OverDose Prevention staff, have provided:

- 255 Referrals to OHL services, treatment, counseling and/or MAT at another provider
    - Double the rate from previous grant year
- 140+ Medicaid Enrollment

    - Double the rate from previous grant year
- 580 HIV Tests and linkage to rapid treatment
    - Double the rate from previous grant year
- 477 Hepatitis C Tests and linkage to rapid treatment
    - Double the rate from previous grant year
- Hepatitis A Vaccines in Detox, Residential, and IOP In New Orleans and Lake Charles

Naloxone Distribution:

To ensure the New Orleans community has access to the lifesaving resource Naloxone, the Revive. Survive. ODP team continued to expand naloxone access throughout our various efforts. Naloxone distribution occurs within our various treatment facilities, at trainings hosted, and via outreach efforts. Each naloxone kit distributed by the Revive. Survive. OverDose Prevention team includes 2 doses, a face mask, and an educational instruction packet developed by the Revive. Survive. OverDose Prevention Team.

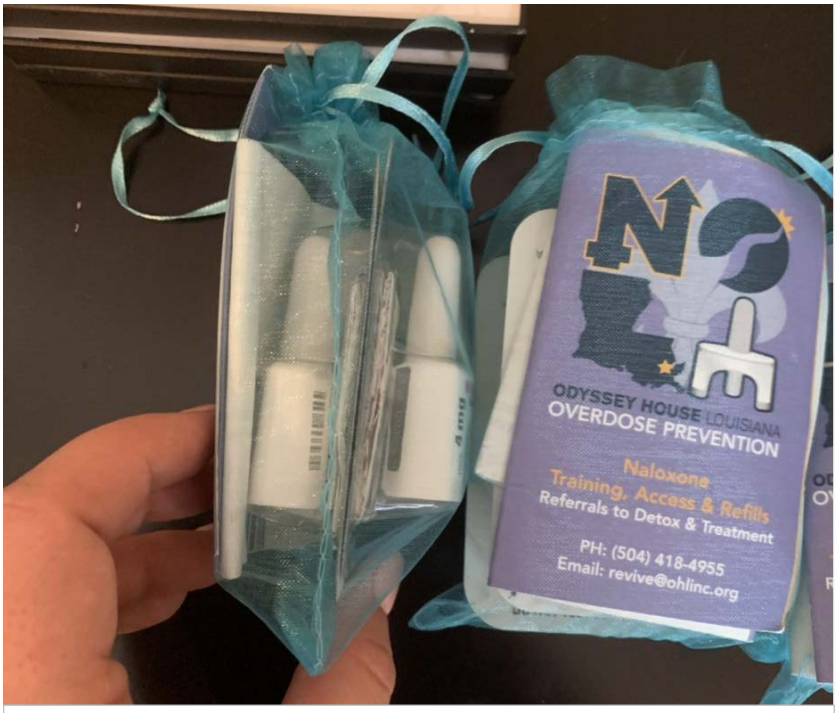


Image: Revive. Survive. OverDose Prevention Naloxone Kit

From October 1, 2019-September 30, 2020 the Revive. Survive. Overdose Prevention Team distributed 3,275 naloxone kits through various efforts. Of the 3,275 distributed, 562 kits were self-reported by clients to have been used for an opioid overdose, of which 911 was called 139 times.

Funding for these efforts came from SAHMSA and additional funding sources secured by the Revive. Survive. OverDose Prevention Team.

Below are a few anecdotes from individuals who were impacted by the naloxone distributed by the Revive. Survive. OverDose Prevention Team:

- "A client who attended our training at OHL's Detox facility shared that he overdosed on three separate occasions in June 2020. Fortunately, each time he was with someone that carried naloxone (Narcan). He asked where the person had gotten it and the individual told him he had initially received it through the Detox program at OHL and then through OHL's short-term treatment facility and now gets it through his local pharmacy, which he learned about through OHL Client Outreach Training, while as a resident of the short-term program. The client came to OHL Detox because of the conversation he had with his friend and because that Narcan saved his life three times in a very short span of time. He was grateful to receive the Outreach Overdose Prevention and Naloxone training himself."

- "A client at Detox said he had gotten a few Narcan kits from previous visits to Detox. He was with 6 individuals on separate occasions who overdosed while he was with them over the course of a month in August/September. He was able to call 911 and administer Narcan, which reversed the overdose on each occasion and stated that having gone through the Overdose Prevention Client Outreach Training helped him to remain calm and know exactly what to do in each situation."

Due to COVID 19, many of the ways in which our clients and community members receive naloxone were adjusted. We continued to distribute naloxone to our clients in our treatment programs and via our modified outreach efforts. We also implemented no contact pickups for community members and training attendees. Individuals may contact us via our 24/7 outreach phone and our various social media platforms to request a date and time to pick up naloxone from our office, or staff will meet community members to drop off naloxone.

Even when faced with a pandemic, the Revive. Survive. OverDose Prevention team increased access to naloxone, information regarding the opioid epidemic, and linkage to care. The Revive. Survive. ODP team has successfully developed a multi-faceted program to serve the New Orleans community. We ensure that both staff and members of the community are included in the development and implementation of our programs. Strategies, tactics, and resources are continually changing to meet the needs of our communities and to adjust to the ongoing pandemic. Flexibility, strategic partnerships, community engagement, development of evaluation tools, and maintaining a community centered approach are vital in the success of our program.

As we prepare for the next year of the grant, we continue to prioritize our various efforts and are intentional to expand trainings, naloxone distribution and access, outreach, and linkage to care. We are currently striving to build capacity throughout the city, and through partnerships and webinar development we hope to see the impact of our services to continue to increase.

What Are Opioids?

Opioids are a class of drugs originally derived and extracted from the opium poppy plant but can also be either semisynthetic or synthetic compounds with similar properties that can interact with opioid receptors on the nerve cells in the body and brain. [13] This occurs when opioids bind to different combinations of the three transmembrane opioid receptors mu (μ), delta (δ), kappa (κ) that work in the brain producing a variety of effects, including changes in perception of pain, pleasure, and emotions, slower breathing, a sense of euphoria or clouded thinking, and other physiological outcomes. Traditionally, opioids have been used to treat both acute and chronic pain disorder due to its analgesic (pain relieving) and sedative effects. However, researchers like Hartrick (2013) and others have indicated that long-term opioid treatment results in increased tolerance, thus resulting in both higher dosing and physiological dependence. As a result, opioids are highly addictive. The table below shows the opioid receptor classes and their effects on the brain when taken [37].

OPIOID RECEPTORS	
Opioid Receptor Class	**Effects**
Mu_1	Euphoria, supraspinal analgesia, confusion, dizziness, nausea, low addiction potential
Mu_2	Respiratory depression, cardiovascular and gastrointestinal effects, miosis, urinary retention
Delta	Spinal analgesia, cardiovascular depression, decreased brain and myocardial oxygen demand
Kappa	Spinal analgesia, dysphoria, psychomimetic effects, feedback inhibition of endorphin system

Terrie, C., Y. (2011). An Overview of Opioids: Table 1[Table]. Pharmacy Times. https://www.pharmacytimes.com/publications/issue/2011/June2011/An-Overview-of-Opioids

Natural, Semi-synthetic and Synthetic Opioids

- *Natural opiates* are made directly from the opium poppy plant. Natural opiates include morphine and codeine.
- *Semi-synthetic* or man-made opioids are created in labs from natural opiates. Semi-synthetic opioids include hydrocodone, oxycodone, and the Schedule I drug, heroin.
- *Synthetic* opioids such as fentanyl, methadone, and tramadol are completely unnatural substances that are not made from the same chemicals as natural opioids.

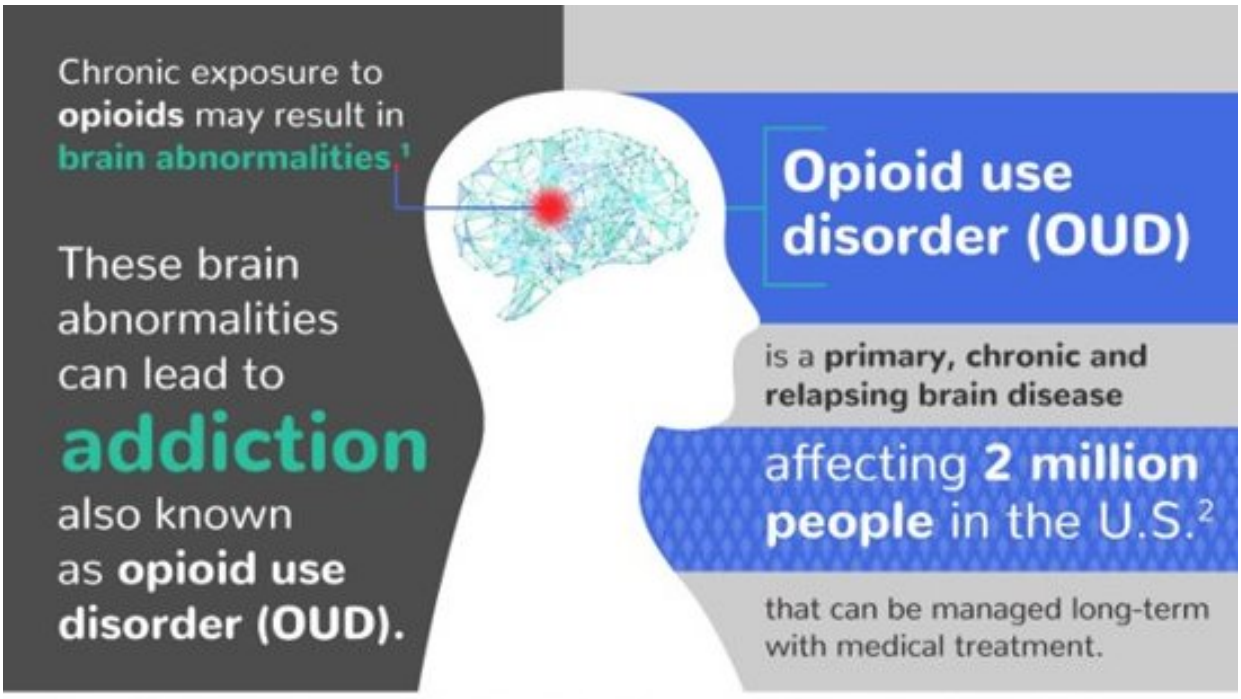
Addication.com Medical Review (2017). *Addiction to Opioids* [Photo]. New York, NY. https://www.addictions.com/blog/opioids-list-beware-the-6-most-addictive-opiates/

Opioid Use Disorder

Opioid Use Disorder or OUD is defined as an addictive disorder that includes physical and psychological reliance on opioids due to the consumption of prescription opioid medication, heroin, and/or illicitly manufactured synthetic opioids. OUD can be a result of addiction caused by reoccurring or chronic brain disease associated with both structural and neurochemical abnormalities. In 2018, an estimated 2.0 million people had an opioid use disorder aged 12 and older. [90] An opioid use disorder may be either mild, moderate, or severe, and the severity is separated by 11 DMS-V criteria [5]. For an individual to be diagnosed with an opioid use disorder, a person must have 2 or more of the following symptoms within a 12-month period:

1. Increased amount/duration of opioids than intended.
2. Desire/inability to decrease, cut down or cease opioid use.
3. Large time investment in procuring, using, and recovering from the opioid and/or its effects.
4. Strong craving or desire to use opioids.
5. Opioids create problems in fulfilling obligations at work, school or home.
6. Continued opioid use despite reoccurring social or interpersonal problems.
7. Giving up or reducing activities because of opioid use.
8. Using opioids in physically hazardous situations.
9. Continued opioid use despite knowledge of negative physical and mental impacts.
10. Increase tolerance to opioids.

11. Experiencing withdrawals or taking opioids to relieve/avoid withdrawal symptoms.



[1]Kosten TR & George TP. The neurobiology of opioid dependence: implications for treatment. *Sci Pract Perspect*. doi:10.1151/spp021113.
[2]Han B, et all. *Ann Intern Med*. doi:10.7326/M17-0865.

Opioid Overdose

An overdose (OD) occurs when a toxic amount of a drug or combination of drugs impairs the physiological functions of the body. Opioids bind to receptors in the brain that signal breathing, and as a result, an opioid overdose can cause respiratory depression and unresponsiveness. When breathing stops during an overdose, oxygen levels in the blood drop (typically identified when an individual's lips and fingers turn blue or ashy color). Lack of oxygen in the blood causes vital organs such as the heart and brain to stop properly functioning, and within 3-5 minutes damage to the brain begins. If the oxygen levels cannot be restored an opioid overdose can become fatal.

In preventing an overdose, it is important to be able to recognize the signs and symptoms of a potential overdose, administer naloxone (if accessible), call for emergency medical services, and provide rescue breaths until EMS arrives. [35] It is very critical that calling EMS is the first step in responding to an opioid overdose because individuals with history of chronic opioid use will likely experience various withdrawals symptoms that may include headache, vomiting, changes in blood pressure, sweating, or nausea, when naloxone (Narcan) is administered. Additionally, naloxone metabolizes faster than opioids and have a shorter half-life than most opioids, putting the individual at risk of rebound toxicity, in which the individual can experience another overdose after the naloxone has worn off in approximately 30-90 minutes.

Recognizing and Responding to Opioid Overdose

Quickly recognizing and responding to an opioid overdose can be vital in saving a life.

The following are some signs of an opioid overdose:

- Small, constricted, pinpoint pupils
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Limp body
- Pale, blue, or ashen lips, skin, and nails
- Loss of consciousness
- Unresponsive to outside stimulus.
- Choking or gurgling sounds (sometimes called the “death rattle”)

prevention/overview/overdose-basics/responding-to-opioid-overdose/

Risk for opioid overdose increases when individuals: [76, 86, 84, and 35]:

- Take high doses of opioids for long-term management of chronic pain
- Receive rotating opioid medications (at risk for incomplete cross-tolerance)
- Are discharged from emergency medical care following poisoning or overdose
- Take extended-release or long-acting opioids
- Complete mandatory detoxification or abstinence programs
- Have recently been released from incarceration and have a history of opioid use disorder
- Have a medical history of addiction, and are seeking treatment for either acute or chronic pain

Naloxone

Naloxone (also known as Narcan) is an opioid antagonist medication used to counter the effects and reverse the symptoms of an opioid overdose within minutes. Patented in 1961 and approved in 1971 by the Food and Drug Administration (FDA) naloxone works by displacing opioid molecules from their receptors, thus the effects of the opioids are immediately withdrawal. [97] Naloxone is intended for emergency response and has proven to be effective and easy to use and has been used by medical professionals for decades. However, as the opioid crisis blossomed into a full-scale national epidemic, the general public became aware of, eventually demanding safe and legal access to personal use naloxone. Pharmaceutical companies recognized this gap, and in response designed products for the medically untrained public. In 2016, ADAPT Pharma developed a nasal spray, the first nasal formulation of naloxone. EVZIO followed suit with an auto-injector including audio instruction. [44] These products have allowed bystanders to reverse opioids overdose due to both their easy-to-use design that does not require specialized medical training to administer the drug.

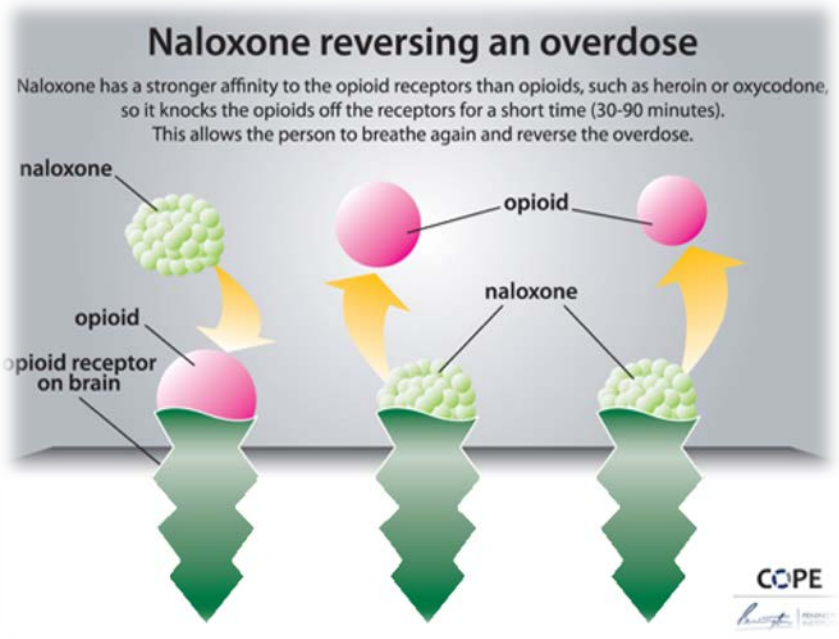
The Surgeon General has publicly announced his support and encouragement of all individual and communities to learn how to use and carry naloxone in case of an emergency.
Nonetheless, even with federal acknowledgment of the impacts of bystander education of and access to Naloxone in case of an emergency factors such as poor implementation of the Standing Orders and the Good Samaritan Law driven by stigma towards addiction have restricted access to Naloxone. Researchers like Winstanley et al. (2017) found that stigma surrounding public perception when carrying Naloxone, fear of punitive actions by law enforcement, access, and affordability played a critical role in determining whether an individual will carry Naloxone. Below are some of community and client responses to the question:

“What are some reasons people won’t carry Naloxone?”

- “Don't want to get in trouble with law enforcement, don't want to be harassed because people think you use.” – OHL Detox Client

- “They are embarrassed, stigma, don't know where to get it, it can be self-incrimination”- OHL Residential Client

- “Scared to administer, the stigma arounds Drugs or fear carrying Narcan will "Out Them”, fear of liability, lack of Knowledge and/ or access to naloxone” – General Community Member



Opioid Use Disorder Treatment

There are a variety of addiction treatment options and specialized programs for opioid use disorder specifically. Medical Detox Programs, Opioid Treatment Programs (OTPs), Office Based Opioid Treatment (OBOT), In-Patient, and Out-Patient services are all evidence-based treatment options. Long-term treatment for OUD consists of medical and nonmedical options— with a combination of both models showing the highest success. [88]

- *Medical Detox Programs:* are staffed with doctors and nurses who are trained to support patients through the process of withdrawals, often using prescribed medications to reduce the severity of certain symptoms and curb cravings.
- *Opioid Treatment Programs (OTPs):* are commonly known as methadone clinics although they offer all three MAT options. They must be certified by SAMHSA, licensed by the state in which they operate, and register with the Drug Enforcement Administration (DEA). Louisiana regulations allows for one OTP per human service district. Refer to Appendix for local OTP, Behavioral Health Group (BHG).
- *Office Based Opioid Treatment (OBOT):* refers to outpatient treatment services provided outside of licensed Opioid Treatment Programs (OTPs) by clinicians to patients with addiction involving opioid use, and typically includes a prescription for the partial opioid agonist buprenorphine, the provision of naltrexone, or the dispensing of methadone, in concert with other medical and psychosocial interventions to achieve and sustain remission. Both the Drug Addiction Treatment Act of 2000 (DATA 2000) and the Comprehensive Addiction and Recovery Act (CARA) of 2016 allowed more healthcare professionals to obtain waivers to prescribe controlled medications used for MAT services.

- *In-Patient Programs:* also known as residential treatment, require patients to check themselves into a controlled environment to overcome addiction. In- Patient Programs can be short or long term.
- *Out-Patient Programs:* non-residential, therapy-based type of treatment for addiction. Outpatient centers for addiction usually include group and individual counseling, as well as behavioral treatments.

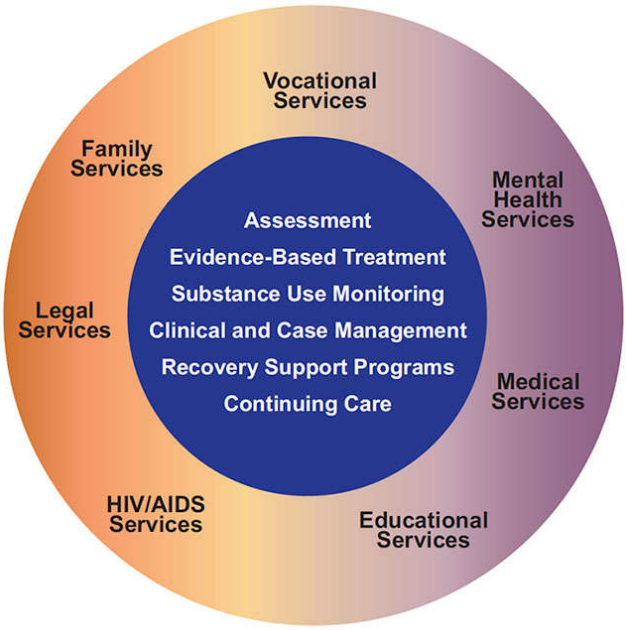
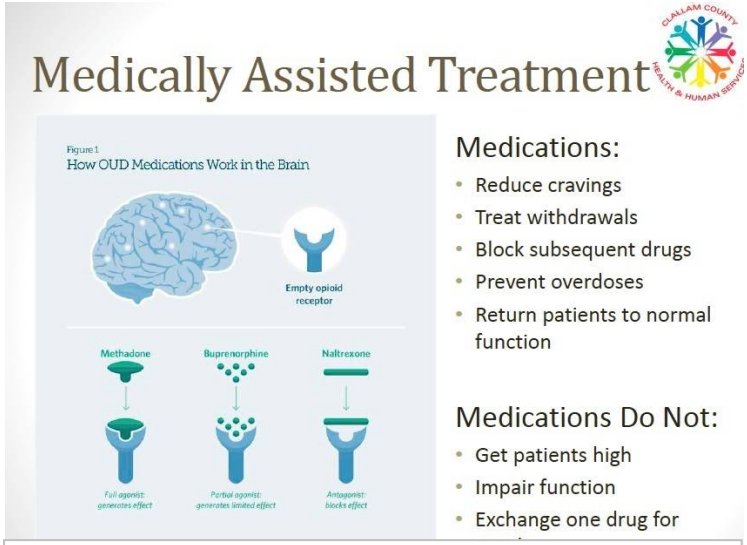


Photo from NIDA

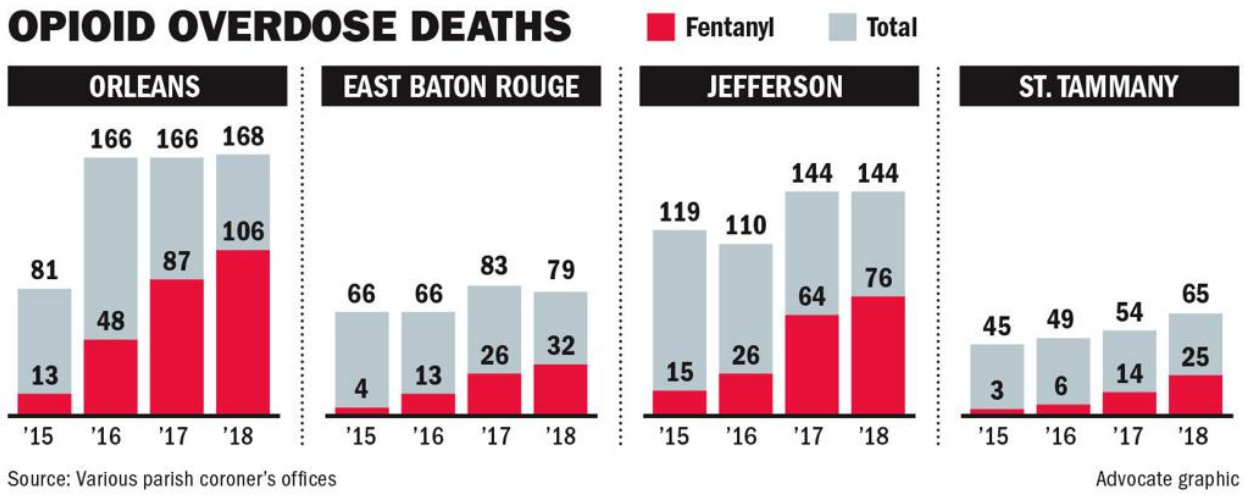
The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient. [69]



Source: Matthew Nash (2019). *Clallam Health Officer talks addiction, MAT* [Photo].

New Orleans

New Orleans has historically been an epicenter for overdose fatalities, and in recent years those numbers have skyrocketed. In 2018, more than 200 people died from accidental drug overdoses in New Orleans according to the Orleans Parish Coroner's Office. In fact, 2018 was the third straight year with such numbers, and of the 168 deaths that year 81% tested positive for opiates. Although the overall deaths decrease slightly from 2017, there has been a drastic increase of fentanyl related deaths, totaling 106 in 2018. There has also been a clear trend of increased drug related deaths among African Americans.



In addition, the New Orleans community is significantly impacted by health disparities that must be addressed to adequately meet local needs. Disparities in socio-economic status, insurance coverage, access to care, and mortality rates illustrate underlying systemic barriers to equitable resources and services throughout marginalized communities in New Orleans. [69] In fact, federal data shows that only 1 in 20 Louisiana residents who need addiction treatment receive it, as compared to 1 in 9 nationally.

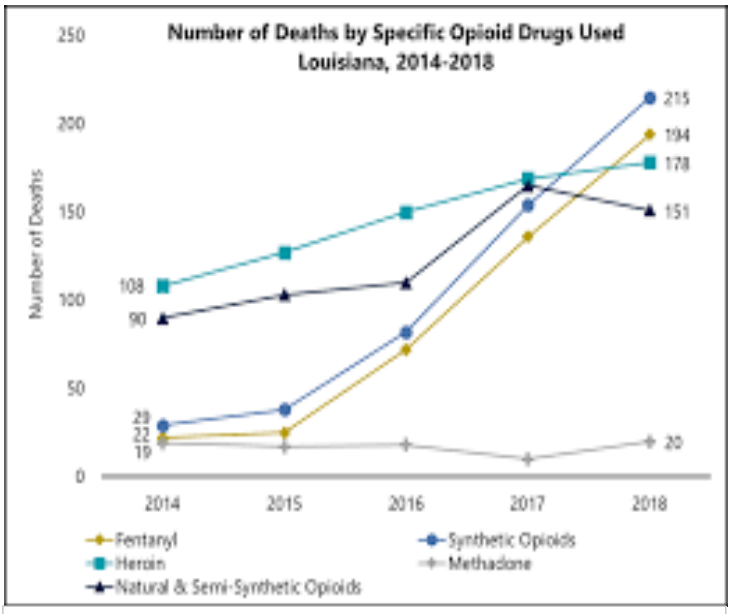
Louisiana

In 2019, 588 opioid involved deaths were recorded in Louisiana, compared to 470 in 2018. It is important to note that the Louisiana Department of Health (LDH) estimates the true number of opioid involved fatalities is underrepresented by 125%, due to lack of ability to accurately collect valid statistics illustrates one of the greatest barriers to adequately addressing the epidemic. [49]. Another challenge in determining the number of opioid-involved deaths is that multiple drugs are often found in the decedent's system, which are known as polysubstance drug overdoses. During a toxicology test, if multiple drugs are present in a person's system it can be difficult to determine which drug caused the death. Many cases have toxicology results that reveal drugs of all types (prescription, over the counter, illicit) which are deadly in combination, like opioids and benzodiazepines [58]. Louisiana ranks 5th in the nation for opioid prescribing rates, according to the Center for Disease Control and Prevention (CDC) with providers writing

79.4 opioid prescriptions for every 100 persons, compared to the average U.S. rate of 51.4 prescriptions in 2018. [68] According to the Louisiana Prescription Monitoring Program (PMP), there were 96 opioid prescriptions per 100 Louisiana residents prescribed in 2018. However, prescription medications are not the only issue contributing to the opioid epidemic in Louisiana. While deaths related to prescription opioids have decreased from 2017-2018 deaths involving heroin have dramatically increased. Deaths involving synthetic opioids including fentanyl and fentanyl analogs continued to rise with more than 28,400 (a rate of 9.9) overdose deaths in 2018, thus ranking Louisiana 18th for most deaths caused by fentanyl. The rise of injection drug use led to a rapid increase in overdose deaths, viral hepatitis and HIV. In 2017, of the new HIV diagnoses in Louisiana totaling 1,011, 7.9 percent were attributed to male injection drug use, and 9.9 percent among women. [69] This crisis has become a major public health concerns affecting our communities and health care systems across the state.

***Changes in Specific Opioid Drug Used from 2014-2018*:**

Looking at the graph to the right the decline in natural and semi-synthetic opioids is evident, while the trend of deaths from fentanyl and synthetic opioids has increased. The Louisiana Department of Health and Office of Behavioral Health contribute these to success with legislation aimed at reducing prescription drug availability in the community and an increase in testing for more potent opioids such as fentanyl and other analogues during drug seizure testing, resulting in more positive testing of these addictive substances.

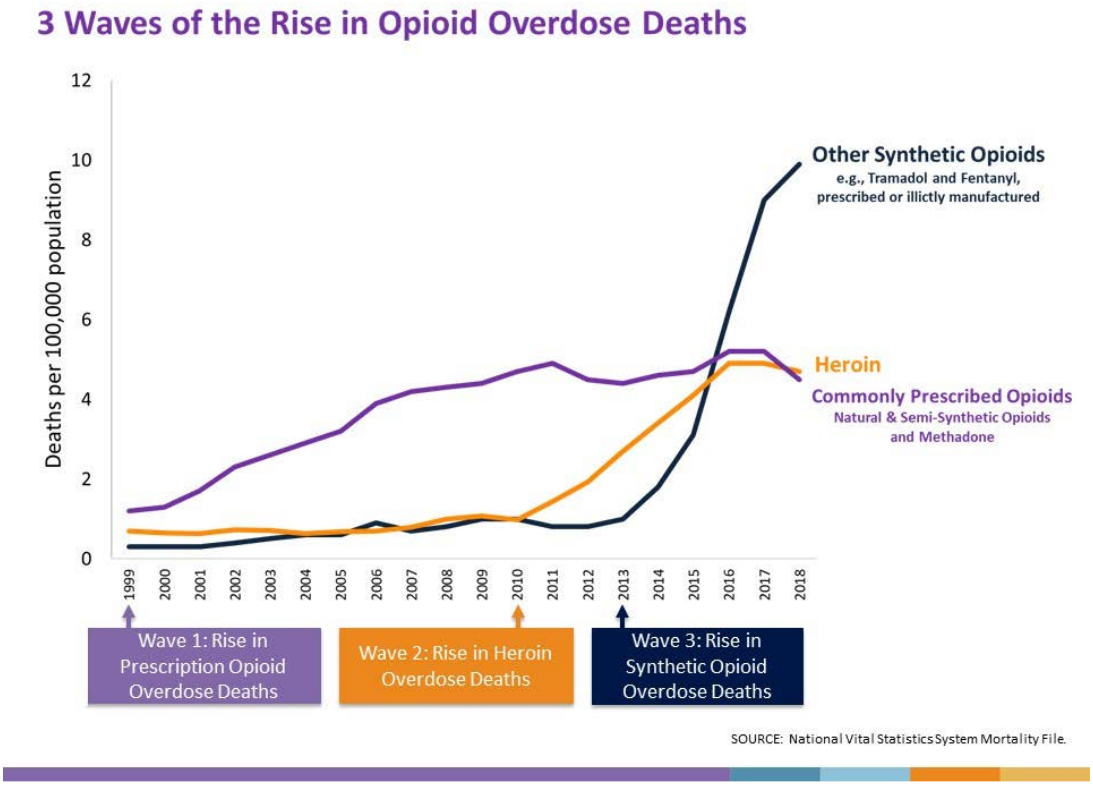


Source: LDH Louisiana's Opioid Response Plan

National

Drug overdose remains a leading cause of injury-related death in the United States accounting for approximately 750,000 deaths in 2018. Overdoses involving prescription and illicit opioids take the lives of 128 people every day. From 1999 to 2018 almost 450,000 people died from an overdose involving opioids, including prescription and illicit opioids. In 2018, opioids were involved in approximately 70 percent of drug overdose deaths, a slight decrease from 2017 death rates involving all heroin, and prescription opioids. However, from 2017 to 2018 there was a 10% increase in overdose deaths involving synthetic opioids, which the Center for Disease Control and Prevention notates is likely driven by illicitly manufactured fentanyl. Two out of three overdose deaths involved an opioid such as prescription opioids, heroin, or synthetic opioids (like fentanyl). Even with the slight decrease from 2017 to 2018 the influence of prescription opioids has been a driving force in the epidemic and has been cited as the most common cause of opioid addiction. In fact, 83% of heroin users reported the use of prescription

opioids before transitioning to illicit drug use, many due to refill denials. [17] Even though the overall national opioid prescribing rate declined from 2012 to 2018, with 2018 prescribing rates being its lowest in 13 years, prescribing rates continue to be exceedingly high in certain areas in the United States. In fact, in 2018, in 11 percent of U.S. counties, enough opioid prescriptions were dispensed for every person to have one opioid prescription. [13] Annually, there are enough prescriptions to supply every American with an average of 36 opioid pills. In 2016 alone, the over prescription of post- surgical opioids resulted in 3.3 billion excess pills that flooded the streets. [19]

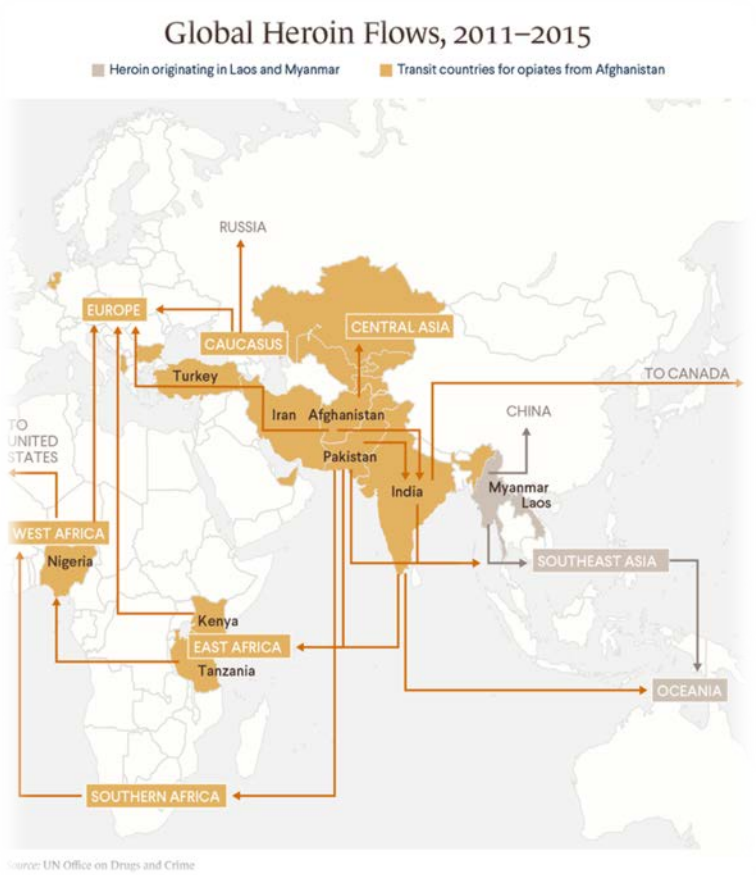


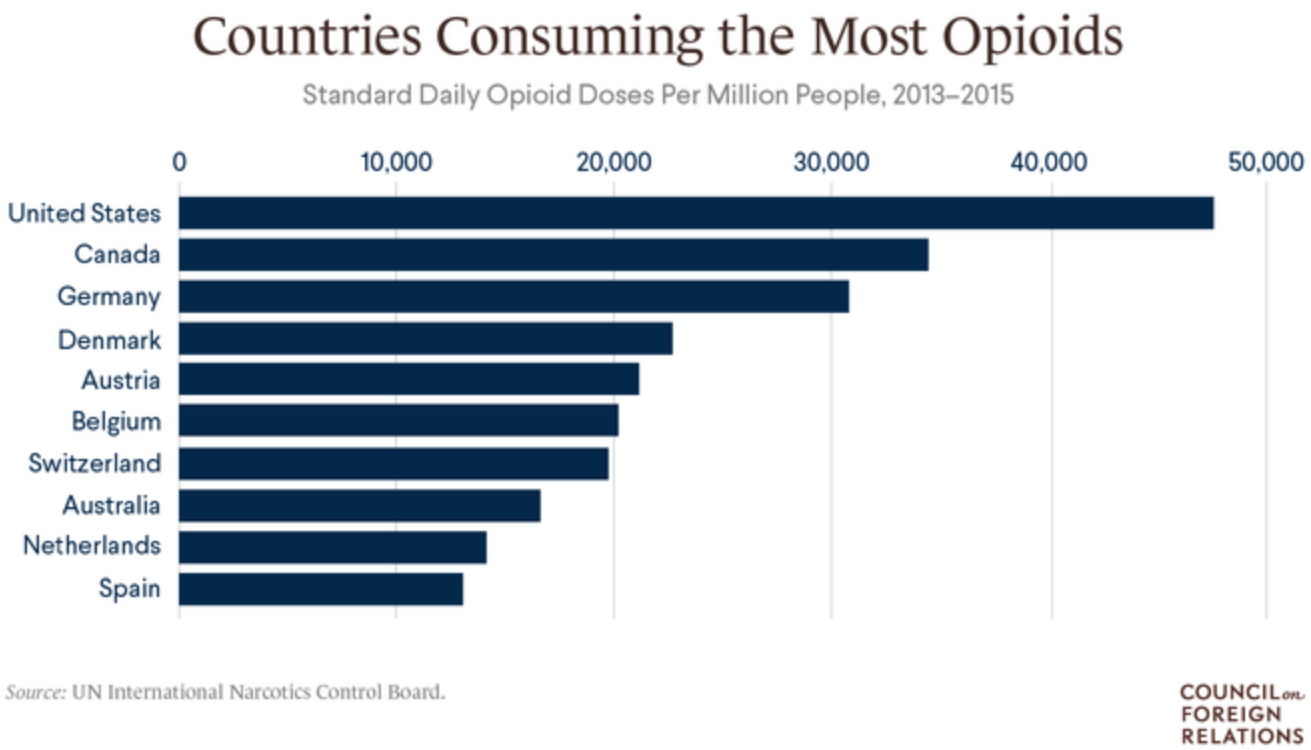
Center for Disease Control and Prevention (2020). *Three Waves of Opioid Overdose Deaths* [Graph].

Global

As the World Health Organization (WHO) has reported, the impacts of the opioid epidemic are felt across the globe. The United Nations Office of Drug and Crimes (UNODC) states that new trends in international drug trafficking have intensified the crisis including the ease of making fentanyl analogues, availability of opioids over the internet, international mail delivery systems and express couriers. A major concern is that individuals who use these substances are often unsure of what they are taking and the difference in potency between products. [74]

- During 2016, about 275 million people worldwide used drugs at least once.
- In 2017, around 53.4 million people worldwide had used opioids in the previous year, 56% more than the estimate for 2016.
- 35 million people worldwide suffer from drug use disorders while only 1 in 7 people receive treatment in 2019**.**
- Most people dependent on opioids used illicitly cultivated and manufactured heroin, but an increasing proportion used prescription opioids.
- Overdose deaths contribute to between 33-50% of all drug-related deaths, which are attributable in most cases to opioids.
- Lifetime prevalence of witnessed overdose among drug users is about 70%.





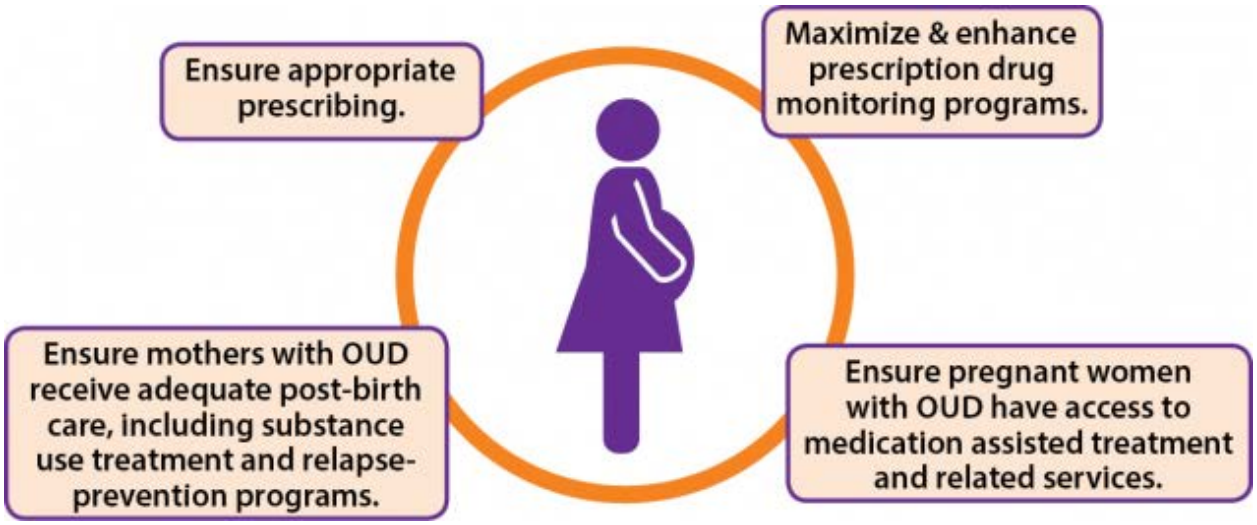
Curious to know what other countries are doing to address and alleviate the Opioid epidemic? Click: https://www.cfr.org/backgrounder/us-opioid-epidemic to find out more information.

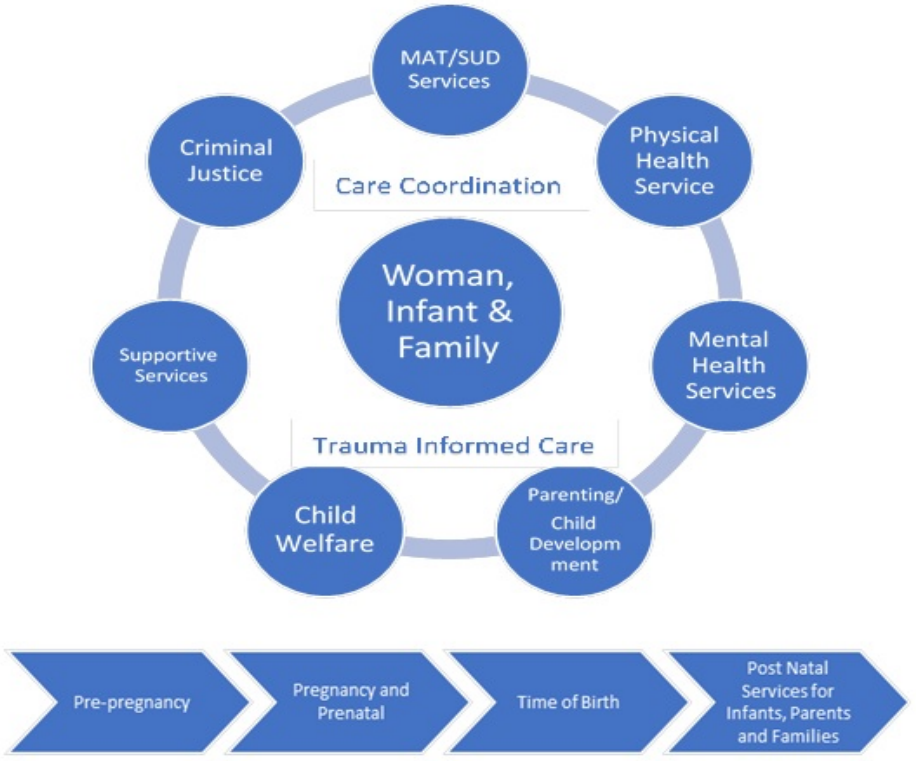
Vulnerable Populations and the Opioid Epidemic

The burden the opioid epidemic has placed on various vulnerable populations such as women and children, as well as minority groups such as Black People and Latin Americans, and LGBTQIA+ people is disproportionate in the United States, thus placing them at greater risk of opioid overdoses, and opioid misuse. [89, 71,39,100,105] Social determinants of health and other community and system level factors cannot be ignored when discussing contextual factors associated with the opioid epidemic and any other major public health issue. Addressing opioid misuse and OUD amongst these populations will need to involve strategies on the local, state, and national level that focus on equitable gender and culturally-specific approaches, trauma-informed care, client-centered services, and policy development that protect these populations from opioid misuse, overdoses, and OUD.

Women

Compared to their male counterparts, women are more likely to experience an opioid use disorder. Both social and environmental factors and experiences such as domestic violence, divorces, and loss of a child or partner can lead women to misuse substances. Additionally, women are more likely to live with chronic pain and receive prescription medications to relieve chronic conditions. As a result, they may utilize prescription opioids in higher doses for longer periods of time. Studies have shown that women are more likely to develop dependency and addiction from smaller amounts of a substance in a shorter period and go to the emergency room or die from an overdose. [67] Between 1999 and 2015, the rate of deaths from prescription opioid overdoses increased 471 percent among women, compared to an increase of 218 percent among men, and heroin deaths among women increased at more than twice the rate than among men. [67] Pregnant women living with an opioid use disorder have been a growing public health issue. In fact, from the years 1999 to 2014, the number of pregnant women with an OUD at labor and delivery more than quadrupled. An opioid use disorder during pregnancy can result in adverse outcomes such as maternal death, preterm births, still birth, and neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS). In 2016, approximately one baby was diagnosed with NAS every 19 minutes in the United States**.** The Center for Disease Control and Prevention has discussed strategies for addressing OUD among pregnant women which involve surveillance of prescribing, access to appropriate MAT, and post-birth care that involves comprehensive services.





Black/African Americans

Black/African Americans have been devastated with the opioid epidemic since the inception of the "The War on Drugs" in the early 1970s. Instead of providing appropriate treatment and services, this campaign led to the mass incarceration of drug users, especially in conjunction with the 1980's rock/powder distinction in sentencing for polysubstance users, and the 1994 Crime Bill, and this led to the carceral disruption of primarily Black/African American families and communities. The black population was criminalized for drug-related offenses at much higher rates than their white counterparts and this has had lasting effects to present day. [31] This form of discrimination and implicit biases prevalent in the under-prescribing of opioids for chronic pain among the African American community. Studies have shown that Black/African Americans were less likely to be prescribed opioids for pain due to some providers believing blacks have lower pain levels, as well as biases aligned with black people being drug-seekers. [89] This reticent, if existent, communication between black patients and healthcare providers and other social inequities in healthcare settings put this community at greater risk of overdosing. Between 2015 and 2016, the Black/African American overdose rate increased by 40 percent whereas the overall population increase in the United States was 21 percent. [89]

Hispanic/Latin American

The Hispanic/Latin American population is becoming one of the fastest growing populations expected to comprise nearly 30 percent of the U.S in 2016. [113] Thus, understanding the sociocultural factors that influence drug use and access to prevention, treatment and recovery

in this population is imperative. In 2018, 1.7 million Hispanic/Latin Americans aged 12 and older were estimated to have engaged in opioid misuse in the past year. From 2014-2017, among the Hispanic population drug overdose death rates involving all types of opioids increased, with the sharpest rise from synthetic opioids by approximately 617 percent. Environmental factors pertaining to occupational exposure to more physically demanding manual labor jobs have been associated with the use of opioid pain medications in the Hispanic/Latin American population, making them more susceptible to multiple injuries and higher rates of disability. Like the Blacks/African American community, studies have shown that the Hispanic/Latin American community are significantly less likely to receive an opioid prescription than whites for pain, despite reporting similar levels of pain severity. [92,100,11]

LBGTQIA+

Unfortunately, the LGBTQIA+ community is no exception to the trend of marginalized status indicating greater prevalence of Opioid Use Disorder. According to statistics, those who belong to a marginalized gender or sexuality community are more than twice as likely to use drugs compared to their heterosexual counterparts. LGBTQIA+ individuals face several challenges that exposes them to greater risk of opioid misuse and overdose that include:

- Stigmatization and discrimination (including internalized stigma)
- Emotional and Physical Abuse/hate crimes
- Rejection by social supports (such as traditional supports like churches, families, etc.)
- Accessible and affordable health care

Programs that integrate behavioral health with primary care, address minority stress, and use a trauma-informed approach have the most potential to produce effective, long-term benefits for LGBTQIA+-identified people with opioid use disorder.

New Orleans

The New Orleans EMS, Fire Department, and Police Department have all implemented first responder naloxone. In January of 2016, the New Orleans Health Department (NOHD) issued a parish-wide standing order allowing residents to access naloxone from participating pharmacies without prescription. [19] Louisiana Department of Health (LDH) expanded the standing order statewide the following year. NOHD is currently establishing the New Orleans Opioid Survival Connection program, where survivors of overdose will be directly linked to treatment services. In addition, Metropolitan Human Services District (MHSD) used the MAT-PDOA grant funding to increase access to treatment and provide naloxone kits at their clinics and partner addiction treatment centers, including OHL. MHSD has more recently received the State Targeted Response to the Opioid Crisis Grant (STR) to further increase treatment services and overdose prevention efforts. NOHD and MHSD facilitate the Opioid Task Force to increase behavioral health resources, coordinate interdisciplinary services, and advocate for individuals with addictive disorders. [19] The Drug Enforcement Administration has implemented their 360 Strategy that involves coordinating local law enforcement agencies, identifying pharmaceutical drug manufacturers, wholesalers, pharmacies, and practitioners operating unlawfully. In addition, the strategy aims to reach out to community members through faith-based groups, schools and health organizations to provide information and resources to educate youth about the risks of opioid use. Orleans Parish has also been selected for The Arnold Ventures grant that will pay for a team of health care experts specializing in substance use disorder to support implementation of MAT services for individuals that are currently incarcerated. These efforts aim to reduce the stigma surrounding addiction and treatment. Other non-government agencies and community organizations have been implementing harm reduction and overdose prevention services including Odyssey House Louisiana, Crescent Care, Trystereo, and Women with a Vision.

Through various partnerships, the City of New Orleans aims to expand media campaigns to educate the community on overdose prevention and treatment services, increase safe medication disposal programs, encourage pharmacies to provide opioid counseling, and to link nonfatal overdose victims in emergency departments directly with care.

Louisiana

Louisiana Department of Health (LDH) has received several federal grants to implement statewide initiatives addressing the opioid epidemic. Most current is the State Opioid Response Grant (LA SOR) awarded for September 2018 for $11 million per year for two years. [53] The grant is aimed at prevention, intervention, treatment and recovery efforts. In addition, the Louisiana Attorney General's Office launched an initiative, "End the Epidemic", offering naloxone to first

responders, and the Louisiana Department of Corrections is investigating the effectiveness of administering naltrexone to individuals released from state custody. [19] In the past year, several pilot programs have been initiated throughout the state:

- Shatterproof, a national non-profit, is working with the Louisiana Office of Behavioral Health to improve the quality of addiction treatment services through a rating system measured using evidence based best practices.

- Louisiana Department of Health is working with Woman's Hospital in Baton Rouge and Slidell Memorial Hospital on the Neonatal Opioid Withdrawal Syndrome Pilot Project in an effort to improve the identification and treatment of pregnant women with opioid use disorders and improve care of infants with neonatal opioid withdrawal syndrome.

Aligning with HHS 5-Point Strategy, Louisiana has embraced the evidence-based "Hub and Spoke" model of addiction treatment and is moving toward this structural model of integrated care.

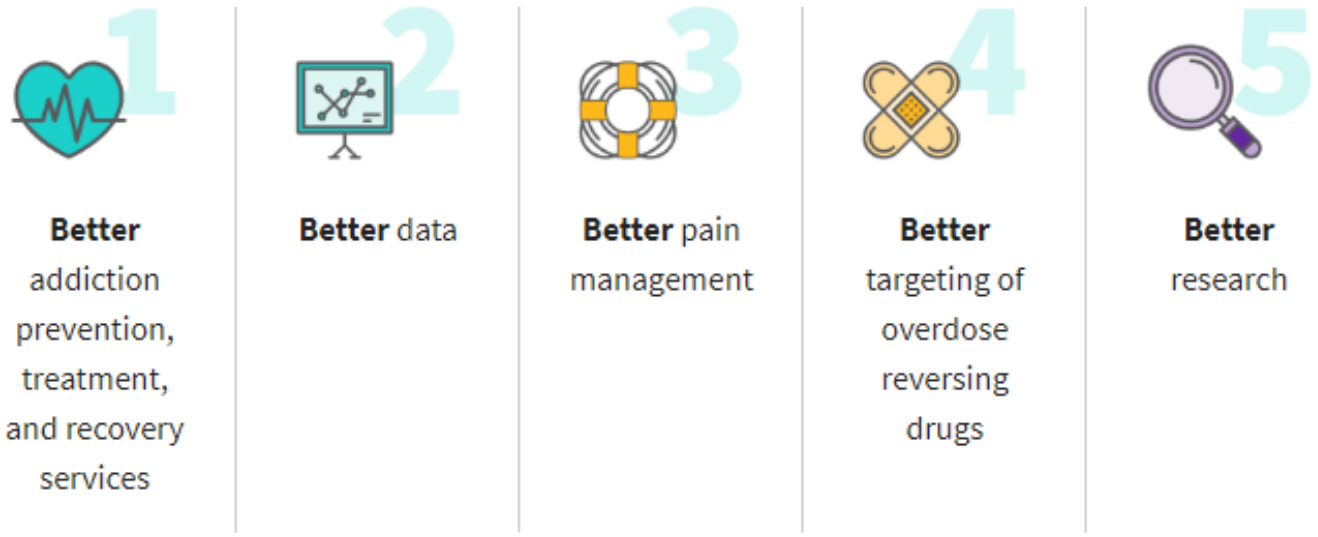
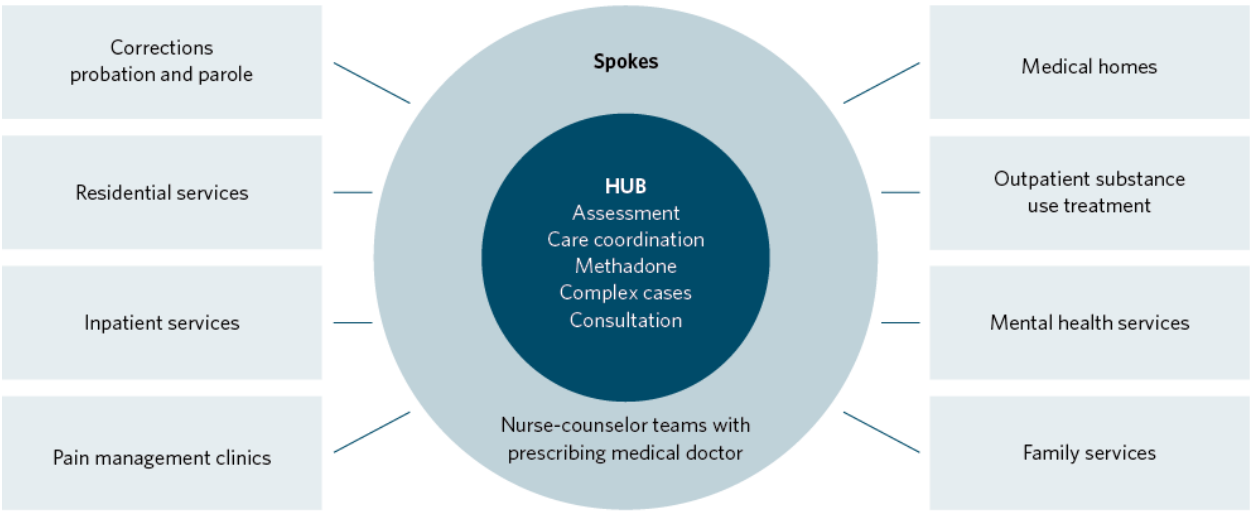


Figure 1

Integrated Health System for Addictions Treatment



Source: Vermont Agency of Human Services, "Integrated Treatment Continuum for Substance Use Dependence, 'Hub/Spoke' Initiative—Phase 1: Opiate Dependence" (January 2012), http://atforum.com/documents/HUBSPOKEBriefingDocV122112.pdf

Louisiana Legislation Addressing the Opioid Epidemic

2006: ACT 676 authorized the Louisiana Board of Pharmacy to develop a Prescription Monitoring Program (PMP).

2013: ACT 110 strengthened the PMP by allowing an unlimited number of delegated users to access the database.

2014: ACT 392, the Good Samaritan Law protects individuals calling 911 in the event of an overdose from criminal charges if drug paraphernalia is found at the scene—first responders may administer opioid antagonists without prescription to an individual exhibiting symptom of overdose.

- ACT 472 mandates the reporting of prescription monitoring information to provide for dispenser (pharmacist) reporting within 24 hours.
- ACT 865 limited dispensing of certain controlled substances, mandates PMP access for Schedule II narcotics for patients' treatment of non-cancer related chronic or intractable pain.

2015: ACT 192 Opioid Antagonist Administration authorizes a licensed medical practitioner to prescribe or dispense Naloxone without having examined the individual to whom it may be

administered. Limits civil and criminal liability for persons who receive or administer an opioid antagonist to a person believed to be undergoing an opioid-related drug overdose.

2016: ACT 370 Naloxone authorizes storage and dispensing of opioid antagonists; authorizes any person to possess an opioid antagonist. Limitation of liability relative to naloxone prescription, dispensing and administration by a third party. House Concurrent Resolution 113 created the Louisiana Commission on Preventing Opioid Abuse.

2017: April 2017- The Opioid Epidemic: Evidence-Based Strategies Legislative Report, recommended strategies for adopting the Guidelines for Prescribing Opioids for data sharing; improving access for pregnant women, prescriber training needs, alternatives to incarceration.

- ACT 310 authorized a Naloxone Standing Order allowing participating pharmacies to dispense naloxone without prescription.
- ACT 76 automatically registered CDS license applicants or renewals in the PMP, mandated PMP review and monitoring prior to opioid prescription, and in order for license renewal, all practitioners with CDS license must take 3 hours of continued education regarding drug diversion, best practices for prescribing controlled substances, addiction treatment, or similar.
- ACT 88 established the Advisory Council on Heroin and Opioid Prevention and Education (HOPE) to establish an Interagency Heroin and Opioid Coordination Plan.
- Lawsuit filed: Louisiana Department of Health, through the Secretary of the Louisiana Department of Health VERSUS Purdue Pharma (and others).

2018: Hope Council published 2018 Year-End Report and State and Local Responses to the Opioid Crisis: Interagency Coordination Plan:
http://ldh.la.gov/assets/docs/BehavioralHealth/HOPE/HOPEendofyear-APPROVED.pdf

- ACT 174 Provides for a neonatal opiate withdrawal syndrome pilot project to improve outcomes associated with neonatal abstinence syndrome
- ACT 232 Adds an LDH epidemiologist to the list of those who have access to the PMP data
- ACT 28 Provides relative to a voluntary non-opioid directive form

2019: Hope Council published Substance Use Disorder Treatment Policy Recommendations for the State of Louisiana Final Report- March 2019
http://ldh.la.gov/assets/docs/BehavioralHealth/PEW_Charitable_Trust_Final_Report.pdf

- The Louisiana Department of Health Opioid Steering Committee published Louisiana's Opioid Response Plan: A Roadmap to Decreasing the Effects of the Opioid Epidemic http://ldh.la.gov/assets/opioid/LaOpioidResponsePlan2019.pdf
- ACT 80 Authorizes the Pharmacy Board to provide PMP information to electronic health information systems and pharmacy information systems located in other states, territories, federal districts, and federal jurisdictions.

- ACT423 Provides a requirement that each coroner report drug overdose deaths where the decedent's toxicology results indicate that an opioid was present at the time of death.
- SCR 31 Designates LDH as the lead authority over the HOPE Advisory Council
- ACT 425 Requires each residential treatment facility licensed pursuant to existing law, R.S 40:2151 et seq., which provides treatment for opioid use disorder to provide MAT
- HCR 71 Requests the LDH issue regulations to allow the establishment of new opioid treatment programs and methadone dosing sites.

2020: On October 2020 Louisiana United States Attorneys Announce $26,541,823 in awards to address local criminal justice needs and victims' rights issues in Louisiana. Three grants were awarded to the Louisiana Commission on Law Enforcement (LCLE).

- The first award in the amount of $23,490,366 provides funds from the federal Crime Victims Fund to enhance crime victim services in the state.
- The second award of $1,414,000 provides funds from the Crime Victims Fund to enhance State Victim Compensation payments to eligible crime victims.
- The third, $190,769 was awarded to the Louisiana Statistical Analysis Center (SAC), which is the research division of the LCLE. LSAC has been tasked with assessing how law enforcement in the State of Louisiana is meeting the challenge of the present opioid crisis.

The purpose of this program is to support state and local delinquency prevention and intervention efforts and juvenile justice system improvements. Supported activities and efforts may include planning and administration and development of more effective education, training, research, prevention, diversion, treatment, and rehabilitation programs in the area of juvenile delinquency and programs to enhance the effectiveness of the juvenile justice system.

Louisiana State Legislation surrounding Naloxone and the Opioid Epidemic

Below shows Louisiana State Legislation discusses revised statuses addressing and responding to opioid overdose, reporting and opioid overdose, administering naloxone, and continuing education for prescribing of controlled substances.

Public Health and Safety:

- RS 40:978- Prescriptions
  - http://www.legis.la.gov/legis/Law.aspx?d=98895
- RS 40:978.1- Naloxone; first responder; prescription; administration to third party; limitation of liability
  - http://www.legis.la.gov/legis/Law.aspx?d=920749
- RS 40:978.2.1- Reporting of opioid related overdose.
  - http://www.legis.la.gov/legis/Law.aspx?d=1147537
- RS 40:978.2- Naloxone; prescription; dispensing; administration by third party; limitation of liability

    - http://www.legis.la.gov/legis/Law.aspx?d=965145
- RS 40:978.3- Continuing education for the prescribing of controlled substances.
    - http://www.legis.la.gov/legis/Law.aspx?p=y&d=1054653

Criminal Law:

- RS 14.403.10- Drug-related overdoses; medical assistance; immunity from prosecution
    - http://www.legis.la.gov/legis/Law.aspx?p=y&d=919601
- RS 14.403.11- Administration of opiate antagonists; immunity
    - http://www.legis.la.gov/legis/Law.aspx?d=919602

National

Due to the escalation of the Opioid Epidemic, there has been a drastic increase in responsiveness at the national level, and an increased prevalence in policy implementation attempting to mitigate and reduce opioid overdose fatalities. The Consolidated Appropriations Act, 2017 provided HHS with $20 million for Comprehensive Addiction Recovery Act (CARA)-authorized programs, specifying $56 million for SAMHSA's Medication Assisted Treatment for Prescription Drug and Opioid Addiction program.[94] Congress provided $103 million for "comprehensive opioid abuse reduction activities" from the Department of Justice (DOJ). The Department of Veterans Affairs provided $50 million to increase opioid and substance misuse prevention and treatment.[94]

Recent legal trends across all fifty states concerning liability, treatment/prevention, and privacy illustrate a national movement toward reducing opioid misuse and overdose. Good Samaritan Statutes have been increasingly implemented across multiple states, providing immunity from arrest for drug possession when a person dials 911 or seeks medical attention in the event of an overdose.

Class Action Product Liability suits against manufacturers and distributors of prescription opioids by states and individuals for fraudulent marketing and negligent distribution have increased in frequency and have yielded success for the plaintiffs. Similar lawsuits have been issued against the Joint Commission, holding them liable for issuing misinformation to prescribers and pharmacy boards for failing to report excessive orders of opioids. [94] There has also been an increase in federal prosecutions through Department of Justice's Opioid Fraud and Abuse Detection Unit against healthcare fraud cases related to wrongful or over-prescribed opioids [40].

Overdose prevention and treatment efforts have seen increasing legal support across the nation as well. Opioid Prescription Limitations are being implemented across numerous states typically permitting only a 5-day supply of opioids for acute pain or a 7-day supply following surgery. Policies encouraging naloxone expansion are now common among first responders and law enforcement agencies. Statewide Standing Orders authorizing pharmacists to dispense naloxone to individuals 18 or older without prescription have been widely accepted, as well.

Legislative support for Harm Reduction programs such as safe disposal programs, syringe exchanges, and safe injection facilities is growing, as research illustrates their effectiveness in reducing overdose and infectious disease rates. Overall, there has been an increase of educational initiatives including the Drug Enforcement Administration's (DEA) partnership with Discovery Education to implement Operation Prevention— offering free educational tools and material for youth to combat opioid misuse. Countless other governmental, not-for profit, and private resources have been made available to promote educational initiative surrounding the opioid epidemic and linkage to care.

Use of Prescription Drug Monitoring Programs (PDMPs) has increased significantly, which allow prescribers to check prescription databases that track individual prescription histories. There have been legislative proposals to allow law enforcement agencies to access the PDMPs without court orders, in order to investigate doctor-shopping. While the CDC already practices extensive surveillance, prevention, and research efforts, there is growing federal support for research partnerships that would increase data collection on addiction and overdose.

National Legislation Addressing the Opioid Epidemic

2016: The Center of Disease Control and Prevention published the Opioid Prescribing Guidelines.

2017: President Trump issues Executive Order establishing White House Commission on Combating Drug Addiction and the Opioid Crisis.

- President Trump announces HHS Public Health Emergency (PHE).
- Final White House Commission Report issued recommending:
    - Increasing federally funded initiative to support opioid-related efforts at the state level. The spending bill passed by Congress in March 2018 included $3.3 billion increase for opioid funding.
    - Media campaigns encouraging at-risk individuals to seek treatment.
    - Removing legal barriers to use Prescription Data Monitoring Programs (PDMPs). On February 2018, Jeff Sessions announced a plan to use medical data from PDMPs to hold doctors and pharmacies dispensing large amounts of opioid accountable.
    - Expanding drug courts nationally to embrace MAT.
    - Developing opioid prescribing guidelines, regulations, and education. April 2018, CMS released final Medicare rule requiring pharmacists to contact prescribers and document discussions before filling prescriptions of over 90 mg of morphine. September 2018, CDC published Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain.
    - Ensuring greater health care coverage for substance use treatment. Current Administration has continued prior policy of approving waivers to let Medicaid programs pay for addiction and mental health treatment in facilities >16 beds.
    - Encouraging non-opioid pain treatment.

- Raising criminal penalties for illicit drug trafficking, especially for fentanyl. In January 2018, Pres. Trump signed the Interdict Act giving federal agents further tools for detecting synthetic opioids at the border. March 2018, Pres. Trump announced a plan to increase penalties for drug traffickers, including the death penalty.
- Implementing naloxone co-prescribing programs and EMT best practices.

2018: U.S. Surgeon General, Dr. Jerome Adams, issued a Public Health Advisory on Naloxone and Opioid Overdose, encouraging more community members to carry naloxone.

- Center for Medicare & Medicaid Services (CMS) released guidance on Medicaid detailing reimbursement tools and resources for states that can be used to curb the opioid crisis and highlighting successful practices.
- The Comprehensive Opioid Recovery Act of 2018 passed the House. It would grant $10 million to HHS to fund at least 10 new or existing recovery centers.
    - SAMHSA opened applications for $930 million of funding for states and territories to pursue prevention, treatment, and recovery services.
    - The SITSA Act passed the House. It classified synthetic opioids above the CSA Schedule 1 and tightens importation checks.
    - The House passed the SUPPORT for Patients and Communities Act that combined numerous opioid bills for Senate consideration.
    - SUPPORT for Patients and Communities Act (the SUPPORT Act) includes provisions to prevent opioid addiction and increase access to treatment as well as control the supply of illicit drugs into the country. The law provides loan repayment options for professionals in areas of high need, promotes telehealth, revises the Institutions for Mental Disease exclusions for pregnant and post-partum women, and allows for Medicare coverage of Opioid Treatment Programs.
    - Synthetics Trafficking and Overdose Prevention Act (STOP Act) strengthens coordination between FDA and Customs and Border Protection to improve illicit drug detection.

2019: The U.S. Department of Health and Human Services (HHS) announced more than $1.8 billion in funding to states to continue the Trump Administration's efforts to combat the opioid crisis by expanding access to treatment and supporting near real-time data on the drug overdose crisis.

Louisiana Opioid Spending by Department

Department	FY2017	FY2018
Health and Human Services	$39,355,629	$66,603,880
Substance Abuse and Mental Health Services Administration	*$37,972,317*	*$50,820,229*
Centers for Disease Control and Prevention	*$997,702*	*$4,159,002*
Health Resources and Services Administration	*$0*	*$8,969,833*
Administration for Children and Families	*$385,610*	*$1,661,377*
National Institutes of Health	*$0*	*$993,439*
Office of National Drug Control Policy	$5,480,170	$5,815,883
Department of Justice	$3,424,118	$9,513,672
Department of Labor	$0	$0
Total Opioid Spending	**$48,259,917**	**$81,933,435**

Louisiana Opioid Spending by Category

Category	FY2017	FY2018
Treatment and Recovery	19%	24%
Prevention	21%	21%
Mixed: Treatment/Recovery and Prevention	41%	36%
Research	0%	1%
Criminal Justice	9%	13%
Law Enforcement	9%	6%

Opioid Appropriation by Department

Department	FY2017	FY2018
Health and Human Services	$2,765,589,000	$5,521,368,000
Substance Abuse and Mental Health Services Administration	*$2,603,679,000*	*$3,685,479,000*
Indian Health Service	*$6,000,000*	*$6,000,000*
Centers for Disease Control and Prevention	*$112,000,000*	*$630,579,000*
Health Resources and Services Administration	*	*$480,000,000*
Administration for Children and Families	*$43,910,000*	*$125,310,000*
National Institutes of Health	*	*$500,000,000*
Food and Drug Administration	*	*$94,000,000*
Office of National Drug Control Policy	$351,000,000	$379,000,000
Department of Justice	$194,000,000	$515,839,484
Veterans Affairs	*	$704,552,000
Homeland Security	*	$261,100,000
Department of Labor	*	$21,000,000
Total Opioid Spending	**$3,310,589,000**	**$7,402,859,484**

* = No opioid-specific appropriations.

Source: Bipartisan Policy Cent

Global

In June of 2018, the United Nations Office on Drugs and Crime (UNODC) launched The UNODC Integrated Strategy on the Global Opioid Crisis, to address the global opioid epidemic, which is predominately affecting North America, parts of Africa and the Middle East. The initiative aims to address international control of substances, law enforcement efforts to target supply, and implementation of initiatives to strengthen prevention efforts. The strategy plans on forming global partnerships with the World Health Organization and International Narcotics Control Board, along with other international and regional organizations, academic institutions, and civil society. In collaboration with Member States, the UNODC is working to support programs in the areas of synthetic drugs monitoring, early warning and trend analysis, national forensic and counter-narcotic capacity building, law enforcement operational work, and prevention and treatment [107]. The UNODC Opioid Strategy is laid on the following five pillars:

Lessons and Recommendations

There have been significant successes, efforts, and lessons to learn as communities around the globe have been battling the opioid epidemic. Law enforcement, emergency medical services,

governmental offices, corporations, and non-profit agencies alike have all played a role. Taking a closer look at these lessons and drawing recommendations from them will ensure the New Orleans Community structures and implements evidence-based initiatives.

Examples across the world illustrate a variety of models that can be used to effectively distribute naloxone:

1. State or City Public Health Departments fund and have a role in administering a naloxone program (i.e. Massachusetts, New York, Washington, New Mexico, Ohio, San Francisco, Baltimore)

2. Non-profit community-based organizations (CBO) provide overdose prevention services and access to naloxone without state or city involvement using non-governmental grants (i.e. Pennsylvania, Connecticut, Michigan, Wisconsin, Colorado)

3. Naloxone is prescribed during a visit with a care provider and filled at a pharmacy or dispensed during the visit (i.e. Project Lazarus, Duquesne University Pilot)

4. Medical personnel are involved directly. Advanced practice nurses or physicians are present when naloxone is distributed to “sign-off” on prescriptions, trainings are done by medical staff

5. Standing Order- written by Medical Director of the program to allow distribution by trained non-medical staff.

<u>Chicago, Il</u>

Harm Reduction is a model of practice aimed at reducing negative physical or social consequences associated with behaviors. Beginning its efforts in 1992, Chicago Recovery Alliance (CRA) is now one of the largest Harm Reduction Programs in the nation. [101] Their initial efforts resulted in providing syringe access and other injection equipment that was otherwise illegal to purchase at the time without a prescription. In collaboration with medical professionals, the agency began naloxone trainings and distribution to program participants, staff, and volunteers. CRA was able to advocate for the implementation of the Good Samaritan Law in 2010, protecting naloxone prescribers and administrators from criminal charges when responding to an overdose. CRA has since become a resource for harm reduction programs across the country, providing guidance and material as new programs emerge.[41}

CRA exemplified the principles of the Harm Reduction model, which recognizes both the internal and external forces feeding addiction, and empowers individuals directly impacted to be the source of their recovery as well as systematic solutions. Research has illustrated the Harm Reduction efforts are incredibly effective in reducing the negative impacts of drug use and connecting individuals with addiction to the treatment services they need for recovery. However, the stigma surrounding addiction has delayed public buy in and support of Harm Reduction policies. Historically, our nation has moralized the issue of substance use, resulting in the criminalization of substances deemed illicit at the time. Concurrently, the socioeconomic disparities found between geographic and demographic groups results in populations being impacted more harshly by the criminalization of substances. As we increase diversion and treatment efforts and move away from punitive policies, reparations to support and rebuild communities that have been negatively impacted by the criminalization of substances is only fair.

Recommendation: Incorporate Harm Reduction Policies, understand the principles of Harm Reduction and implement policies and practices that are aligned in both direct service practice as well as systematic structure.

Wilkes Count, NC

Many of the first overdose prevention programs focused on individuals who inject drugs through Harm Reduction efforts, such as syringe access programs. However, Project Lazarus of Wilkes County, North Carolina, found that their needs differed. In 2009, their rates of overdose mortality were four times higher than the state average. Further research showed that 80% of the individuals who had died of overdose also had legal prescriptions for the substance that killed them. [21] This information led to an intervention targeting various medical practices, such as long-term pain management and substance use treatment. The initiative trains prescribers to assess and identify patients with a high risk of overdose, and to prescribe or co-prescribe naloxone as needed. [21] The initiative was able to successfully reduce overdose rates by 69% between the years of 2009 and 2011. The outstanding success of their pilot program resulted in additional grant funding, partnership with Community Care North Carolina (CCNC), the state's nonprofit Medicaid managed care plan, and statewide expansion of their initiative including the implementation of a prescription monitoring program.[70] As the program grew, Project Lazarus

was able to provide naloxone training to community members, case managers, primary care providers, emergency room physicians, and pharmacists.

Recommendation: Train medical professionals

Louisiana's opioid prescribing rates are above national average, therefore the risks for addiction and overdoses are also higher for Louisiana residents. Medical professionals including prescribers need additional training in evidence-based practices that will reduce patient risk for opioid overdose. This includes assessing for opioid overdose risk, implementing best practices for prescribing opioids, and prescribing/co-prescribing naloxone as needed.

Pittsburgh, PA and Rhode Island

The Overdose Prevention Project (OPP) of Prevention Point Pittsburgh replicated the initiative pioneered by Project Lazarus by making naloxone available through standard prescription. However, the unique partnership with the Center for Pharmacy Services (CPS) incorporated pharmacists in a novel way. Starting in 2011, patients coming to CPS to fill opioid prescriptions were offered information on opioid safety including signs of an overdose and administration of naloxone. If requested, the pharmacist could write/fill a naloxone prescription on behalf of the patient [21]. This trend to incorporate pharmacists directly in overdose prevention efforts was occurring concurrently in other parts of the country as well.

Rhode Island was hit hard by the opioid epidemic, and by 2005, it had the highest rates of illicit drug use per capita. The RI Board of Pharmacy played a critical role in addressing the crisis by approving a collaborative pharmacy practice agreement for naloxone (CPAN) which in collaboration with prescribers, allowed pharmacists to distribute naloxone. Beginning in 2011 with only five Walgreens Pharmacies, the pharmacy-led initiative expanded significantly by 2014. [84] This model of public health and commercial partnership is conceptually like Standing Orders that allow pharmacies to distribute naloxone without a prior prescription that began being implemented in several states around that same time. [29]

Recommendation: Train and build collaborative practices with Pharmacies.

Although Louisiana has implemented a state-wide Standing Order for Naloxone since 2016, public knowledge and implementation of the Standing Order has not been maximized. Many people who inject drugs face barriers to accessing Naloxone via pharmacies. Building partnerships with corporate and local pharmacies will build sustainable access to naloxone.

Prevention Point Pittsburgh

Aside from the collaborative efforts with pharmacists, Prevention Point Pittsburgh (PPP) also established partnerships focused on the needs of incarcerated individuals, who experience an especially high risk of overdose within the first two weeks of release. [10] Recognizing the unique needs of inmates, PPP established the Jail Collaborative in 2000 to reduce recidivism and

establish better outcomes for inmates following incarceration. The program included hour-long training sessions conducted within the jail that focused on overdose, naloxone administration, and rescue breathing, along with local Harm Reduction resources. The initiative successfully disseminated information and participants' feedback illustrated utilization of services upon release. [38]

Recommendation: Train and link individuals who are at risk of addiction and opioid overdose to services.

Research has identified characteristics that increase an individual's risk for opioid overdose. Efforts should prioritize these groups, which include individuals taking opioids for long-term management of chronic pain, those leaving institutionalization such as incarceration, addiction treatment, and hospitalization

Massachusetts

The statewide overdose prevention initiative in Massachusetts began in the late 1990s with only a few committed activists working with individuals who inject drugs. They began informally distributing naloxone to at high-risk individuals. At the time, their efforts were not sanctioned, and they had growing concern that they were jeopardizing their participants with potential legal complications. To build a case for the initiative, they began tracking their naloxone distribution and reversal rates. They presented this information in a report to the Boston Public Health Commission which was then used as a proposal to implement the distribution of naloxone at the city's needle exchange. By 2005, there was growing interest from several agencies to incorporate overdose prevention and naloxone distribution into their state-funded HIV prevention programs. In 2016, with support from the Mayor, community advocates, medical professionals and drug users, the Board of the Boston Public Health Commission and the City of Boston's Health Department sanctioned a city-wide naloxone distribution program. The success was contagious and shortly after the Cambridge Public Health Department implemented the same program for their region.[67] By 2007, the Massachusetts Department of Public Health established a plan to address overdose on a statewide level, implementing many of the strategies presented by the founding overdose prevention activists. By 2011, the state initiative successfully trained more than 10,000 community members and recorded 1,200 confirmed reversals.[41]

Recommendations: Accurate data collection

Without data collection, this initiative would not have had the credibility that encouraged so many agencies to replicate and expand their efforts. Data not only allows us to understand the reality of the impact of opioids, it also holds programs accountable in meeting community needs.

Recommendation: City-and State-wide collaboration

The collaborative practice between activists, non-profits, and governments illustrates that initiatives that are aligned with common goals and programs create a streamlined effort that is simultaneously effective and efficient. Too often, we see agencies working in silos without integrated communication or efforts. This creates a barrier for community member who struggle to find appropriate care and navigate through services.

Incorporate Evidence Based Practice Models in Health Care Settings

As our health care system adjusts to meet the needs of our community, research has identified the success of integrated health care services. This is the systematic coordination of general and behavioral healthcare. This model employs an evidence-based practice that has not traditionally been applied in the medical field to support integrated care, thus allowing for greater health equity.

Harm Reduction Model

Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. The Harm Reduction Coalition lists these defining principles:

1. Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe harmful use to total abstinence and acknowledges that some ways of using drugs are clearly safer than others.

3. Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.

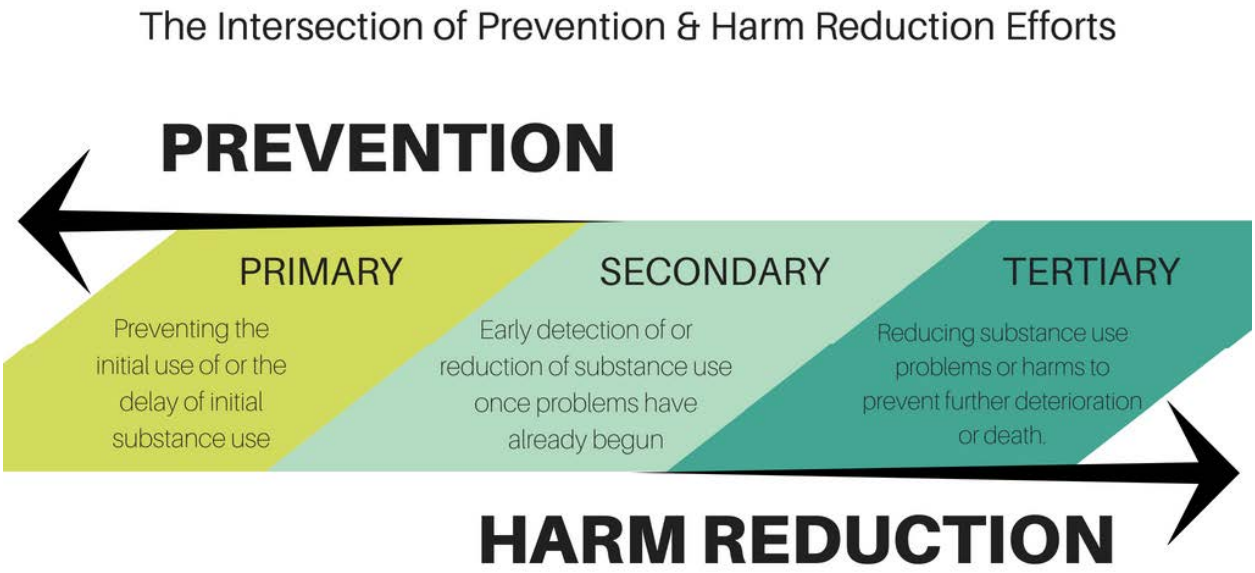
4. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

5. Ensures that individuals who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

6. Affirms that individuals who use drugs themselves are the primary agents of reducing the harms of their drug use and seeks to empower them to share information and support each other in strategies which meet their actual conditions of use.

7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

8. Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.



Outreach and Prevention are intended to bring resources and information to individuals and communities that face barriers to access. Harm Reduction is implemented on both the policy and direct practice level. For instance, naloxone access programs can be implemented in healthcare facilities, opioid treatment programs, and pain management clinics. Naloxone access programs can be as simple as prescribing naloxone upon request, or more comprehensive programming, including take home naloxone kits and training classes. Clinics may consider purchasing naloxone directly from manufacturers or distributors, in order to eliminate additional barriers to access for patients. Through providing education on substance use, addiction treatment, overdose prevention, and appropriate referrals to community resources Outreach and Prevention effectively reduces community risk and links individuals to a continuum of care they need. [41]

Trauma Informed Care

Much like the Harm Reduction Model, a Trauma Informed Approach to services can be accomplished both in macro and micro practice. The Adverse Childhood Experience (ACES) Study unveiled the lasting impacts of childhood trauma and the direct correlation with health outcomes. The 10-question survey assesses early trauma experiences and research has shown that as the number of traumatic experiences increase an individual becomes more at risk for a variety of health concerns. Knowing that trauma directly impacts health outcomes,

incorporating a Trauma Informed Approach within our healthcare systems has the potential to increase successful treatment interventions and improve the overall health of patients and communities.[102] Take, for example many trauma survivors are either misdiagnosed or under-diagnosed, because general assessment tools to evaluate mental health disorders misclassify post-traumatic symptoms with other disorders. This can result in inappropriate treatment and even re-traumatization. [120]

"What's wrong with you?" versus "What happened to you?"

Trauma informed care shifts the focus of asking "what's wrong" to "what happened?" This approach to care acknowledges the need to understand a patient or client's life situation (past and present) in order to provide effective healthcare services. Adopting trauma informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. As healthcare providers moves toward becoming trauma- informed, ensuring emotional wellness among professional and non-professional staff is vital requirement for providing quality care. It can also help reduce avoidable care and excess costs for both the health care and social service sectors. Trauma-informed care seeks to:

- Realize the widespread impact of trauma and understand paths for recovery.
- Recognize the signs and symptoms of trauma in patients, families, and staff.
- Integrate knowledge about trauma into policies, procedures, and practices.
- Actively avoid re-traumatization.

The impact of trauma and instances of addiction have been directly linked. There are three hypotheses posed to explain the relationship between trauma and addictive disorders:

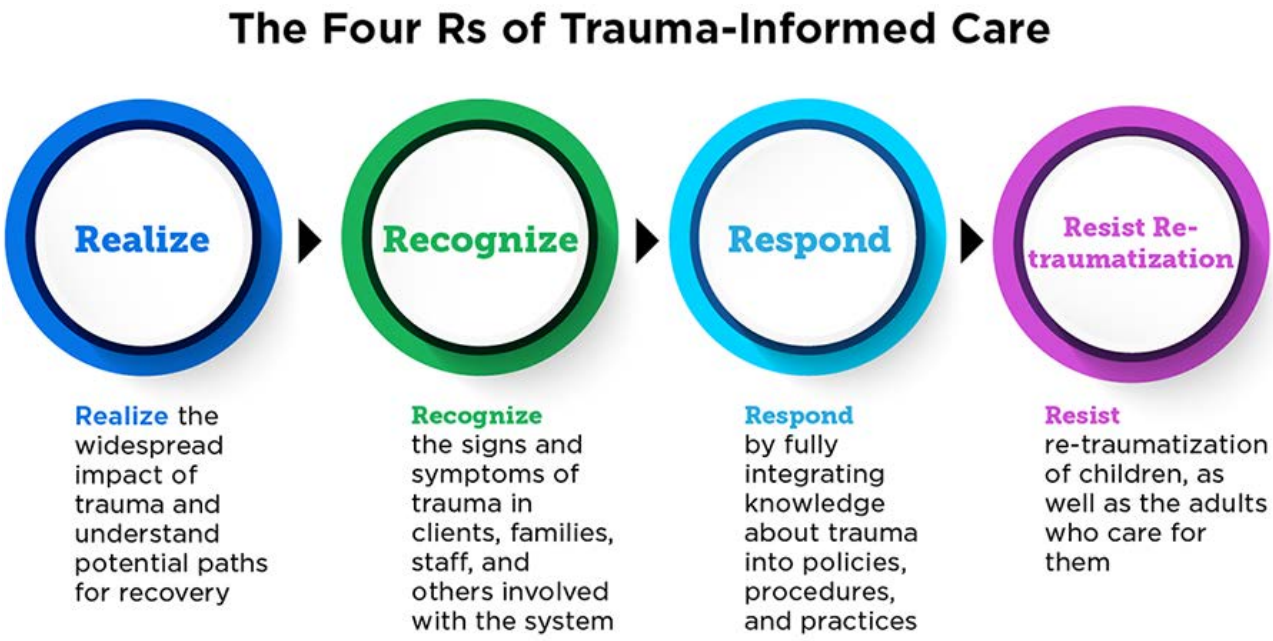
1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently used in attempts to relieve or numb emotional pain or to forget the event.

2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.

3.

3.The “susceptibility” hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use. [120]

SAMHSA encourages community service providers and agencies to embrace a Trauma Informed Approach and lists four principles that are the foundation to developing and practicing under this model.



This figure is adapted from: Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and Guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

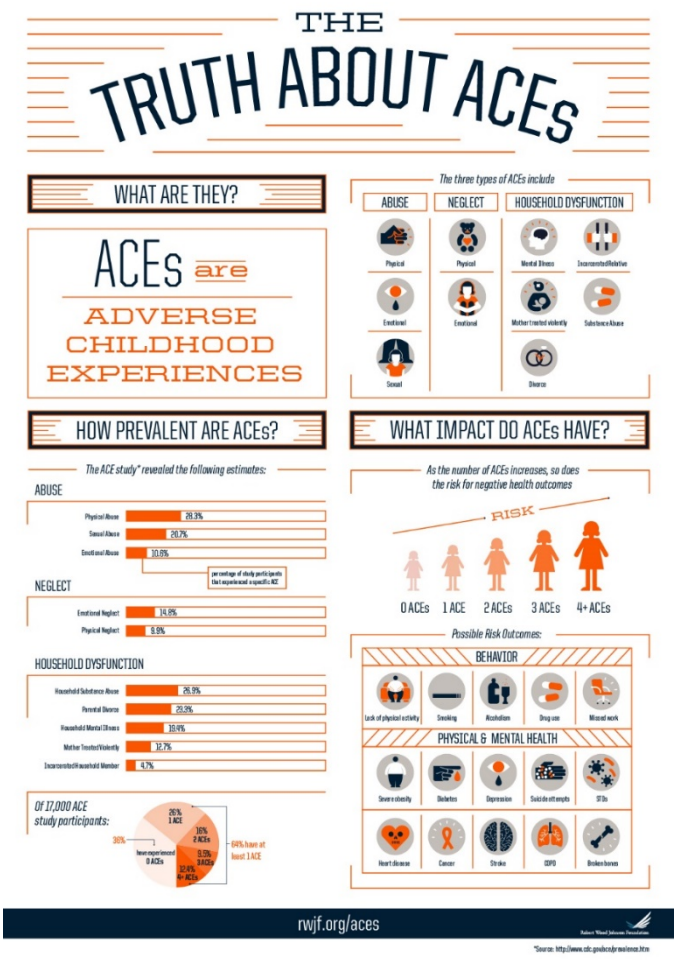
Expanding on these foundational principles, SAMHSA has outlined six values and practices that define a Trauma Informed health care agency.

ACEs are common. Approximately 61% of adults surveyed across 25 states reported that they had experienced at least one type of ACE, and nearly 1 in 6 reported they had experienced four or more types of ACEs.

Preventing ACEs could potentially reduce a large number of health conditions. For example, up to 1.9 million cases of heart disease and 21 million cases of depression could have been potentially avoided by preventing ACEs.

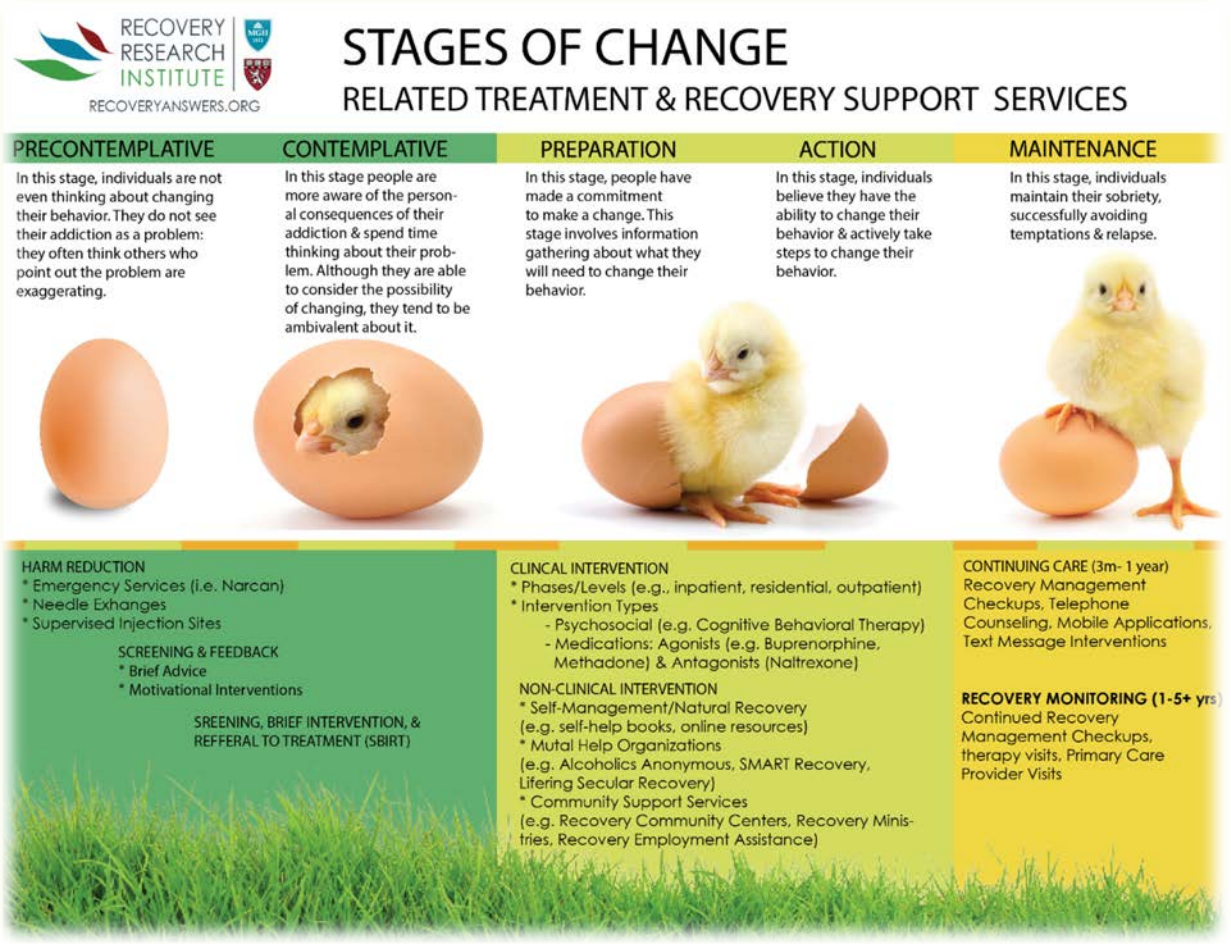
Some children are at greater risk than others. Women and several racial/ethnic minority groups were at greater risk for having experienced 4 or more types of ACEs.

ACEs are costly. The economic and social cost to families, communities, and society of adverse childhood experiences total hundreds of billions of dollars each year. [14]



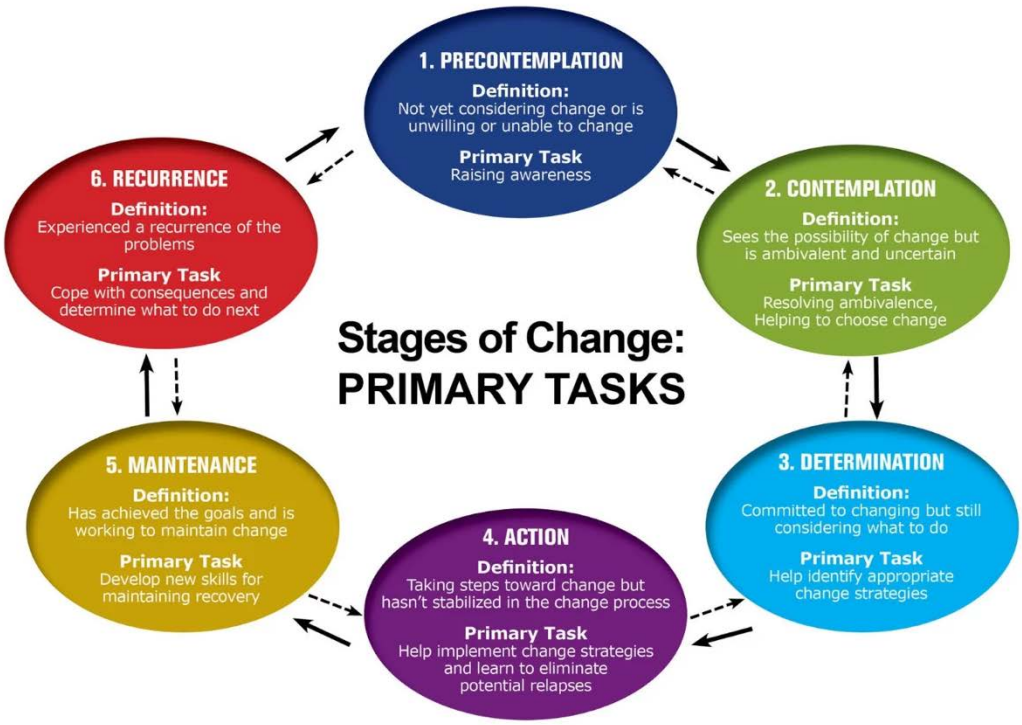
Adverse Childhood Experiences are preventable when appropriate measures are taken. Creating and sustaining safe, stable, nurturing relationships and environments for children can prevent ACEs. Additionally, screening and assessing for trauma can support reducing connecting patients with the services, support, and treatment they need to recover and lead healthier lives. Please visit the Center for Disease and Control to learn more about Adverse Childhood Experiences and their after effects: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

Harm Reduction Models and Trauma Informed Approaches to treatment both derive from the same radical, that providers should meet their clients where they currently are in their process of recovery and life. The Transtheoretical Model of Change and Stages of Change Models, in conjunction with assessing a client's readiness for change allow us to meet clients where they are, as proscribed in these larger actionable frameworks. There are a variety of processes of change that may transition an individual from one stage to another, and the resolution of stage specific tasks supports successful transition to a following phase of change. Health care providers should be familiar with these stages of change, processes of change, and primary tasks in order to provide their patients with stage appropriate interventions, which result in more successful treatment outcomes. Motivational Interviewing is a common practice that outlines communication techniques proven to empower and support individuals through the change process. [102]



Patient Screening and Assessment

Research has shown that the development of addictive disorders and risk of overdose are impacted by a range of biopsychosocial influences. Screening and assessing potential risk factors beyond physical health lead to more accurate diagnosis and therefore effective treatment interventions. Using evidence-based screening and assessment tools to guide referral and treatment decisions is best practice:



<u>Pain Screening Tools:</u>

- Pain Assessment and Documentation Tool (PADT)- designed to be easily included in a patient's medical record and to facilitate ongoing evaluation of patient pain and documentation of pain management.

The McCaffrey Initial Pain Assessment can be used to guide health care professionals through an initial assessment of patient Behavioral Health Screening Tools:

- Patient Health Questionnaire (PHQ-9)- common screening tool for depression
- Patient Stress Questionnaire- used in primary care settings to screen for behavioral health symptoms.
- Life Events Checklist (LEC)- A brief, 17-item, self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC assesses exposure to 16 events known to potentially result in PTSD or distress and includes one item assessing any other extraordinarily stressful event not captured in the first 16 items.

- Primary Care PTSD Screen (PC-PTSD) designed for use in primary care and other medical settings to screen for possible PTSD
- Generalized Anxiety Disorder 7-item (GAD-7) scale- screens for generalized anxiety
- Adverse Childhood Experience (ACEs) Questionnaire-screens for potential trauma during childhood

Opioid Use Specific Screening Tools:

Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.

Choose evidence-based screening tools and assessment resource materials

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Screens						
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	X	X	X	See APA Adapted NM ASSIST tools	See APA Adapted NM ASSIST tools	X
Alcohol Use Disorders Identification Test-C (AUDIT-C (PDF, 41KB))	X		X		X	X
Alcohol Use Disorders Identification Test (AUDIT (PDF, 233KB))	X		X			X
Opioid Risk Tool (PDF, 168KB)		X	X		X	
CAGE-AID (PDF, 30KB)	X	X	X			X
CAGE (PDF, 14KB)(link is external)	X		X			X
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Assessments						
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
CRAFFT(link is external)	X	X		X	X	X
Drug Abuse Screen Test (DAST-10)* *For use of this tool - please contact Dr. Harvey Skinner(link sends email)*		X	X		X	X
Drug Abuse Screen Test (DAST-20: Adolescent version)* *For use of this tool - please contact Dr. Harvey Skinner(link sends email)*		X		X	X	X

NIDA Drug Use Screening Tool (NMASSIST)	X	X	X			X
Helping Patients Who Drink Too Much: A Clinician's Guide (NIAAA)	X		X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
**Tools with associated fees*						

Click:https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools to find more information.

Use CDC Guidelines for Prescribing Opioids

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

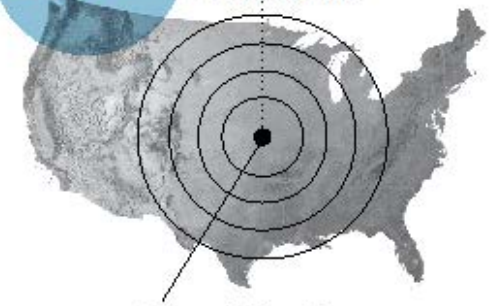
WHAT IS A PDMP?

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

249M prescriptions for opioids were written by healthcare providers in 2013

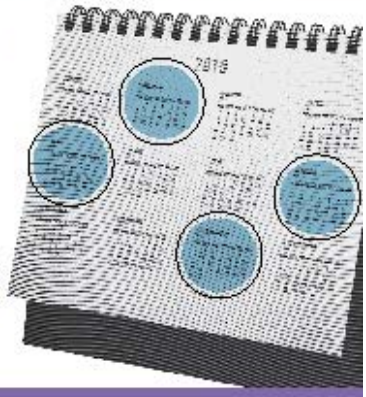


enough prescriptions for every American adult to have a bottle of pills

Improving the way opioids are prescribed will ensure patients have access to safer, more effective chronic pain treatment while reducing opioid misuse, abuse, and overdose. Checking your state's PDMP is an important step in safer prescribing of these drugs.

WHEN SHOULD I CHECK THE PDMP?

State requirements vary, but CDC recommends checking at least once every 3 months and consider checking prior to every opioid prescription.



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Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1. **Confirm that the information in the PDMP is correct.**
   Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2. **Assess for possible misuse or abuse.**
   Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**

WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?

High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.

Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

For more information on the Center for Disease Control and Prevention guideline's for prescribing opioids Click: https://www.cdc.gov/drugoverdose/prescribing/guideline.html

Patients Who Benefit from Naloxone Prescription

"I, Surgeon General of the United States Public Health Service, VADM Jerome Adams, am emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, knowing how to use naloxone and keeping it within reach can save a life. BE PREPARED. GET NALOXONE. SAVE A LIFE."

Surgeon General Jerome Adams, MD, MPH 2018

Naloxone is not a controlled substance and can be prescribed routinely to patients at risk of an opioid overdose or family, friends, and caregivers of individuals at risk of an opioid overdose. Patients who could benefit from Naloxone prescription include those who: [95,21]

1. Have received emergency medical care for opioid detoxification or overdose
2. Have just been released from incarceration or institutionalization with a history of opioid addiction
3. Have reported or suspected history of harmful substance use or non-medical opioid use
4. Have a known severe psychiatric illness or history of suicide attempt
5. Are on medication assisted therapy for opiate addiction (such as methadone or buprenorphine)
6. Are prescribed long-acting opioids
7. Are on a higher dose (>50 mg morphine equivalent/day) opioid prescription or have used opioids for greater than 30 days
8. Have a history of current poly-opioid use
9. Have difficulty accessing emergency medical services (distance, remoteness, lack of transportation, homelessness and/or without phone services)
10. Are from households with people at risk of overdose, such as children or someone with a substance use disorder
11. Are elderly (>65) receiving an opioid prescription
12. Are teens receiving an opioid prescription

13. Have requested Naloxone

14. Have received opioid pain prescription plus:

    a. Have rotated from one opioid to another because of possible incomplete cross-tolerance

    b. Are smoking or have COPD, emphysema, asthma, sleep apnea, respiratory infection, other respiratory illness

    c. Have been diagnosed with renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS

    d. Have known or suspected current alcohol use

    e. Have concurrent prescription or OTC medication that could potentiate the Central Nervous System and respiratory depressant properties of opioid medication such as benzodiazepines or other sedative medications, antipsychotics, carisoprodol or antihistamine use

    f. Have a concurrent antidepressant prescription

Prescribe/ Co-Prescribe Naloxone

Both the HHS and FDA have supported implementation of prescription and co-prescription protocols to increase naloxone access. Because of the State-Wide Standing Order, a prescription is not needed; however, does encourage individuals to follow through and access the medication.

When prescribing naloxone:

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. Overdose prevention education could be a part of a Screening, Brief Intervention, or Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050. [98]
2. Consider insurance coverage and pricing to meet patient access needs when prescribing
    a. NARCAN® (naloxone hydrochloride) nasal spray: Nasal spray- 2 mg and 4 mg of naloxone hydrochloride
    b. EVZIO® (naloxone hydrochloride injection) Auto-Injector for intramuscular or subcutaneous use 2 mg
    c. Nasal naloxone: 2x 2mg/2ml prefilled Luer-Lock ready needleless syringes. The atomization device can be purchased by patients through a pharmacy
    d. Intramuscular naloxone: 2x 0.4mg/ml single dose 1 ml vials and 2x intramuscular syringes

3. Assess for patient's interest in behavior changes and as appropriate introduce and refer to treatment services.
4. Alert local pharmacy before sending naloxone prescription to ensure it is properly stocked.

Odyssey House Implementation of Naloxone Distribution Protocols

As the largest substance use treatment facility in Louisiana, Odyssey House Louisiana serves individuals and communities who are at a high risk of a potentially fatal opioid overdose. For this reason, OHL has implemented naloxone distribution to ensure all clients leaving services receive a naloxone kit. In house naloxone distribution includes a Naloxone Prescription Protocol (Appendix), Naloxone Distribution workflow for Uninsured Individuals, and outreach Protocols.

CONCLUSION

Federal, state, and local governance are working in collaboration with various stakeholders to address and reduce the impacts of the opioid epidemic. Though there has been some progress made, with a modest decline in opioid related fatalities, this epidemic continues to be the leading cause of accidental death in the United States. The effects resonate throughout society as the average American life expectancy continues to decline; employers feel the national workforce impacted by addiction and recovery; parental substance is becoming a growing cause of child foster care placement; and newborns diagnosed with opioid addiction continues to rise. We realize that strategic evidence-based approaches are needed on the multiple influences of substance use that move beyond a focus on individual behavior and toward an understanding of the wide range of factors that influence health outcomes.

Although our nation has committed a significant amount of money to addressing this public health crisis, dollars alone will not cure this disease. Recognizing the underlying influences such as stigma, socioeconomic determinants, and structural discrimination has on health outcomes is the first step towards effective prevention and treatment. Policymakers, healthcare workers, and all direct service providers must align interventions with their professional guidelines and ethical responsibility to the wellbeing of the individuals they serve. The opioid epidemic has allowed us to acknowledge and comprehend the true nature of addiction with its ability to dismantle and debilitate communities and the economy while robbing us of loved ones. Let this be an opportunity to shift our perspective and approach to addressing behavioral health. Naloxone has given us all a second chance to confront addiction. Implementation of harm reduction policies, Trauma Informed Care, the Stages of Change, and other evidence-based appropriate interventions rely upon the essential respect, acceptance, and compassion towards others that empower individuals through the process of change.

The crisis is complex and often appears impossible to untangle, but genuine human connection is the foundation of recovery. We can heal through knowledge, understanding, and professional care. With community-wide education, we can dissolve stigma, advance systemic and direct care interventions, and improve the health of our communities.

MORE INFORMATION

Resources for Prescribers:

1. National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain: https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf
2. Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain: www.cdc.gov/drugoverdose/prescribing/qi-cc.html
3. Implementing Care for Alcohol and Other Drug Use in Medical Settings: https://integration.samhsa.gov/sbirt/Implementing_Care_for_Alcohol_and_Other_Drug_Use_In_Medical_Settings_-_An_Extension_of_SBIRT.pdf
4. Substance Use Screening and Assessment Instruments Database: http://lib.adai.washington.edu/instruments/
5. Prescribe to Prevent: Prescribetoprevent.org https://prescribetoprevent.org/wp2015/wp-content/uploads/Naloxone-product-chart.17_04_14.pdf
6. Interactive Training Series for Healthcare Providers https://www.cdc.gov/drugoverdose/training/online-training.html?s_cid=CDC-Rx-Guide-190

Resources for Individuals Treating Substance Use Disorder:

1. Louisiana Board of Pharmacy: http://www.pharmacy.la.gov/
2. Opioid Overdose Prevention and Related Trauma: Incorporating Overdose Prevention, Responses, and Experience into Substance Use Disorder Treatment: http://prescribetoprevent.org/wp2015/wp-content/uploads/Incorporating-OD-into-SUDTx-12.141.pdf
3. Substance Use Screening and Assessment Instruments Database: http://lib.adai.washington.edu/instruments/
4. Treating Substance Use Disorder and Quick Reference Guide: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substa n ceuse-guide.pdf
5. Trauma-Informed Care Champions: From Treaters to Healers: https://www.traumainformedcare.chcs.org/trauma-informed-champions-from-treaters-to-healers/
6. The ASAM NATIONAL PRACTICE GUIDELINE For the Treatment of Opioid Use Disorder 2020 Focused Update: https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

Resources for Stakeholders:

1. Prescription Drug Abuse Policy System: http://www.pdaps.org/
2. Louisiana Opioid Surveillance Portal: https://lodss.ldh.la.gov/
3. Harm Reduction Coalition: https://harmreduction.org/
4. Project Lazarus: https://www.projectlazarus.org/

5. Louisiana Opioid Response Plan: http://ldh.la.gov/assets/opioid/LaOpioidResponsePlan2019.pdf
6. SAMSHA Opioid Overdose Prevention Toolkit: https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742
7. The Network Public Health Law: https://www.networkforphl.org/wp-content/uploads/2020/01/legal-interventions-to-reduce-overdose.pdf

Resources for People Who Use Drugs:

1. Getting Off Write: A Safety Manual for Injection Drug Users Harm Reduction Coalition https://harmreduction.org/issues/safer-drug-use/injection-safety-manual/
2. Treatment Options: www.findtreatment.samhsa.gov
3. Find Local resources: https://www.addictionresourcecenter.org/find-local-resources
4. Find Local Buprenorphine Providers: https://www.samhsa.gov/medication-assistedtreatment/practitioner-program-data/treatment-practitioner-locato
5. Treatment Options: https://vialink.org/
6. Find Treatment: https://findtreatment.gov

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APPENDIX

Addiction Services

Resource Guide 1: Substance Use Resource Guide (English)

Resource Guide 2: Substance Use Resource Guide (Spanish)

Resource Guide 3: Revive. Survive. OverDose Prevention Resource Guide

Naloxone Distribution Templates

Protocol 1: OHL Naloxone Prescription Protocol

Resource Guide: Prevent to Prescribe

Evidence Based Practice Model Worksheet

Worksheet 1: Language Matters: A Quick Guide

Worksheet 2: Assessing Your Stage of Change Worksheet

Worksheet 3: Harm Reduction Coalition- Overdose Prevention Worksheet

Worksheet 4: Overdose Prevention Frequently Asked Questions

Worksheet 5: Voluntary Non-Opioid Directive Form

Worksheet 6: SBIRT Guidelines

Naloxone Access Programs

Guide1: Naloxone Donation and Purchasing Guide

Enrollment Form 1: Evzio 2 You Enrollment Form- For commercial insurance carriers who are concerned about risk of an overdose from opioid use for chronic pain.

Enrollment Form 2: Evzio 2 You Enrollment Form- For commercial insurance carriers who are concerned about risk of an overdose from opioid misuse or dependence.

Enrollment Form 3: Kaleo Cares Patient Assistance Program- For individuals who are uninsured or have government insurance

Enrollment forms can be faxed to 5 pharmacies servicing Louisiana: Avella of Austin- phone: (877) 470-7608 fax: (877) 480-1746 Avella of Deer Valley- Phone (877) 546-5779 Fax (877) 546-5780 Evzio Direct- Phone (844) 805-8884 Fax: (844) 805-8885 Palliative Pharmacy Solutions- Phone (337) 262-9777 Fax (844) 200-9771 Walker- Phone (225) 243-4852 Fax (225) 243-7983

Request Form 1: State of Louisiana- Department of Justice Naloxone Request Form (First Responders only)

Screening and Assessment Tools

Tool 1: Adverse Childhood Experiences Questionnaire

Tool 2: Opioid Risk Tool

Tool 3: Screener and Opioid Assessment for Patients with Pain-Revised

Tool 4: Screening Instrument for Substance Abuse Potential Questionnaire

Tool 5: DIRE Score- Patient Selection for Chronic Opioid Analgesia

Tool 6: Drug Abuse Screening - DAST-10

Tool 7: Current Opioid Misuse Measure (COMM)

Tool 8: Pain Medication Questionnaire (PMQ)- Information Sheet

Tool 9: Pain Assessment and Documentation Tool (PADT)

Tool 10: Addiction Behavior Checklist

Tool 12: Project Implicit

Legislation

Policy 1: Naloxone Standing Order

Policy 2: Good Samaritan Law

Policy 3: Prescription Monitoring Program

ORLEANS PARISH
SUBSTANCE USE RESOURCES

Medically Supported Detox

Utilizes basic oral medications to treat symptoms of withdrawal for people.

Odyssey House Louisiana
4730 Washington Avenue, New Orleans, LA
- Capacity: 40 Beds
- Age Requirement: 18+ years old
- Insurance: Medicaid, Uninsured
- Phone: (504) 821-9211, option 1
- Website: www.ohlinc.org
- For referrals: Referrals.ohlinc.org

Qualis Care
4201 Woodland Dr. New Orleans, LA
- Capacity: 12 Beds
- Age Requirement: 18+ years old
- Insurance: Medicaid, private insurance, private pay
- Phone (504) 272-2350
- Website: www.qauliscare.com

Clinics

Metropolitan Human Services District (MHSD)
Algiers Behavioral Health Center: 3100 General DeGaulle Dr. New Orleans
Central City Behavioral Health & Access Center: 2221 Phillip St. New Orleans
Chartres-Pontchartrain Behavioral Health Center: 719 Elysian Fields New Orleans
New Orleans East Behavioral Health Center: 5630 Read Blvd. New Orleans
- Open-access and scheduled appointments
- Adult & Child Services
- Insurance: Medicaid & Medically Uninsured
- Phone: (504)-568-3130
- Website: www.MHSDLA.org

Odyssey House Louisiana Community Health Center
1125 N Tonti Street New Orleans LA 70119
- Open-access and scheduled appointments
- Adult Primary Care & Behavioral Health Services
- Insurance: Medicaid & Medically Uninsured
- Phone: (504) 821-9211, Option 2
- Website: www.ohlinc.org

Residential Programs

In-house residential drug rehabilitation programs, which intensively focuses on the most basic aspects of drug rehab treatment, such as abstinence from drug abuse, life skills building, and recovery tools.

Bridge House/Grace House
4150 Earhart Blvd, New Orleans, LA
- Capacity: 84 Males/51 Females
- Pregnant women welcomed
- Age Requirement: 18+ years old
- Insurance: Medicaid
- Phone: (504) 821-7120
- www.bridgehouse.org

Odyssey House Louisiana
1125 N. Tonti Street, New Orleans, LA
- Capacity: 144 Beds
- Pregnant women welcomed
- Age Requirement: 18+ years old
- Insurance: Medicaid, Uninsured
- Phone: (504) 821-9211, option 3
- Website: www.ohlinc.org
- For referrals: www.referrals.ohlinc.org

Qualis Care
4201 Woodland Dr. New Orleans, LA
- Capacity: 38 beds
- Age Requirement: 18+ years old
- Insurance: Medicaid, private insurance, private pay
- Phone: (504) 272-2350
- Website: www.qualiscare.com

Intensive Outpatient Program

CADA Prevention & Recovery Center
2640 Canal Street New Orleans, LA
- Capacity: Same day or next day appointments; no capacity limitations
- Age Requirement: 18+ years
- Insurance: Medicaid & uninsured
- Phone: (504) 821-2232
- Website: www.cadagno.org

IOP with Housing

Odyssey House Louisiana
1125 N. Tonti Street, New Orleans, LA
- Capacity: 30 Beds
- Age Requirement: 18+ years old
- Insurance: Medicaid & uninsured
- Phone: (504) 821-9211 - option 4
- Website: www.ohlinc.org
- Referrals: Referrals.ohlinc.org

V1: 08/2019

Medication Assisted Treatment

Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders.

Health Care for the Homeless
Algiers: 1111 Newton St. New Orleans
Central City: 2222 Simon Bolivar Ave. 2nd Floor, New Orleans
Downtown: 1530 Gravier St. New Orleans
- Capacity: no capacity limits
- Age Requirement: 18+ years old
- Insurance: Medicaid & Private
- Phone: (504) 658-2785

Odyssey House Louisiana
1125 N Tonti Street New Orleans
- Capacity: no capacity limits
- Age Requirement: 18+ years old
- Insurance: Medicaid & uninsured
- Phone: (504) 821-9211, Option 2
- Website: www.ohlinc.org

Qualis Care
4201 Woodland Dr. New Orleans
- Capacity: no capacity limits
- Age Requirement: 18+ years old
- Insurance: Medicaid, private insurance, private pay
- Phone: (504) 272-2350
- Website: www.qualiscare.com

BHG - Methadone Provider
2235 Poydras St. Ste. B, New Orleans
- Capacity: no capacity limits
- Age Requirement: 18+ years old
- Insurance: Private insurance or self-pay
- Phone: (504) 524-7205
- Website: www.bhgrecovery.com

University Medical Center - Integrated Health Clinic
Buprenorphine/medication assisted treatment for patients with opiate use disorder who want to stop using, provided in a supportive primary care setting.
2000 Canal Street, New Orleans
- Capacity: No capacity limits
- Age Requirement: 18+ years old
- Insurance: All major insurances including Medicaid
- Phone: (504) 962-6110

DID YOU KNOW?

There are new treatment and prevention opportunities to protect you and those around you from hepatitis.

More than 4 million people in the US are living with viral Hepatitis. Most don't know it!

Hepatits A can be prevented with a safe, effective vaccine.

Many people got infected with Hepatitis B before the vaccine was widely available.

Treatments are available that can cure Hepatitis C.

Interested in getting tested for HIV or Hep C? Go to www.gettested.cdc.gov to find your nearest location!

In Louisiana, the number of newborns diagnosed with neonatial abstinence syndrome nearly tripled in 10 years due to increasing opiate use among pregnant women.

Interested in supportive services while pregnant? Call **Healthy Start New Orleans** at (504) 658-2600 for more information.

FREE trainings regarding Opioid Epidemic for community members, pharmacists, prescribers, services providers, EVERYONE!

Please call the **Revive. Survive. OverDose Prevention** Program of OHL at (504) 418-4995.

SYRINGE ACCESS PROGRAMS

Crescent Care
1631 Elysian Fields, New Orleans
Fridays 12:00-5:00pm

Trystereo
For free supplies, TEXT (504) 535-4766 to meet up with a volunteer.

Women With A Vision
1266 N. Broad St. New Orleans
Phone: (504) 301-0428

Want more resources in your area? Go to: www.vialink.org/our-resources.php

PARROQUIA DE ORLEANS

RECURSOS PARA EL USO DE SUSTANCIAS

Desintoxicación con Soporte y/o Supervisión

Uso de medicamentos orales básicos para tratar los síntomas de la abstinencia en las personas.

Odyssey House Louisiana
4730 Washington Avenue, New Orleans, LA
- Capacidad: 40 Camas
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid y sin seguro
- Teléfono: (504) 821-9211, opción 1
- Sitio Web: www.ohlinc.org
- Para Referencias: www.referrals.ohlinc.org

Qualis Care
4201 Woodland Dr. New Orleans, LA
- Capacidad: 12 Camas
- Edad: Mayores de 18 anos
- Seguro de vida: Medicaid, seguro privado, o pago en efectivo
- Teléfono: (504) 272-2350
- Sitio Web: www.qauliscare.com

Clínicas

Metropolitan Human Services District (MHSD)
Algiers Behavioral Health Center: 3100 General DeGaulle Dr. New Orleans
Central City Behavioral Health & Access Center: 2221 Phillip St. New Orleans
Chartres-Pontchartrain Behavioral Health Center: 719 Elysian Fields New Orleans
New Orleans East Behavioral Health Center: 5630 Read Blvd. New Orleans
- Acceso abierto y citas programadas
- Servicios para adultos y niños
- Seguro de vida: Medicaid & sin seguro
- Teléfono: (504)-568-3130
- Sitio Web: www.MHSDLA.org

Odyssey House Louisiana Community Health Center
1125 N Tonti Street New Orleans LA 70119
- Acceso abierto y citas programadas
- Atención primaria para adultos y servicios de salud conductual
- Seguro de Salud: Medicaid y sin seguro
- Teléfono: (504) 821-9211, opción 2
- Sitio Web: www.ohlinc.org

Programa Intensivo Para Pacientes Ambulatorios

CADA Prevention & Recovery Center
2640 Canal Street New Orleans, LA
- Capacidad: Citas el mismo día o para el día siguiente; sin limite
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid y sin seguro
- Teléfono: (504) 821-2232
- Sitio Web: www.cadagno.org

Programas Residenciales

Programas de rehabilitación de drogas para residentes internos enfocados de manera intensa en los aspectos mas básicos del tratamiento, como abstinencia por el abuso de drogas, desarrollo de habilidades para la vida y herramientas de recuperación.

Bridge House/Grace House
4150 Earhart Blvd, New Orleans, LA
- Capacidad: 84 Hombres/51 Mujeres
- Mujeres embarazadas son bienvenidas
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid
- Teléfono: (504) 821-7120
- Sitio Web: www.bridgehouse.org

Odyssey House Louisiana
1125 N. Tonti Street, New Orleans, LA
- Capacidad: 144 Camas
- Mujeres embarazadas son bienvenidas
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid y sin seguro
- Teléfono: (504) 821-9211, opción 3
- Sitio Web: www.ohlinc.org
- Para referencias: www.referrals.ohlinc.org

Qualis Care
4201 Woodland Dr. New Orleans, LA
- Capacidad: 38 Camas
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid, seguro privado, pago en efectivo
- Teléfono: (504) 272-2350
- Sitio Web: www.qualiscare.com

Programa Intensivo Para Pacientes Ambulatorios con Vivienda

Odyssey House Louisiana
1125 N. Tonti Street, New Orleans, LA
- Capacidad: 30 Camas
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid y sin seguro
- Teléfono: (504) 821-9211, opción 4
- Sitio Web: www.ohlinc.org
- Para Referencias: Referrals.ohlinc.org

V1: 08/2019

Tratamiento Asistido con Medicamento

El tratamiento asistido con medicamentos (MAT), incluye los programas de tratamiento (OTP), combinando terapia conductual con medicamentos para tratar los trastornos por uso de sustancias.

Health Care for the Homeless
Algiers: 1111 Newton St. New Orleans
Central City: 2222 Simon Bolivar Ave. 2nd Floor, New Orleans
Downtown: 1530 Gravier St. New Orleans
- Capacidad: Sin limites
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid y seguro privado
- Teléfono: (504) 658-2785

Odyssey House Louisiana
1125 N Tonti Street New Orleans
- Capacidad: Sin limites
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid y sin seguro
- Teléfono: (504) 821-9211, opción 2
- Sitio Web: www.ohlinc.org

Qualis Care
4201 Woodland Dr. New Orleans
- Capacidad: Sin limites
- Edad: Mayores de 18 anos
- Seguro de Vida: Medicaid, seguro privado, pago en efectivo
- Teléfono: (504) 272-2350
- Sitio Web: www.qualiscare.com

BHG - Methadone Provider
2235 Poydras St. Ste. B, New Orleans
- Capacidad: Sin limites
- Edad: Mayores de 18 anos
- Seguro de Vida: Seguro privado y pago en efectivo
- Teléfono: (504) 524-7205
- Sitio Web: www.bhgrecovery.com

University Medical Center - Integrated Health Clinic
En un entorno de atención primaria se brinda tratamiento medico asistido con buprenorfina para pacientes con trastorno por consumo de opioides que desean dejar de consumir.
2000 Canal Street, New Orleans
- Capacidad: Sin limites
- Edad: Mayores de 18 anos
- Seguro de Vida: Todos los seguros principales, incluido Medicaid
- Teléfono: (504) 962-6110

¿SABIAS QUE?

Existen nuevas oportunidades de tratamiento, protección, y de prevención de la hepatitis para protegerlo a usted y a quienes lo rodean.

Mas de 4 millones de personas en los Estados Unidos viven con Hepatitis viral. ¡La mayoría no lo saben!

La Hepatitis A se puede prevenir con una vacuna segura y efectiva.

Muchas personas se han contagiado con Hepatitis B antes de que vacuna estuviera disponible al publico.

Existen tratamientos disponibles que pueden curar la Hepatitis C.

¿Interesado en realizarse una prueba del VIH o de Hepatitis C?
¡Visite www.gettested.cdc.gov para encontrar su localidad mas cercana!

En Louisiana, el numero de recién nacidos diagnosticados con síndrome de abstinencia neonatal casi se ha triplicado en 10 anos debido al aumento del uso de opioides entre mujeres.

¿Interesada en servicios de apoyo durante el embarazo? Llame a **Healthy Start New Orleans** al (504) 658-2600 para obtener mas información.

¡Capacitaciones **GRATUITAS** sobre la depidemia de opioides para miembros de la comunidad, farmacéuticos, prescriptores, proveedores de servicios, TODOS!

Por favor llame a programa de **Prevención de Sobredosis. Revivir. Sobrevivir** de OHL al (504) 418-4995.

PROGRAMA DE ACCESO A JERINGA

Crescent Care
1631 Elysian Fields, New Orleans
Viernes 12:00-5:00pm

Trystereo
Para suministros gratis, textea a (504) 535-4766 para reunirse con un voluntario.

Women With A Vision
1266 N. Broad St. New Orleans
Teléfono: (504) 301-0428

¿Quieres mas recursos en tu área? Vaya a: www.vialink.org/our-resources.php

Revive. Survive. OverDose Prevention Resource Guide

Local Pharmacies Known to Carry Naloxone:

1. Any Walgreens
2. Avita Pharmacy: 1631 Elysian Fields Ave, 2nd floor
3. Crescent City Pharmacy: 2240 Simon Blvd, New Orleans 504-267-4113
4. University Medical Center Pharmacy : 2000 Canal St New Orleans 504-702-3000

Local Addiction Services:

Agency	Services	Payment	Location	Telephone	MAT Medications if Available
211- Via Link	24/7 telephone resource for counseling and social services	Free	http://www.vialink.org/	211	
Alcoholics Anonymous	Peer Support Group (12-step Program) Sponsor services	Free	Central Office 638 Papworth Ave Metairie, LA 70005 www.aaneworleans.org	24- Hour Hotline 504.838.3399 Office 504.836.0507	
Bethel Colony South Transformation Ministries	Faith Based Women at the Well Family House Transitional living Program	Free	4114 Old Gentilly Rd, New Orleans, LA 70126	504.943.0456	
BHG Clinic	Medication-Assisted Treatment Addiction Counseling	Humana, Tricare, Private, Grants for eligible individuals	Downtown Office: 2235 Poydras St. Suite B New Orleans, LA 70119 West Bank Office: 1141 Whitney Ave Gretna, LA 70056	504.524.7205 504.347.1120	Suboxone Methadone

Bridge House/ Grace House	Bridge House: Long term residential substance use treatment for males Grace House: Long term residential substance use treatment for Females Pregnant women are PRIORITY	Free if qualified, Medicaid, Medicare	4150 Earhart Blvd. New Orleans, LA 70125	504.821.7120	Does not prescribe medication but does allow individuals to follow prior MAT regiment
CADA Prevention & Recovery Center	Intensive Outpatient Program	Medicaid Uninsured	2640 Canal St New Orleans, LA	504.821.2232	
CrescentCare New Orleans Syringe Access Program	Safe Sterile Syringes Safe Injection Materials Authorized Syringe Disposal	Free	1631 Elysian Fields Ave New Orleans, LA 70117 Hours of Operation: Fridays 12pm-5pm	504.945.4000	Can provide direct referral to CrescentCare MAT Services
CrescentCare Recovery Works	Intensive Outpatient Program	Most insurances and sliding scale discount eligible patients, Medicaid, Medicare, private insurance	1631 Elysian Fields Ave. New Orleans, LA	504.821.2601	Suboxone
Gateway Recovery Systems	Substance Use Services Domiciliary IOP services IOP Housing Transportation to appointments	Private Pay, Medicaid plans ONLY	4103 Lac Couture Drive Harvey, LA 70058 Westbank	504.368.9935	
Green Path	Outpatient services for Adults and Youth		411 S. Broad Avenue, New Orleans, LA 70119	504.827.2928	
Health Care for the Homeless	Primary Care Services MAT, Referral to Treatment	Medicaid Uninsured	2222 Simon Bolivar Ave, New Orleans, LA 70113	504.658-2785	Suboxone

Jesus Miracle Power	One-year faith-based residential addiction treatment services ONLY offer services to men)	Free	8309 Apple St New Orleans, LA 70118	504.931.5179	Do not permit any mood- or mind- altering medications
Lake Wellness Center	Medical Detox Intensive Outpatient Services	Private Insurance	3620 Chestnut St. New Orleans, LA 70115	504.676.5253	
Living Witness Church of God in Christ, Inc	1-year faith-based male addiction treatment services	$100 weekly payment or $400 monthly payment	1528 Oretha Castle Haley Blvd New Orleans, LA 70113	504.524.2959	
Louisiana Adult and Teen Challenge	Faith based residential and education program for youth.	$750 one time fee	1905 Franklin Ave, New Orleans, LA 70117	504-947-7949	Medication not permitted
Metropolitan Human Services District	Children, youth, and adult services including intellectual/developmental disability and behavioral health services	Uninsured, Medicaid, Medicare	Main Office 3100 General De Gaulle Dr. New Orleans, LA 70114 24/hr Crisis Line	504-568-3130 504.826.2675	Direct referral to BHG Clinics
Narcotics Anonymous	Peer support group (12-step program)	Free	www.nona.org	504.899.6262	
New Orleans Harm Reduction Network Trystereo	Sterile injection equipment Overdose prevention Harm reduction training	Free	http://nolaharmreduction.tumblr.com/	504.535.4766	
Odyssey House Louisiana	Detox Short term adult residential program Long term housing Intensive Outpatient Community Health Center Housing Programs OHMEGA LEAD Program iPrevent Revive.Survive OverDose Prevention	Medicaid or Uninsured	Detox 4730 Washington Ave New Orleans, LA 70125 Residential & Community Health Clinic 1125 N. Tonti St New Orleans, LA 70119 Prevention Department 2830 Bell St New Orleans, LA 70119	504.821.9211 504.383.8559 504.913.6776	Suboxone Vivitrol

Responsibility House	Residential treatment program, outpatient treatment program, housing program	Medicaid, HIV positive individuals in Jefferson Parish (verified by state ID)	Residential Treatment Program Outpatient Treatment Program Supportive Housing 90-day Program	504.367.4234 504.367.4234 504.366.6217	
River Oaks Hospital	Adult Behavioral Health Services, Adolescent Behavioral Health Services, Eating Disorders Treatment, Addictive Disorders/Dual Diagnosis Program, Military Mental Health Program, The New Orleans Institute, Outpatient Treatment Mental Health Programs, People with Homicide Ideation and Suicide Ideation are accepted	Accepts most insurance TRICARE, V.A. Benefits, Medicare, Medicaid	1525 River Oaks Rd W New Orleans, LA 70123	800.366.1740 Or 504.734.1740	Suboxone Vivitrol
Townsend Outpatient Addiction Treatment Townsend Inpatient Addiction Treatment	Residential, outpatient treatment services, and detox	Most commercial insurance 30-45 days 90 days (depending on insurance provider)	Metairie Office: 4330 Loveland St Ste. A Metairie, LA 70006 New Orleans Office: 5620 Read Blvd. New Orleans, LA 70127 Consultation	504.454.5174 504-513-4200 888.979.7493	
University Medical Center	Emergency Department Addiction Treatment Unit	Medicaid, Private, Military	2000 Canal St, New Orleans, LA 70112	(504) 702-3000	Suboxone Vivitrol

Odyssey House Louisiana
Naloxone Prescription Protocol

"Given the scope of the opioid crisis, it's critically important that healthcare providers and patients discuss the risks of opioids and how naloxone should be used in the event of an overdose," said Adm. Brett Giroir, MD, assistant secretary for health and senior advisor for opioid policy at HHS, in a statement.

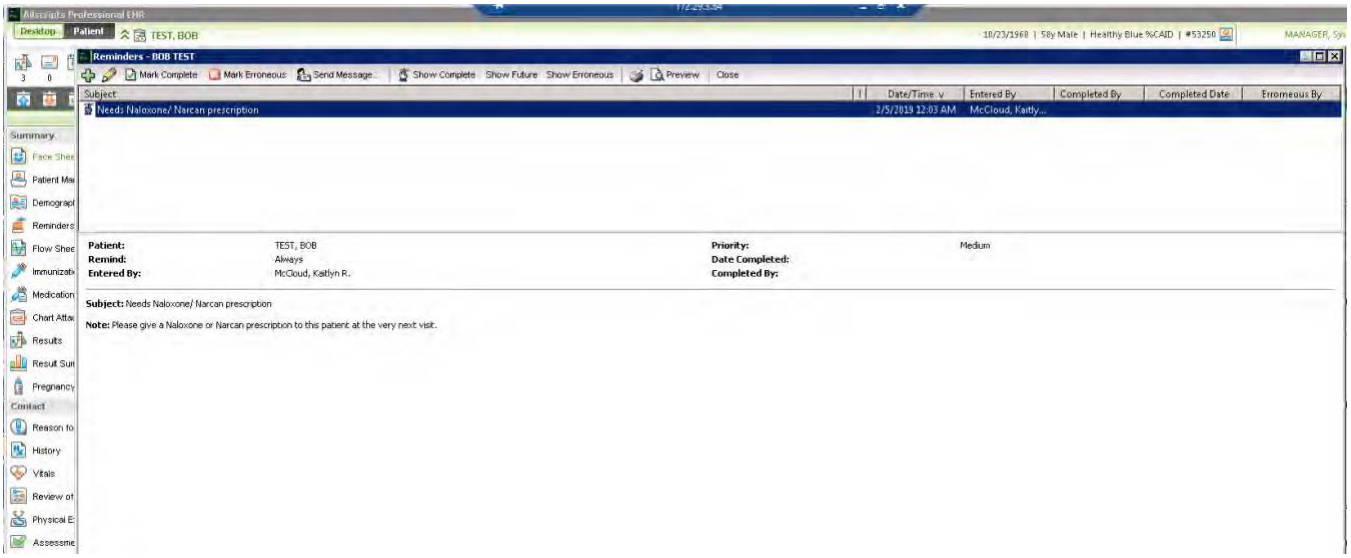
Odyssey House Louisiana's Federally Qualified Health Center has developed and implemented a prescription protocol in their Federally Qualified Health Center located at 1125 N. Tonti Street, New Orleans, LA 70119.

Prescribers are trained to prescribe Naloxone to all patients with an active opioid dx. Clients can refuse or state they are already in possession of Naloxone.

OHL's EHR system has been programed to populate a reminder for prescribers to prescribe naloxone. The report runs in the background on a schedule and once it is determined that patients are active opioid dx with no naloxone prescription, it generates a high-level patient reminder any time someone opens the chart, until it is marked complete that the patient has received a naloxone prescription.

Below you can find screen shots of the reminder.

***For agencies and individuals who prescribe opioids, the above protocol can be adapted to include co-prescription of naloxone with all opioids (FDA practice recommendation).*



Naloxone Product Comparison

	Injectable (and intranasal-IN) generic	Intranasal branded		Injectable generic[1]		Auto-injector branded	
Brand name		Narcan Nasal Spray				Evzio Auto-Injector	
Product comparison							
			(Product not yet released[2])			(yellow & purple)  (Formulation to be discontinued[3])	(blue & purple) 
FDA approved Labeling includes instructions for layperson use	X (for IV, IM, SC)	X X		X		X X	
Assembly required	X			X			
Fragile	X						
Can titrate dose	X			X			
Strength	1 mg/mL	4 mg/0.1 mL	2mg/0.1mL	0.4 mg/mL	4 mg/10 mL	0.4 mg/0.4mL	2 mg/0.4mL
Storage requirements (All protect from light)	Store at 59-86 °F Fragile: Glass.	Store at 59-77 °F Excursions from 39-104 °F		Store at 68-77 °F Breakable: Glass.		Store at 59-77 °F Excursions from 39-104 °F	
Cost/kit[4]	$$	$$		$		$$$	
Prescription variation							
Refills	Two	Two		Two		Two	
Rx and quantity	#2 2 mL Luer-Jet™ Luer-Lock needleless syringe plus #2 mucosal atomizer devices (MAD-300)	#1 two-pack of two 4 mg/0.1 mL intranasal devices	#1 four-pack of four 2 mg/0.1 mL intranasal devices	#2 single-use 1 mL vials PLUS #2 3 mL syringe w/ 23-25 gauge 1-1.5 inch IM needles	#1 10mL multidose vial PLUS #2 3 mL syringe w/ 23-25 gauge 1-1.5 inch IM needles	#1 two-pack of two 0.4 mg/0.4 mL prefilled auto-injector devices	#1 two-pack of two 2 mg/0.4 mL prefilled auto-injector devices

Naloxone Product Comparison

	Injectable (and intranasal-IN) generic		Intranasal branded		Injectable generic[1]		Auto-injector branded	
Sig. (for suspected opioid overdose)	Spray 1 ml (1/2 of syringe) into each nostril. Repeat after 2-3 minutes if no or minimal response.		Spray 0.1 mL into one nostril. Repeat with second device into other nostril after 2-3 minutes if no or minimal response.		Inject 1 mL in shoulder or thigh. Repeat after 2-3 minutes if no or minimal response.		Inject into outer thigh as directed by English voice-prompt system. Place black side firmly on outer thigh and depress and hold for 5 seconds. Repeat with second device in 2-3 minutes if no or minimal response.	
Ordering information								
How supplied	Box of 10 Luer-Jet™ prefilled glass syringes		Two-pack of single use intranasal devices		Box of 10 or package of 25 single-dose fliptop vials (1 ml)	Case of 25 multi-dose fliptop vials (10 ml)	Two pack of single use auto-injectors + 1 trainer	
Manufacturer	IMS/ Amphastar	Teleflex (off-label IN adapter)	Adapt Pharma		Pfizer, Mylan and West-Ward Pharmaceuticals	Pfizer	kaléo	
Web address	Amphastar.com	Teleflex. com	Narcannasalspray.com		Pfizerinjectables.com Mylan.com West-ward.com	Pfizerinjectables.com	Evzio.com	
Customer service	800-423-4136	866-246-6990	844-462-7226		877-946-7747 (P) 724-514-1800 (M) 800-631-2174 (W)	877-946-7747 (P)	855-773-8946	
NDC	76329-3369-01	DME- no NDC	69547-353-02	69547-212-04	00409-1215-01 (P) 67457-0292-02 (M) 0641-6132-25 (W)	00409-1219-01	60842-030-01	60842-051-01

[1] Pfizer acquired Hospira in 2015. Pfizer has an additional naloxone product, which is ***not recommended*** for layperson and take-home naloxone use because it is complicated to assemble. (Naloxone Hydrochloride Injection, USP, 0.4 mg/mL Carpuject™ Luer Lock Glass Syringe (no needle) NDC# 0409-1782-69)

[2] This product concentration is not yet currently available. As a result, some of the content is left blank.

[3] EVZIO 2 mg is now available. As of February 2017, EVZIO 0.4 mg will no longer be manufactured, but is still currently available and effective.

[4] There is considerable price variance for each product- local pharmacists are able to provide specific local pricing.

Image development supported by 1R01DA038082-01 Friedmann/Rich

LANGUAGE MATTERS

A QUICK GUIDE

ODYSSEY HOUSE LOUISIANA

LANGUAGE MATTERS

Our choice of language impacts the quality of care we provide. We must actively work to address and limit the use of stigmatizing language when discussing addiction. Stigma creates barriers to care and leads to poorer health outcomes. For example, parents or expecting parents with substance use disorders often fear judgement and possible consequences as a result of their disorder (i.e. criminal charges or removal of children). This often deters individuals from seeking needed health service such as prenatal care, SUD treatment, and preventative care.

Choice of words significantly impact understanding, perception, and engagement between individuals as well as throughout our systems. To provide appropriate and equitable services to those living with addiction, the following must be understood:

Addiction is a primary, chronic and reoccurring brain disease that affects reward, motivation, memory and related circuitry. Genetics, neurology, psychology, and social influences can all contribute to the appearance of addiction. Addiction can cause permanent disability or premature death, especially when left untreated or treated inadequately [1].

Stigma is defined as an attribute, behavior, or condition that is socially discrediting. It is influenced through the understanding of cause and controllability being either internal or external. The misconception that addiction is a choice and an individual has caused it or can control it has resulted in significant stigma surrounding substance use disorder [2]. As a result, individuals with addiction are less likely than those with other medical conditions, to receive treatment, remain engaged in treatment, or receive adequate services unrelated to addiction. The resulting health disparities illustrate the need for improvements in practice and services.

Shifting language used around addiction is critical in addressing misconceptions of individuals living with substance use disorder and providing effective treatment options.

Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Below are recommendations on language to steer away from and alternative language that creates a nonjudgmental space for our community.

NOT THAT SAY THIS!

WHEN REFERRING TO AN INDIVIDUAL:

Avoid labeling a person by their illness. These labels imply permanency to the condition and do not allow space for change.

Addict
Alcoholic
Abuser
User
Junkie/ Crackhead / Drunk/ Pothead
Sober
Clean

Always use person-first langue. These modifies give identity to individuals as people rather than labeling them by their illness.

"A person with/in…"
Substance use disorder
Active disorder/disease/addiction
Remission
Abstinent from substances
Substance/Addiction free
Person in recovery

WHEN REFERRING TO SUBSTANCE USE AND DIAGNOSIS:

Avoid projecting judgment and stigma. The following words convey an individual chooses to have a medical condition, blames the individual and perpetuates stigma.

Misuse
Abuse/ Drug abuse/ Substance abuse
Drug habit/ Drug problem
Drug of Choice

Use current medical terminology that objectively defines substance consumption and its impact on physical, psychological, and social wellbeing.

Use/ Recreational use
Unhealthy/ Harmful/ Hazardous use
Substance Use Disorder (SUD)
Opioid Use Disorder (OUD)
Addiction

WHEN DESCRIBING AN INDIVIDUAL'S BEHAVIOR:

Avoid descriptions that assume specific behaviors are the result of an individual's character rather than accounting for the neurological impact of addiction that influences decision making and behavior.

Drug seeking
Manipulative
Non-compliant/ Resistant

Use a strength-based approach in understanding and describing behavior.

Trying to get specific needs met
Choosing not to; would rather...
Prefers not to; is unsure about
Ambivalent
Task may not be culturally appropriate

WHEN DESCRIBING MEDICAL EQUIPMENT OR PROCEDURES SUCH AS DRUG TEST OR SYRINGES:

Avoid associating objects and individuals with connotations of filth.

Clean
Dirty

Use medical and technical terminology.

Negative/positive
Sterile
Used/unused syringes

WHEN REFERRING TO TREATMENT OPTIONS:

Avoid describing the use of medication in addiction treatment as a lateral move from illegal substance use to legal substance use which disregards the positive impacts of treatment on physical, psychological, and social well-being.

Substitution or Replacement Therapy
Opioid Replacement
Methadone Maintenance

Use current terminology to describe addiction treatment that incorporates pharmacology.

Treatment or medication for addiction
Medication for Opioid Use
Medication Assisted Treatment (MAT)

CALL TO ACTION:

1. Chose a word from the left-hand column that you currently use: _____
2. Select an alternative for this word from the right-hand column: _____
3. Make a commitment to use this new language moving forward.
4. Set an alarm on your phone for one month from today to check on your progress. If you have made an improvement, move on to another word.
5. Continue this process until you are no longer using stigmatizing language when referring to addiction.

References:

1. ASAM Board of Directors (2011). Public Policy Statement: Definition of Addiction (Long Version). *American Society of Addiction Medicine*.
2. Kelly, J. F., Saitz, R., & Wakeman, S. (2016). Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an "Addiction-ary". *Alcoholism Treatment Quarterly*, *34:*1, 116–123.

Additional Resources:

Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., Gordon, A. J. (2014). Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response. *Substance Abuse*, *35*(3), 217–221. doi: 10.1080/08897077.2014.930372

Goldsmith, R. J. (2016). Letter to Director Botticelli. *American Society of Addiction Medicine*.

The Words We Use Matter: Reducing Stigma through Language. The National Alliance of Advocates for Buprenorphine Treatment. Naabt.org

Words Matter: How Language Choice Can Reduce Stigma. SAMHSA'S Center for the Application of Prevention Technologies.www.smhsa.gov/capt/

Assessing Your Stage of Change Worksheet

Answer the fillowing questions to help you determine where you are in your change process. Remember, progress is any movement through one stage to the next. Aim for change, not perfection! Place a check mark (√) in the appropriate box for each question.

	Absolutely Yes	Probably	Not Sure	Absolutely Not
Precontemplation/contemplation stages				
1. Do you think you have a problem with alcohol, tobacco, or other drugs?				
2. Are you clear about why you want to quit using substances?				
Preparation stage				
3. Are you willing to make a commitment to quit using within the next month?				
4. Do you know what steps to take to stop using on your own?				
5. Do you need to be detoxified from alcohol or other drugs to stop using?				
6. Have you told others (family, friends, etc.) about your desire to change your problem with alcohol or other drugs?				
Action stage				
7. Do you have a strong commitment to quit alcohol or drugs and stay sober?				
8. Do you need to change people, places, or things to help you stay sober?				
9. Do you need to learn to control your thoughts and cravings for substances?				
10. Do you need to address the effects of your substance use on your family or other relationships to increase your chances of staying sober?				
11. Do you need to address new ways of dealing with upsetting feelings to increase your chances of staying sober?				
12. Are you willing to participate in self-help groups or other forms of social support to increase your chances of staying sober?				

	Absolutely Yes	Probably	Not Sure	Absolutely Not
Maintenance stage				
13. Do you know the warning signs of a potential relapse and have strategies to help you cope with these **before** you use alcohol, tobacco, or other drugs again?				
14. Do you know your personal high-risk factors that make you feel vulnerable to using substances and have strategies to cope with these?				
15. Do you know what steps to take should you actually go back to using substances following a period of abstinence?				
16. Is your life generally in balance?				

There are no questions about the termination phase because we assume that you would not need this workbook if you were in that phase of change.

WORKSHEET

Overdose Prevention Tips

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

This worksheet highlights common overdose risks and provides prevention tips.

We understood that every prevention message might not be applicable or pragmatic in every situation; we hope these tips can provide and messages can be shared and adapted as needed.

More information on each risk factor can be found at harmreduction.org.

Mixing Drugs:

- ☐ Use one drug at a time.
- ☐ Use less of each drug.
- ☐ Try to avoid mixing alcohol with heroin/pills – this is an incredibly dangerous combination.
- ☐ If drinking or taking pills with heroin, do the heroin first to better gauge how high you are – alcohol and especially benzos impair judgment so you may not remember or care how much you've used.
- ☐ Have a friend with you who knows what drugs you've taken and can respond in case of an emergency

Tolerance:

- ☐ Use less after any period of abstinence or decreased use – even a few days away can lower your tolerance.
- ☐ If you are using after a period of abstinence, be careful and go slow
- ☐ Use less when you are sick and your immune system may be weakened.
- ☐ Do a tester shot, or go slow to gauge how the shot is hitting you.
- ☐ Use a less risky method (i.e. snort instead of inject).
- ☐ Be aware of using in new environments, or with new people—this can change how you experience the effects of the drugs and in some cases, increase the risk of overdose

Quality:

- ☐ Test the strength of the drug before you do the whole amount.
- ☐ Try to buy from the same dealer so you have a better idea of what you're getting.
- ☐ Talk to others who have copped from the same dealer.
- ☐ Know which pills you're taking and try to learn about variations in similar pills.
- ☐ Be careful when switching from one type of opioid pill to another since their strengths and dosage will vary.

Using Alone:

- ☐ USE WITH A FRIEND!
- ☐ Develop an overdose plan with your friends or partners.
- ☐ Leave the door unlocked or slightly ajar whenever possible.
- ☐ Call or text someone you trust and have them check on you.
- ☐ Some people can sense when they are about to go out. This is rare, but if you are one of the people that can do this, have a loaded syringe or nasal naloxone ready. People have actually given themselves naloxone before!

continued on next page

Overdose Prevention Tips, *continued*

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

This worksheet highlights common overdose risks and provides prevention tips.

We understood that every prevention message might not be applicable or pragmatic in every situation; we hope these tips can provide and messages can be shared and adapted as needed.

More information on each risk factor can be found at harmreduction.org.

Age and Physical Health:

- ☐ Stay hydrated! Drink plenty of water or other fluids.
- ☐ Eat regularly.
- ☐ Get enough sleep and rest when you feel worn down.
- ☐ Pharmaceuticals (like opioids and benzos) – especially those with Tylenol® (acetaminophen) in them – are harder for your liver to break down. If you have liver damage, stay away from pharmaceuticals with a lot of acetaminophen in them, like Vicodin and Percocet.
- ☐ Carry your inhaler if you have asthma, tell your friends where you keep it and explain what to do if you have trouble breathing.
- ☐ Go slow (use less drugs at first) if you've been sick, lost weight, or have been feeling under the weather or weak—this can affect your tolerance.
- ☐ Try to find a good, nonjudgmental doctor and get checked out for any health factors that may increase your risk of overdose, like HIV, viral hepatitis, COPD, high or low blood pressure, high cholesterol, heart disease or other physical issues that could increase your risk for a stroke, seizure, respiratory problems or heart attack.

Mode of Administration of the Substance:

- ☐ Be mindful that injecting and smoking can lead to increased risk.
- ☐ Consider snorting, especially in cases when you're using alone or may have decreased tolerance.
- ☐ If you inject, try and remove the tie after registering and before injecting – this will allow you to better taste your shot and inject less if it feels too strong.
- ☐ Be careful when changing modes of administration since you may not be able to handle the same amounts.

Previous Nonfatal Overdose:

- ☐ Always use with a friend or around other people.
- ☐ Use less at first, especially if you are using a new product.
- ☐ Make an overdose plan with friends or drug partners.

Frequently Asked Questions and Answers

1. What is the naloxone shelf life?
    a. **18- 24 months**
2. How should naloxone be stored?
    a. **Room temperature and out of direct sunlight**
3. If naloxone has expired, should I still use it?
    a. **Yes. It may lose potency, but it will not hurt the individual. We always recommend replacing expired naloxone kits but if that is all that is available please use it.**
4. What is the difference between rescue breathing and CPR?
    a. **CPR chest compressions are used in the case of a heart attack. Rescue breaths are used when an individual is not breathing or has weak breaths.**
5. If I am using the IM naloxone, do I have to be sure there is no air in the syringe before I administer?
    a. **No, air bubbles are not dangerous in muscle injections.**
6. What kind of needle should be used with the IM naloxone?
    a. **Experts recommend using a thicker, longer needle designed for injecting into muscles. This is typically 22-gauge and 3cm or longer that can easily be injected into the upper arm or thigh. These larger needles also allow you to save time by injecting through someone's clothes if necessary. However, laypeople have reported successful naloxone reversals using smaller needles as well.**
7. If people who use opioid are given naloxone, will they continue using more opioids?
    a. **Research has shown that having naloxone available does not increase risk-taking behavior, or cause people to use more opioids. The goal of distributing naloxone and training laypeople to prevent, recognize and respond to overdose is to prevent death and reduce brain injury or brain damage. Other goals such as getting people into treatment are only possible if people are alive.**
8. How long has Naloxone been out?
    a. **It was patented in 1961 and approved for opioid overdose by the Food and Drug Administration in 1971.**
9. Why is it important to leave someone in the recovery position?

a. **If a person is unconscious but is breathing and has no other life-threatening conditions, they should be placed in the recovery position. Putting someone in the recovery position will keep their airway clear and open. It also ensures that any vomit or fluid won't cause them to choke.**

10. Is tramadol an opioid?
    a. **Tramadol is an opioid. It is often confused with Toradol, which is not an opioid and can be used to treat pain (it is in the same class as Advil). Toradol is an anti-inflammatory, while tramadol is not.**

11. What pharmacies do you recommend?
    a. **We have received feedback that Walgreens carries and provides naloxone more consistently than CVS. Crescent City Pharmacy in mid-city, UMC pharmacy downtown, and Best Life at Tulane and Broad**
    b. **Local Walgreens locations that we have received positive feedback from customers include:**
        i. **Walgreens on St Bernard and Broad**
        ii. **Walgreens on Elysian Fields and St Claude**
        iii. **Walgreen on Carrolton near St Charles intersection**

12. If a training attending or individual in the community share an experience with ODP staff regarding negative experience with NOPD regarding an overdose experience or naloxone, especially if it violated their rights or Good Samaritan Law we should:
    a. **go to the NOPD 5th District station at 3900 N. Claiborne (504) 658-6050, to report the experience. Ask for an NOPD rank if need be.**

13. Is naloxone effective with an overdose involving fentanyl?
    a. **Yes, it is still effective, but fentanyl is more potent and does bind more tightly to the receptors than heroin**
    b. **Therefore, multiple doses of naloxone may be needed to revive the person and get them to breathe again, and it is more likely that they go into a second overdose when the naloxone wears off.**
    c. **This is why it is always important to call 911!**

14. So I called 911, gave naloxone, gave recovery breaths, and they are breathing in the recovery position. Can I leave now?
    a. **It is essential to the person's chances that you stay around the scene:**

i. **You can give EMS information about the individual, what drugs they were doing, how long they have been unconscious, and how their overdose signs and symptoms progressed**
ii. **Furthermore, it is ideal to have someone continue to check on the person for a pulse, if they are breathing, and if their airway is clear until EMS arrives**
iii. **Keeping the person warm is another way that you can help**

15. Does speedballing (combining opioids with cocaine or methamphetamines) help to prevent overdosing on opioids?
    a. **NO!!! In fact, it increases the risk.**
    b. **First, the reason that individuals speedball is because the side effects of the two drugs *seem* to cancel each other out. This allows the user to experience a greater euphoria, without nodding off or losing consciousness. This "canceling out" is a simplified explanation, and we will not get into the complex pathophysiology associated with drug metabolism.**
    c. **Problems with speedballing:**
        i. **Combining a stimulant and depressant makes the user feel like they can tolerate more of the drugs, which increases chances of overdose**
        ii. **Every drug put into the body has a different amount of time that it is active before it is broken down, also known as the drug's "half-life". Therefore, the "canceling out" of the stimulant and depressant will stop when the shorter acting drug wears off, most likely sending the user into an overdose from the longer-acting drug.**
        iii. **The body has to break down two or more drugs instead of one, which puts significant strain on the liver and kidneys**
        iv. **The combination of more than one drug makes it more difficult for medical professionals to assess symptoms and treat the individual**

16. How do you effectively differentiate "going on the nod" or "ducking" from an overdose?
    a. **People who misuse opioids often seek the experience of "ducking" while getting high, which is a euphoric feeling while drifting in and out of consciousness**
    b. **This phenomenon is achieved when an individual is very close to overdosing, and it is therefore very hard to tell the difference. It is not your job to be a medical professional --> if you are unsure or worried about the person, call a 911 dispatcher and describe the person's symptoms**
    c. **If they show other signs, such as decreased breathing, choking, blue or ashy lips, then, in addition to calling 911, distribute naloxone and perform rescue breathing**

17. When a urine tox is done, does Fentanyl show up as Fentanyl or under opioids in general?
    a. **The standard urine drug toxicology report just lumps together all opioids. However, there is a test that will differentiate Fentanyl specifically that may be used at different facilities.**

18. How long has the Good Samaritan Law been enacted nationally?
    a. **The Good Samaritan Laws are slightly different in each state, but a law was enacted in 1998 nationally requiring all states to have some sort of law on the books.**

19. If there is no face mask available to, should I still provide rescue breaths? Am I at risk of contracting COVID 19?
    a. **Yes, whenever rescue breathing is carried out, particularly on an unknown victim, there is some risk of cross infection, associated particularly with COVID-19. Normally, we encourage rescue breathing in this circumstance, but decision to actively provide rescue breaths or not.**

20. Where can I get face mask from, to preform rescue breaths? What is the cost?
    a. **Face mask can be purchased in bulk on Amazon for $14.99 per pack of 20.**

21. What is Gray Death?
    a. **Illicit opioid combination of powerful and dangerous drugs, according to the National Institute on Drug Abuse (NIDA), is not a single drug, but typically contains several potent opioids, including whatever a drug dealer has on hand.**
    b. **It can be a toxic mix of other potent opioids, such as carfentanil, or other illegal drugs:**
        - **heroin**
        - **fentanyl**
        - **carfentanil**
        - **U-47700 (pink)**
        - **possibly other opioids or unidentified drugs or toxins.**

22. Can CPS get involved if children are on site around the scene of opioid overdose?

The laws surrounding CPS at the scene of an opioid overdose are unclear because referrals for child protection associated with parental substance use are not required data collection. CPS does have a right to investigate if it appears a child is in danger of abuse or neglect due to substance-using parents. Substance use during pregnancy is considered reportable child abuse.

23. What does the Good Samaritan Law explicitly state?

Louisiana enacted Act 192, commonly known as the "Good Samaritan Law," of the 2015 Regular Legislative Session so that overdose victims can get emergency assistance and follow-up treatment without fear of prosecution. Essentially, Act 192 allows for a person acting in good faith

to receive a naloxone or other opioid antagonist prescription from a licensed healthcare professional, possess and administer the naloxone to an individual appearing to experience an opiate-related overdose, and they and the healthcare professional shall be immune from prosecution and civil liability as a result of their good-faith effort to provide medical assistance. The person administering the naloxone or other opioid antagonist shall assist the victim with seeking emergency medical attention as evidence of their good faith.

24. What is a Mandated reporter and what are they required to report?

The legal definition of a mandated reporter is "an individual who holds a professional position (as of social worker, physician, teacher, or counselor) that requires him or her to report to the appropriate state agency cases of child abuse that he or she has reasonable cause to suspect" (Merriam-Webster Dictionary). Mandated reporters are required to make a report of suspected abuse when they have reasonable cause to suspect that a child or elderly person is a victim of child or elderly abuse, including in the cases of parental substance use.

25. Twilight anesthetia

a. https://www.westlakedermatology.com/blog/different-types-of-anesthesia/
b. Being used as a substitutive for opioids response for if you were in

24. Is there a limit on the number of times a community member can request naloxone from participating pharmacies?

a. **No, the State of Louisiana's Standing Order for the Distribution and Dispensing of Naloxone or Other Opioid Antagonists states, "refills may be filled *as needed*, pursuit to this order..."**

25. Does the OHL Prevention Department number take collect calls from prison or an institution?
Yes, the OHL Prevention Department Hotline accepts phone calls, text messages and collect calls.

26. Are the signs and symptoms of an opioid overdose the same as a crack cocaine overdose?
No, opioid overdoses cause respiratory depression. Crack cocaine overdoses cause over-stimulation and can include seizures and heart rate and rhythm disturbances.

27. Can you overdose on naloxone?
No, you cannot harm a person with too much naloxone. Naloxone is safe to use on all ages, has no misuse potential, and has minimal negative side effects if used on someone experiencing something other than an opioid overdose. Naloxone is a medication that acts as an opioid overdose antidote. It works by displacing opioid molecules from their receptors so that the effects of the opioids are immediately withdrawn. This can be an uncomfortable experience and it is important that the individual receive medical attention immediately for a few reasons 1. because it is very uncomfortable

experience and 2. because once the naloxone wears off the individual may still overdose - the impact of Naloxone may wear off but the effects of the opioid may last longer.

28. Can you build a tolerance to naloxone?
No, naloxone will be just as effective each time it is administered.

29. Can naloxone be administered intravenously?
Naloxone can be administered in several different ways, including intravenously, intramuscularly and subcutaneously. For the sake of saving time in the event of an overdose, it is recommended to inject naloxone intramuscularly since it is the fastest method of injection for the vial form of naloxone.

30. If you keep naloxone/Narcan in a locked box in your vehicle, are the police allowed to search the lock box?
Generally, police are not allowed to search a lockbox in your vehicle without your consent or probable cause. While keeping naloxone/Narcan in a safe, protected place is a good idea, when thinking about where to keep your lockbox, remember that naloxone should be stored at room temperature and out of direct sunlight.

31. Is carfentanil the same thing as fentanyl?
Carfentanil, a derivative of fentanyl, is a synthetic opioid that was developed as a large mammal tranquilizer and has no human use application. Carfentanil is 100 times stronger than fentanyl.

32. Do police officers carry naloxone?
In response to the national opioid epidemic, more and more law enforcement agencies are equipping officers with naloxone. Currently, more than 220 law enforcement agencies in 24 states now carry naloxone. Louisiana has added naloxone administration to the scope of practice of law enforcement personnel, which explicitly permits them to administer the medication under a standing medication order.

33. Can my Primary Care Physician call my pharmacy to put in an order for naloxone for me to pick up?

Yes, your prescriber can place an order for naloxone for you to pick up and the pharmacy can determine whether it is covered by your insurance. In Orleans Parish, naloxone is covered by most insurances, including Medicaid. If you do not have a Primary Care Physician, you can visit local participating pharmacies and receive naloxone without a prescription. Naloxone is also available free of charge from several community agencies, including Odyssey House Louisiana. You may call our 24/7 outreach phone number at (504) 418-4955 for more information on obtaining naloxone for yourself or others.

34. How are different opioids classified?

Opioids, or narcotics, are classified by the United States' Drug Enforcement Administration (DEA) and Food and Drug Administration (FDA) as controlled substances with the potential of misuse. Opioids fall under Schedules 1-5. "Schedule 1" substances are the most dangerous with the highest potential for misuse and have NO medicinal value, such as heroin. Schedule 2 opioids also have a high potential for misuse and can lead to severe psychological or physical dependence, such as hydrocodone, oxycodone and fentanyl. Schedule 3 substances have a moderate to low potential for physical and psychological dependence. Schedule 4 substances are classified as having a low potential for abuse

and low risk of dependence and Schedule 5 substances have a lower potential for misuse than Schedule 4, and contain very low or limited quantities of narcotics, such as cough syrups with a small amount of codeine.

35. Does OHL offer tours of the short term Residential facility? How many clients share a room?
Due to precautions surrounding COVID-19, OHL facilities are not offering tours at this time. Clients are tested for COVID19 upon admission and are to wear masks at all times, and cleaning is extensive in all of our facilities. The number of clients per room is dependent on the number of residents at that given time, but typically ranges from 2-3 clients per room.

36. Does Narcan contain adrenaline in it?
No, Narcan - or any other form of naloxone - does not contain any adrenaline (also called epinephrine). Epinephrine, such as an EpiPen, is NOT effective in the reversal of an opioid overdose because it does not affect the brain receptors in the way that naloxone does to reverse symptoms of an opioid overdose, such as respiratory depression.

37. Does the Naloxone Standing Order, in which a prescription **IS NOT** required to obtain naloxone from participating pharmacies, only apply to Orleans Parish or the Greater New Orleans region?
No, the Naloxone Standing Order was issued in 2016 and is a STATE WIDE standing order, so naloxone can be obtained from participating pharmacies WITHOUT a prescription across the state of Louisiana. You can obtain a list of participating pharmacies by calling our 24/7 outreach phone number at (504) 415-4955.

38. Are there detox and/or residential facilities for individuals that only use marijuana?
Yes, there are treatment facilities across the country for individuals that only use marijuana.

39. If fentanyl was mixed into a substance I used without my knowledge or awareness, how long will the fentanyl stay in my system? Will fentanyl show up on a drug test panel?
The effects of fentanyl can vary depending on the amount that was mixed in with the other substance(s) and the potency. Effects can last for several hours, depending on the amount, potency, the individual's size, speed of metabolism, amongst other factors. Fentanyl is broken down in the body into norfentanyl which can stay in a person's system for up to 4 days. A person can test positive for fentanyl on a urine test for 24--72 hours after last use.

40. What is opioid "half-life" and what does it mean for substance use?
The half life of an opioid or drug is an estimate of the period of time that it takes for the amount of the drug in the body to be reduced by exactly one half (50%). For example, if a 50mg dose of an opioid has a half life of one hour, that means that one hour after taking the 50mg dose, 25mg of the drug remain in the body. Half lives of opioids are important to be aware of because the longer the half life is, the longer that opioid or drug will remain in a person's system, potentially increasing the danger of an opioid overdose.

41. What is the difference between OPIATES and OPIOIDS?
Opiates are "natural" substances, meaning that the active ingredients contained in the opiate are derived from poppy plants. A few examples of opiates include opium, morphine and codeine. Opioids are substances that are made synthetically or partly synthetically, meaning that the active ingredients in the drug are created chemically. A few examples of opioids are OxyContin, hydrocodone, and

fentanyl. Even though they are derived from different sources, opioids act just like opiates in the body.

42. What are some of the risk factors to be aware of for developing an Opioid Related Disorder (ORD)?
There are many risk factors involved with Opioid Related Disorders and can vary from person to person. Some risk factors can include past or current substance abuse, untreated psychiatric disorders, younger age, and social or family environments, among many others.

43. What is the difference between naloxone, naltrexone and Vivitrol?
Naloxone is a medication that is an opioid antagonist, meaning it can reverse an opioid overdose by binding to opioid receptors to block the adverse effects of opioids, mainly respiratory depression.
Naltrexone is a medication that blocks the effects of opioids. Blocking the effects of opioids can help reduce cravings or urges to use opioids, amongst other substances such as alcohol and can be effective in helping individuals refrain from substance use.
Vivitrol is the brand name for naltrexone and is a once monthly injection opioid blocker. It is available through prescription and administered by a healthcare provider. Individuals must be opioid-free for 7-14 days to receive Vivitrol.

45. What substances are most related to overdoses in the state of Louisiana?
Opioid related overdoses are the # 1 cause of drug related fatalities in Louisiana. In 2018, nearly 40% of the 1,140 reported drug overdose deaths in Louisiana involved opioids.

46. I am familiar with which pharmacies I can get naloxone from in Orleans Parish. Are there pharmacies that are participating in the Naloxone Standing Order in Jefferson Parish? Where are they located?
The Naloxone Standing Order is a state-wide order. Pharmacies are expected to abide by the standing order and so should carry a supply of naloxone. You may call or stop by your local pharmacy to check.

47. Is there any way to have naloxone directly delivered to my place of residence?
YES. The NaloxoneExchange.com website DOES NOT take insurance, but does offer direct delivery to places of residence. It is currently available in 35 states, including Louisiana.

47. If a person discharges from OHL Detox or Residential facilities, how long must he/she wait until they are able to be readmitted as a client?
The time period an individual must wait to be readmitted into either OHL's Detox or Residential facilities can vary is contingent on type of insurance, reason for discharge and other possible variables. You may ask staff at Detox or Residential at time of intial discharge when you may be readmitted.

48. What is the difference between Suboxone and sublocade/Subutex? Are these medications used to reverse an opioid related overdose instead of naloxone?
Suboxone is a single dose daily film that is placed under the tongue for absorption and contains both buprenorphine and naloxone. Sublocade or Subutex is an injection given once a month and contains only buprenorphine. Both Suboxone and sublocade are designed to help with opioid related withdrawal symptoms, NOT for reversals of opioid related overdoses. Even though Suboxone contains some naloxone, it is NOT recommended for use for an opioid related overdose in place of naloxone.

49. Can you overdose on Suboxone?

It is possible to overdose on Suboxone. Because Suboxone contains naloxone in it, some may get the incorrect impression that the naloxone will prevent an overdose. However, Suboxone contains a very small amount of naloxone and it is NOT enough to prevent an overdose. Naloxone is not meant to be taken orally, so the effect from the naloxone contained in Suboxone will be very minimal so it is important to not take more Suboxone than you are prescribed.

50. If we breathe out carbon dioxide when we exhale, how does Rescue Breathing provide oxygen to the individual that is overdosing?

While humans do exhale more carbon dioxide than they inhale (we exhale 4% carbon dioxide in each breathe), our bodies still exhale some oxygen. We exhale 16% oxygen, which is a significant amount, especially when trying to revive an individual who is not able to breathe on their own. If you are in a situation where an individual is overdosing, always first Call 911, next Administer naloxone (Narcan), and then administer Rescue Breathing until EMS arrives.

51. What are Rapid Fentanyl Test Strips (RFTS) and where can I get them?

Rapid Fentanyl Test Strips (RFTS) are designed so that a substance can be tested to check if fentanyl has been mixed into the substance. 10 drops are added to a small amount of the substance and mixed together. Then, holding the blue end of the test strip, the wavy end of the test strip is dipped into the mixture for approximately 30 seconds. You must be sure to expose the wavy end of the test strip to the substance for it to work properly! Within a minute or two, if a solid red line appears across the white area of the test strip, that indicates that the substance DOES contain fentanyl. If a solid red line PLUS a faint red line (2 lines) appear, that indicates that the substance is negative for fentanyl. If a test strip shows negative for fentanyl, caution should still be used because the substance could still contain other, harmful or dangerous substances. Fentanyl Test Strips are available through New Orleans community agencies such as Trystereo and at various health centers in the area.

52. Will naloxone work for Mojo?

(I (Chris) fielded this one accurately twice in the last week. While Mojo/Spice/K2 may have similar effects in some iterations, naloxone will not work for synthetic cannabinoids. As states move to legislate against the active chemical component(s) in Mojo, laboratories are just as quick to shift the chemical composition so this "legal high" remains legal. In the decade to decade and a half since Mojo's introduction, the active cannabinoid is shying away from mirroring the effects of cannabis to mirroring the effects of stimulants, with instances of mania emerging similar to excessive use of cocaine or methamphetamine. Further, there is no evidence of synthetic cannabinoids being laced with opiates.)

Drug Enforcement Administration. United States Department of Justice. *Drugs of Abuse (2017 Edition).* 88-89.

Voluntary Non-Opioid Directive Form

Louisiana Department of Health – Office of Behavioral Health

Patient's Last Name	Patient's First Name	Middle Initial
Date of Birth (MM/DD/YYYY)		

Street or Residential Address		
City	State	Zip Code

Last Name of Guardian or Healthcare Agent (if applicable)	First Name of Guardian or Healthcare Agent	Middle Initial

PATIENT/GUARDIAN/HEALTHCARE REPRESENTATIVE STATEMENT (Signature & Date Required)

I _____ (☐patient ☐guardian ☐healthcare representative) certify that I am refusing at my own insistence the offer or administration of any opioid medications. I understand the risks and benefits of my refusal, and hereby release the health care provider(s), its administration, and personnel from any responsibility for all consequences, which may result by my abstinence under these circumstances. I further certify my understanding that I may effectively revoke this certification at any time orally or in writing, for any reason.

I hereby direct that health care provider(s), medical practitioners, their administration, and personnel comply with the Louisiana Department of Health's Voluntary Non-Opioid Directive as authorized by Louisiana Revised Statues of 1950, comprised of R.S. 40:1156.1.

Health Care Practitioner (or Attending Physician) Last Name	Practitioner/Physician First Name	Date
Signature		

The signed original form should be kept in the patient's medical record, and a signed copy should be provided to the patient.

Louisiana Non-Opioid Directive Information Sheet

Benefits of this form:

- It helps prescribers and patients have a dialogue of substance use history, if applicable.
- It may prevent inadvertently offering certain controlled substances to those who could be adversely affected.
- It allows for a patient to proactively inform their physician that they do not wish to receive opioids for any reason.

Considerations for the prescribing physician:

- This form may be considered as a communication aide, similar to identification of a patient allergy.
- This form does not take the place of a detailed biopsychosocial history.
- While this form is designed specifically for opioids, due to the risk of cross addiction, it is important to use caution when prescribing any other substances with a risk of misuse, such as stimulants, benzodiazepines or other medications that the FDA has identified with risk of SUD.

Considerations for the patient:

- If you are in an emergency situation, a physician may override this directive.
- This form does not take the place of ongoing collaboration with your health care provider.
- No person acting in good faith as a duly authorized guardian or healthcare representative shall be liable for damages in a civil action or subject to criminal prosecution for revoking or overriding a voluntary non-opioid directive form.

Considerations for the pharmacist:

- An electronically transmitted prescription to a pharmacy is to be presumed valid, and a pharmacist will not be held in violation of this directive for dispensing a controlled substance in contradiction to a voluntary non-opioid form.

No prescribing practitioner who has signed and executed a non-opioid directive form with a patient, acting with reasonable care, shall be liable for damages in a civil action or subject to criminal prosecution or be deemed to have violated the standard of care for refusing to issue a prescription for an opioid.

Guideline for Alcohol and Substance Use Screening, Brief Intervention, Referral to Treatment (SBIRT)

Why screen for alcohol and drug use?

Brief motivational conversations with patients can promote significant, lasting reduction in risky use of alcohol and other drugs. Nearly 30% of adult Americans engage in unhealthy use of alcohol and/or other drugs, yet very few are identified or participate in a conversation that could prevent injury, disease or more severe use disorders.*

STEP 1

Brief Screening

Frequency:

» *Tobacco*: Every visit.

» *Alcohol and Drugs*: At least yearly; consider screening at every visit.† Consider more frequent screening for women who are pregnant or who are contemplating pregnancy; adolescents; and those with high levels of psychosocial stressors.

Youth (ages 11-17 years)

See **CRAFFT Toolkit** for youth information, talking points, tools and more at http://healthteamworks-media.precis5.com/sbirt-crafft-toolkit

Adults (18+ years old)

Substance	Questions	Positive Screen	Negative Screen
Alcohol: *Assess frequency and quantity*	1. How many drinks do you have per week? --- 2. When was the last time you had 4 or more (for men >65 years and all women) or 5 or more (for men ≤65 years) drinks in one day?	1. All women or men >65 years: **More than 7.** Men ≤65 years old: **More than 14.** ---------- ***OR*** ---------- 2. In the past 3 months.	Reinforce healthy behaviors. See **"For all patients, consider:"**
Drugs‡	In the past year, have you used or experimented with an illegal drug or a prescription drug for nonmedical reasons?	Yes	
Tobacco	Do you currently smoke or use any form of tobacco?	Yes	

For all patients, consider:

- Any alcohol use is a positive screen for patients under 21 yrs. or pregnant women.§
- Potential for alcohol-exposed pregnancy in women of childbearing age; assess for effective contraception use.§
- Alcohol/medication interactions.
- Chronic disease/alcohol precautions.
- Role of substance use in depression and other mental health conditions.¶
- Medical marijuana use.

A standard drink is:

Positive on alcohol and/or drug brief screen: proceed to Step 2.
Tobacco use only: see page 2 for Tobacco Advise and Refer.

STEP 2

Further Screening

Patients with a positive brief screen should receive further screening/assessment using a validated screening tool. Scoring instructions are on each tool. Screening tools in English and Spanish available at www.healthteamworks.org/guidelines/sbirt.html

Screening tools:

- AUDIT *(adult alcohol use)* http://healthteamworks-media.precis5.com/sbirt-audit
- DAST-10© *(adult drug use)* http://healthteamworks-media.precis5.com/sbirt-dast-10
- ASSIST *(adult poly-substance use)* http://healthteamworks-media.precis5.com/sbirt-assist
- CRAFFT *(adolescent alcohol and drug use)* http://healthteamworks-media.precis5.com/sbirt-crafft

Low risk: Provide positive reinforcement
Moderate risk: Provide brief intervention
Moderate-high risk: Provide referral to brief therapy
High risk: Refer to treatment

STEP 3 ⟶ *(page 2)*

* "Helping Patients Who Drink Too Much: A Clinician's Guide," U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism. Updated 2005. www.niaaa.nih.gov/guide
† See Clinical Preventive Health Recommendations for the General and Targeted Populations Guideline at: www.healthteamworks.org/guidelines/prevention.html.
‡ See Prescription Drug Misuse supplement at www.healthteamworks.org/guidelines/sbirt.html.
§ See Fetal Alcohol Spectrum Disorder (FASD) supplement, Preconception and Interconception Care Guideline, and Contraception Guideline at www.healthteamworks.org.
¶ See Depression in Adults: Diagnosis and Treatment Guideline at: www.healthteamworks.org/guidelines/depression.html.

This guideline is designed to assist clinicians with alcohol and substance use screening and management. It is not intended to replace a clinician's judgment or establish a protocol for all patients. For national recommendations, references and additional copies of the guideline, go to www.healthteamworks.org or call (303) 446-7200. This guideline was supported with funds from SBIRT Colorado. Approved September 2011.

STEP 3

Brief Intervention - Brief Therapy - Referral to Treatment

For more information, demonstration videos, an online training module and the CRAFFT Toolkit with adolescent talking points, go to www.healthteamworks.org.

A Brief Intervention is a short motivational conversation to educate and promote health behavior change.
Important: Recognize a person's readiness to change and respond accordingly.

Use OARS:
Open-ended questions
Affirmations
Reflections
Summaries

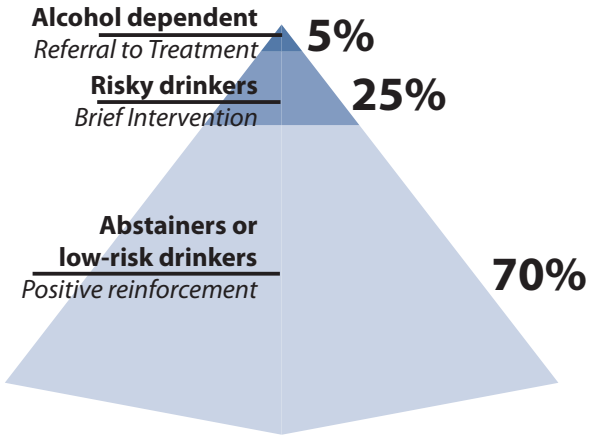
Brief Intervention (Brief Negotiated Interview model[\\]): This model may also be used to address other substance use.

1. **Raise the subject.**
   - » *"Would you mind if we talked for a few minutes about your alcohol use?"*
     - › Ask permission.
     - › Avoid arguing or confrontation.
2. **Provide feedback.**
   - » *"We know that drinking above certain levels can cause problems such as..."*
     - › Review reported substance use amounts and patterns.
     - › Provide information about substance use and health.
     - › Advise to cut down or abstain.
     - › Compare the person's alcohol use to general adult population (see drinking pyramid below).
   - » *"What do you think about this information?"*
     - › Elicit patient's response.
3. **Enhance motivation.**
   - » *"What do you like about your current level of drinking? What do you not like about your current level of drinking?"*
   - » *"On a scale from 0-10, how **important** is it for you to decrease your drinking?"*
   - » *"What makes you a 5 and not a lower number?"*
   - » *"On a scale from 0-10, how **ready** are you to decrease your drinking?"*
   - » *"What would make you more ready to make a change?"*
     - › Assess readiness to change.
     - › Discuss pros and cons.
     - › Explore ambivalence.
4. **Negotiate and advise.**
   - » *"What's the next step?"*
   - » *"What are the barriers you anticipate in meeting this goal? How do you plan to overcome these barriers?"*
   - » *"On a scale from 0-10, how **confident** are you that you will be able to make this change?"*
   - » *"What might help you feel more confident?"*
     - › Negotiate goal.
     - › Provide advice and information.
     - › Summarize next steps and thank the patient.

Importance — Readiness — Confidence

U.S. Adult Alcohol Use Estimate

Potential consequences of risky drinking: multiple health, work and family issues



Tobacco Advise and Refer:

Ask permission, then advise every tobacco user to quit with a personalized health message.

Colorado QuitLine and Other Programs
Refer individuals age 15+ to the Colorado QuitLine (1-800-QUIT-NOW [1-800-784-8669] or www.coquitline.org):

- Personally tailored quit program
- Five scheduled, telephone-based coaching sessions
- May include free nicotine replacement therapy (age 18+ and medically eligible)

Information on programs for specific populations and ages: www.myquitpath.com

Order free tools and materials: www.cohealthresources.com

Pharmacotherapy options: HealthTeamWorks Tobacco Cessation and Secondhand Smoke Exposure Guideline at www.healthteamworks.org/guidelines/tobacco.html

STEP 3 continued:

Referral to treatment

Brief Therapy: For moderate to high risk use of alcohol or drugs	**Substance Use Disorder Treatment:** For high risk alcohol or drug use
• Motivational discussion; focused on empowerment and goal setting • Includes assessment, education, problem-solving, coping strategies, supportive social environment • Typically 4-6 sessions, each one approached as though it could be the last	• Proactive process to facilitate access to specialty care • Focus on motivating a person to follow-up on referral for further assessment and possible treatment • Appropriate level of care may include inpatient, outpatient, residential • Pharmacotherapy options: www.healthteamworks.org/guidelines/sbirt.html

***Referral information in Colorado*: http://linkingcare.org**

SBIRT is reimbursable if:	**Documentation: Key points**
• A validated screening tool is used • It is properly documented • Time requirement is met See www.healthteamworks.org for up-to-date information.	• SBIRT should be documented like any other healthcare service. • These records may require special permission for release. Consult your organization's privacy policy. • Documented use of a validated screening tool (e.g., AUDIT, DAST, CRAFFT, ASSIST) required for reimbursement.

[\\] The Yale Brief Negotiated Interview Manual. D'Onofrio, et al. New Haven, CT: Yale University School of Medicine. 2005.

Naloxone Donations:

- Direct Relief:Pfizer is working with Direct relief to make up to 1 million doses of naloxone available at no cost to qualified non profit health providers and public health departments nationwide (Contact usaprograms@directrelief.org 877-303-7872)
    - https://www.directrelief.org/2017/05/direct-relief-providing-overdose-reversing-naloxone-nationwide-safety-net-health-clinics/
- LADOJ Naloxone Request: http://www.ag.state.la.us/Article/2408/5
- Evzio2You Enrollment Form: For commercial insurance Carriers
    - Enrollment Form 1 for concern due to chronic pain
    - Enrollment Form 2 for concern due to dependence
- Kaleo Cares Patient Assistance Program: For uninsured or Government Insurance carriers
- Evzio Product donation Grant Program: **Notice:** The kaléo Cares Product Donations Program web portal is migrating to a new and improved software platform. We expect to begin accepting new charitable grant applications through the upgraded portal during the second quarter of 2019. We apologize for the inconvenience during the period of the upgrade to the new system.

Naloxone Purchasing Cost:
Company: Adapt Pharma
Cost/unit:
$75- Public Interest Price
Concentration:
2 mg and 4 mg of naloxone hydrochloride in 0.1 mL
Container:
Nasal spray
Contact:
https://www.narcandirect.com/
Adapt Pharma® has collaborated on and researched several types of naloxone distribution models. If you or your organization would like additional information, including a live presentation for your team, please send us an email at customerservice@adaptpharma.com or call 1-844-ADAPT-11 (1-844-232-7811).

Company: Evzio
Cost/unit:
$178: for government agencies, first responders, health departments, and other qualifying groups when they purchase directly from kaléo or authorized distributors.
Container:
Auto Injector
Contact:
https://www.evzio.com/patient/public-access-pricing/

Company: Pfizer
Cost/Unit:
$7.50
Concentration:
0.4mg/ml
Container:
Vial or carpuject luer-lock syringe
Syringe purchased seperately
Contact:
https://www.pfizerinjectables.com/products/naloxone-hydrochloride

Company: Amphastar
Cost/Unit:
$21
Naloxone HCl Injection, USP, 2mg/2mL:
Naloxone HCl Injection is indicated for the complete or partial reversal of narcotic depression and diagnosis of suspected acute opioid overdose.
Provided in 2 types of prefilled syringes for convenient, safe, and quick Intravenous, Intramuscular, and Subcutaneous administration:

- Needleless Luer Jet Prefilled Syringe: completely needleless syringe, provided in Luer Lock syringe, complies with OSHA's Needlestick Safety and Prevention Act. Compatible with most Luer Activated Systems (includes ICU Medical Clave® Valve)
- Min-I-Jet Prefilled syringe with 21 Gauge and 1 ½" fixed Needle

Not sure of pricing but link to contact info
Contact
http://www.amphastar.com/assets/naloxone.pdf
1800-423-4163

EVZIO2YOU

Through the EVZIO2YOU direct-delivery service:

- All commercially insured patients pay absolutely nothing out of pocket for EVZIO. See terms and conditions below.* Savings limits apply
- No other naloxone product, branded or generic, is more affordable than EVZIO for commercially insured patients who go through the direct-delivery service
- EVZIO is delivered to your home or to your healthcare provider's office with free shipping

For patients with government insurance:

- Many patients may get EVZIO at no cost. If you decide the cost is not affordable, the pharmacy may work with your healthcare provider to offer an alternative naloxone

***Terms and Conditions: THIS OFFER IS NOT INSURANCE.** This offer is valid only in the United States. Program is applicable only for commercially insured patients who utilize the direct delivery service. Offer not valid for patients insured in whole or in part by government programs such as Medicaid, Medicare, Tricare or other federal or state health programs (such as state prescription drug programs). If the patient is eligible for benefits under any such program, the patient cannot use this offer. By using this offer, the patient certifies that he or she will comply with any terms of his or her health insurance contract requiring notification to his or her payer of the existence and/or value of this offer. It is illegal to (or offer to) sell, purchase, or trade this offer. This offer is not transferable. Cannot be combined with any rebate/coupon, free trial, or similar offer for the specified prescription(s). Void where prohibited by law. Cash discount cards are not commercial payers and are not eligible to be used for this program. Kaleo, Inc. reserves the right to rescind, revoke, amend, or terminate this offer without written notice at any time. Savings limits apply. Call (877) 438-9463 for questions regarding eligibility.

To learn more about EVZIO and obtaining an EVZIO prescription, be sure to:

- ☑ **Print the enrollment form on the next page and bring to your healthcare provider**
- ☑ **Talk to your healthcare provider today**

If you have questions about EVZIO2YOU, visit EVZIO.com

Evzio
(naloxone HCl injection)
2 mg auto-injector

Evzio2YOU

EVZIO2YOU ENROLLMENT FORM

Fax to (225) 243-7983

PATIENT INFORMATION

Patient Name (First & Last): _____

Phone Number: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

ICD-10 Code: _____

PHYSICIAN INFORMATION

Physician Name: _____ NPI#: _____

Office Contact Name: _____ Phone Number: _____

Physician Address: _____

City: _____ State: _____ ZIP: _____

TREATMENT

Medication	Dosage & Strength	Directions	QTY	Refills
Evzio (naloxone HCl injection) 2 mg auto-injector	☑ 2 mg/0.4mL auto-injector	_____ _____ _____	☐ 1 Carton ☐ 2 Cartons ☐ __ Cartons	☐ 1 ☐ 2 ☐ 3 ☐ ___ Refills

Prescriber Signature

_____
Signature Date

☐ Substitution Permissible

☐ I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on my behalf. I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge.

Patient Signature

I authorize for EVZIO to be sent to the patient address listed above or to _____ (Address), if EVZIO has a $0 copay. I am also declining counseling on EVZIO from the pharmacy. If I have further questions, I will be responsible for contacting the pharmacy.

_____
Signature Date

INSURANCE

Please attach a copy of the patient's prescription insurance coverage and a printout of patient demographic information.

Evzio 2 YOU ENROLLMENT

FAX: (877) 546-5780 | PHONE: (877) 546-5779

Step 1. Please complete **all** fields on this form (to prevent delays in processing).
Step 2. Fax this form, along with the signed HIPAA Authorization and copies of both sides of insurance and pharmacy benefit cards, to **(877) 546-5780**.
For assistance or more information, please visit **EVZIO.com** or call **(877) 438-9463**.

SECTION 1: PATIENT INFORMATION

PATIENT INFORMATION

Name (Last, First): _____ Date of Birth: __/__/____ ☐ Male ☐ Female

Address: *(Cannot be a PO Box)* _____ City: _____ State: _____ ZIP: _____

Email: _____ SSN (last 4 digits): _____

Cell #: _____ ☐ OK to leave message Home Phone #: _____ ☐ OK to leave message

Preferred contact: ☐ Cell ☐ Home Phone Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

Emergency Contact: _____ Phone #: _____

INSURANCE AND CLINICAL INFORMATION

(1) Fill in fields with pharmacy insurance information (NOT Medical), OR (2) Fax Patient Demographic Information or Patient Insurance Card (COPY FRONT AND BACK) along with this enrollment form.

Insurance Name: _____ Policy #: _____ Group ID #: _____

Insurance Phone #: _____ Policyholder Name (Last, First): _____ Relationship to Patient: _____

Rx Member ID: _____ Rx PCN: _____

Rx Group ID: _____ Rx BIN: _____

Current Medications: _____

Known Drug Allergies: _____

SECTION 2: PRESCRIPTION INFORMATION

PRESCRIPTION INFORMATION *(TO BE COMPLETED BY HEALTHCARE PROVIDER)*

Prescription for EVZIO® (naloxone HCl injection) 2 mg auto-injector

Carton Description: Each Carton contains 2 (two) auto-injectors and 1 (one) Trainer

Prescribed Quantity: _____ Refill(s): _____

Sig (Directions): PRN for Opioid Emergency

ICD-10 Code(s)/Primary Diagnosis: • T40.2X1A • F11.11 • F11.21 • F11.25 • F11.10 • F11.20 • F11.23 • Other

Please write in ICD-10 Code: _____

Previous Visit Notes: _____

Substitution Permissible (prescriber signature): _____ Date: __/__/____

PRESCRIBER INFORMATION *(TO BE COMPLETED BY HEALTHCARE PROVIDER)*

Name (Last, First): _____ Facility Name: _____

Primary Specialty: ☐ Pain ☐ Addiction ☐ Other: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____

NPI #: _____ DEA #: _____ Tax ID: _____

Office Contact: _____ Best time to contact: ☐ Morning ☐ Afternoon

By signing below, I certify the following:

This request for services has been prepared exclusively by the provider or provider's office identified in this request ("my Practice").

- The prescribed medication is medically appropriate for the patient identified based on my best professional judgment and my practice will be supervising the patient's treatment.
- The information provided in this request is accurate to the best of my knowledge.
- Completing this referral form does not ensure that the patient will obtain insurance coverage or reimbursement for the prescribed medication, and that any pharmacy service provided by AVELLA SPECIALTY PHARMACY, is provided for information purposes only and represent no statement, promise or guarantee by AVELLA SPECIALTY PHARMACY or kaléo, Inc.

PRESCRIBER AUTHORIZATION

Prescriber Signature (dispense as written): _____ Date: __/__/____

Shipping Preference (check only one)

☐ Patient Home Address

Address: _____

Phone #: _____

☐ Center/Facility Address

Address: _____

Phone #: _____

Patient Name: _____ Date of Birth: __/__/____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize my doctor(s) and their staff, my health insurer(s) and the specialty pharmacy or distributor that will supply EVZIO and/or fill my prescription (the "Pharmacy") to use and disclose my personal information, including but not limited to, information about my medical condition and treatment (including prescriptions), health insurance, social security number and related information ("Personal Information") to help verify, investigate or coordinate insurance coverage. This information may include spoken or written facts about my medical condition, my health insurance benefits, name, date of birth, address, telephone number(s), social security number, and/or financial information. All of this information may be considered protected health information ("PHI") as governed and protected by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, as amended, and under the rules and regulations thereunder.

I authorize my prescription to be sent to Avella for processing and if Avella is unable to fill the prescription due to insurance requirements, Avella may transfer the prescription to another pharmacy that has authorization to fill the prescription. I know that people who work for, and with AVELLA SPECIALTY PHARMACY may receive and use my information, but they may use it only as authorized in this form or for such purposes as may be required by applicable law. We may be obligated to disclose the Personal Information to law enforcement, public health organizations, reporting victims of abuse or neglect, healthcare oversight, legal proceedings, certain research activities approved by an Institutional Review Board, threat to health or safety, specialized government functions, inmates, laws relating to worker's compensation. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it by contacting AVELLA SPECIALTY PHARMACY, in writing by mail: 24416 N. 19th Ave, Phoenix, AZ 85085, Attention: Pain/Addiction Department or fax (877-546-5780). Unless I revoke my consent earlier, this consent will expire automatically after 5 years.

I understand that I might be denied certain enhanced reimbursement support and financial assistance services if I refuse to sign this authorization. I will not be denied healthcare, insurance reimbursement, or enrollment in any health plan if I refuse to sign this authorization.

I understand that I may refuse to sign this form. My choice about whether to sign this form will not change the way my healthcare providers treat me. However, I understand that my refusal to sign this form may preclude or limit my participation in the prescription delivery service. I understand that AVELLA SPECIALTY PHARMACY does not promise to find ways to pay for my medication(s) and I know that I am responsible for the costs of my care. I agree that a copy of this form may be treated as a signed original.

Patient Signature _____ Date of Signature: __/__/____

If applicable, please list all authorized designees:

Designee Name (1): _____ Relationship: _____ Phone: _____

Designee Name (2): _____ Relationship: _____ Phone: _____

*Parent/Guardian/Legal Representative Name: _____ Authority/Relationship to Patient: _____

*Parent/Guardian/Legal Representative Signature: _____ Date of Signature: __/__/____

**If patient is a minor without capacity to act alone under state law, signature of patient and parent/guardian/legal representative is required*

INDICATION

EVZIO is an opioid antagonist indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression in adults and pediatric patients. EVZIO is intended for immediate administration as emergency therapy in settings where opioids may be present. EVZIO is not a substitute for emergency medical care.

IMPORTANT SAFETY INFORMATION

EVZIO is contraindicated in patients known to be hypersensitive to naloxone hydrochloride or to any of the ingredients in EVZIO.

Seek emergency medical assistance immediately after use. Additional supportive and/or resuscitative measures may be helpful while awaiting emergency medical assistance.

The following warnings and precautions should be taken when administering EVZIO:

- Risk of Recurrent Respiratory and CNS Depression: Due to the duration of action of naloxone relative to the opioid, keep the patient under continued surveillance and administer repeated doses of naloxone using a new EVZIO, as necessary, while awaiting emergency medical assistance.
- Risk of Limited Efficacy With Partial Agonists or Mixed Agonists/Antagonists: Reversal of respiratory depression caused by partial agonists or mixed agonists/antagonists, such as buprenorphine and pentazocine, may be incomplete. Larger or repeat doses may be required.
- Precipitation of Severe Opioid Withdrawal: Use in patients who are opioid dependent may precipitate opioid withdrawal. In neonates, opioid withdrawal may be life-threatening if not recognized and properly treated. Monitor for the development of opioid withdrawal.
- Risk of Cardiovascular (CV) Effects: Abrupt postoperative reversal of opioid depression may result in adverse CV effects. These events have primarily occurred in patients who had pre-existing CV disorders or received other drugs that may have similar CV effects. Monitor these patients closely in an appropriate healthcare setting after use of naloxone hydrochloride.

The following adverse reactions were most commonly observed in EVZIO clinical studies: dizziness and injection site erythema.

Abrupt reversal of opioid effects in persons who were physically dependent on opioids has precipitated signs and symptoms of opioid withdrawal including: body aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, abdominal cramps, increased blood pressure, and tachycardia. In the neonate, opioid withdrawal signs and symptoms also included: convulsions, excessive crying, and hyperactive reflexes.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see full Prescribing Information at EVZIO.com.

EVZIO® (naloxone HCl injection) 2 mg auto-injector

KALÉO CARES Patient Assistance Program

Please fax* completed forms to: 1-800-943-1730

****Faxes must be sent from Prescriber office.***

Kaléo understands the importance in having emergency medications available to patients but recognizes that some patients may have financial difficulties that prevent them from obtaining those needed medications. The KALÉO CARES Patient Assistance Program is here to help those patients who are experiencing financial difficulties.

To be eligible for assistance to receive EVZIO® at no cost, you must:

- Be a legal US resident.
- Not have any government or commercial drug coverage.†
- Not have commercial insurance or be eligible for state or federal government insurance such as Medicare and Tricare.†
- Have an annual household income of less than $100,000.

†Patients who are eligible for Medicaid coverage may be eligible for assistance to receive EVZIO at no cost.

Subject to aggregate and individual volume limitations, availability of EVZIO, and other terms and conditions. Kaléo reserves the right to discontinue the program at any time for any or no reason. This is not insurance.

Section 1: Patient Information		
First Name	**Last Name**	
Street Address (Cannot be PO Box)		
City	**State**	**Zip**
Primary Phone	**Secondary Phone**	
US Resident ☐ **Yes** ☐ **No**	**Social Security Number**	
Gender ☐ **Male** ☐ **Female**	**Date of Birth**	

Section 2: Insurance and Income Attestation		
Do you have prescription drug coverage? ☐ **Yes** ☐ **No**		**Number of Dependents (Total Number of People in Household)**
Do you have commercial insurance? ☐ **Yes** ☐ **No**		
Are you eligible for government insurance, such as Medicare or Tricare? ☐ **Yes** ☐ **No**	**Specifically, are you eligible for Medicaid?** ☐ **Yes** ☐ **No**	**Annual Household Income‡**
All medication will be shipped directly to patient.		**‡Note: Patient may be required to provide proof of income.**

I declare and affirm that the information provided on this application form is true and accurate. I give consent to the KALÉO CARES Patient Assistance Program to disclose my enrollment in this program as needed to comply with legal and regulatory obligations. I agree to notify this program immediately if my prescription drug coverage changes in any way before I receive a prescription or a refill.

Patient Signature	**Date**

Section 3: Patient Privacy and Consent

The information you provide will be used by kaléo, the KALÉO CARES Patient Assistance Program, and parties acting on their behalf to determine eligibility, to manage and improve the KALÉO CARES Patient Assistance Program products and services, to communicate with you about your experience with the KALÉO CARES Patient Assistance Program, and/or to send you materials and other helpful information and updates relating to kaléo programs.

By signing below, I affirm that my answers and my documented income are complete, true, and accurate to the best of my knowledge.

I understand that:

- Completing this enrollment form does not guarantee that I will qualify for the KALÉO CARES Patient Assistance Program.
- kaléo may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medicines supplied by KALÉO CARES Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- kaléo reserves the right to change or cancel the KALÉO CARES Patient Assistance Program, or terminate my enrollment, at any time.
- The support provided by this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by kaléo through the KALÉO CARES Patient Assistance Program:

- I will promptly contact kaléo if my financial status or insurance coverage changes.
- I will not seek reimbursement or credit for the medicine(s) from my insurance provider or payer for any costs of medications.
- I will not seek to have this medicine or any cost from it counted in my out-of-pocket expenses for prescription drugs for any payer.
- I will notify my insurance provider of the receipt of any medicines through the KALÉO CARES Patient Assistance Program.

I may refuse to sign this consent. If I refuse, I will not be able to participate in this program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment, or affect my insurance enrollment or eligibility for insurance benefits.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Patient Signature	**Date**

For assistance with any questions, call 502-213-7601 • Monday through Friday from 8 am to 7 pm Eastern Time

For additional information on EVZIO®, please visit our website **EVZIO.com**

EVZIO® (naloxone HCl injection) 2 mg auto-injector

KALÉO CARES Patient Assistance Program

Please fax* completed forms to: 1-800-943-1730

****Faxes must be sent from Prescriber office.***

Patient Name	**Date of Birth**
Allergies	
Other Medications	

Section 4: Healthcare Provider Information

Prescriber First Name	**Prescriber Last Name**	
Street Address		
City	**State**	**Zip**
Office Contact Name	**Office Phone**	**Office Fax**
State License	**NPI**	**DEA**

Section 5: Prescription

EVZIO®
(naloxone HCl injection) 2 mg auto-injector **Directions** _____ **Quantity** _____

Diagnosis **ICD-10** _____ **Other** _____

Date	**Anticipated Start Date**

I certify that this EVZIO® prescription fits the indication and is medically appropriate for this patient. I affirm that the patient is not eligible for Medicare and the information provided by the patient on this application form is complete and accurate to the best of my knowledge. I give consent to the KALÉO CARES Patient Assistance Program, kaleo, Inc., its affiliated companies, and its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Prescriber's Signature

Dispense as Written _____ Substitution Allowed _____

NY prescribers – *please submit prescription on an original NY State prescription blank*
TN prescribers – *quantity must be written in both numerals and words. Example: 3 (three) doses*

For assistance with any questions, call 502-213-7601 • Monday through Friday from 8 am to 7 pm Eastern Time
For additional information on EVZIO®, please visit our website **EVZIO.com**

Jeff Landry
Attorney General

State of Louisiana
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
P.O. BOX 94005
BATON ROUGE
70804-9005

Naloxone Request Form

Please complete the following information:

Date of Request: _____/_____/_____

Organization Name: _____

Address: _____

_____

Contact Person: _____

Telephone Number: _____ -- _____ --_____

Email Address: _____

Units Requested: _____

Do you need information on Training Resources?

Yes ____ No ____

Additional information, if available:

Number of drug overdoses within jurisdiction during the last calendar year: _____

Number of overdose fatalities within jurisdiction during the last calendar year: _____

Number of naloxone doses purchased during the last calendar year: _____

Number of naloxone doses utilized during the last calendar year: _____

Please submit completed forms to:
Monica Taylor
NaloxoneVouchers@ag.louisiana.gov
Direct Dial: 225-326-6702

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

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

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

SCREENING INSTRUMENT FOR SUBSTANCE ABUSE POTENTIAL (SISAP) QUESTIONNAIRE

1. If you drink, how many drinks do you have on a typical day?
If less than 5 for men/less than 4 for women, then ask question 2.
If 5 or more for men/4 or more for women, then you may stop here ..... *Use caution when prescribing opioids.*

2. How many drinks do you have in a typical week?
If less than 17 for men/less than 13 for women, then ask question 3.
If 17 or more for men/13 or more for women, then you may stop here ..... *Use caution when prescribing opioids.*

3. Have you used marijuana or hashish in the last year?
If no, then ask question 4.
If yes, then you may stop here ..... *Use caution when prescribing opioids.*

4. Have you ever smoked cigarettes?
If no, then you may stop here ..... *Probably a low opioid abuse risk.*
If yes, then ask question 5.

5. What is your age?
If under 40 years of age, then you may stop here ..... *Use caution when prescribing opioids.*
If 40 years of age or older, then you may stop here ..... *Probably a low opioid abuse risk.*

NOTES

- Use caution when prescribing opioids to these patients:
    a. Men who drink more than 4 alcoholic beverages per day or 16 per week
    b. Women who drink more than 3 alcoholic beverages per day or 12 per week
    c. Persons who admit to recreational use of marijuana or hashish in the previous year
    d. Persons who are younger than 40 years of age and smoke

This information was originally published in *Pain Research & Management.* 1996;1(3):155-162

DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right-hand column

SCORE	FACTOR	EXPLANATION
	DIAGNOSIS	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	INTRACTABILITY	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	RISK	(**R** = Total of **P**+**C**+**R**+**S** below)
	Psychological	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of chemical dependence (CD) in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	EFFICACY SCORE	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a good candidate for long-term opioid analgesia

NOTES

A DIRE Score of ≤13 indicates that the patient may not be suited to long-term opioid pain management.

Used with permission by Miles J. Belgrade, MD

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months…		**Circle**	
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 abusing 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 (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)

Current Opioid Misuse Measure (COMM)™

The Current Opioid Misuse Measure (COMM)™ is a brief patient self-assessment to monitor chronic pain patients on opioid therapy. The COMM™ was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long-term opioid treatment are exhibiting aberrant medication-related behaviors:

- *Signs & Symptoms of Intoxication*
- *Emotional Volatility*
- *Evidence of Poor Response to Medications*
- *Addiction*
- *Healthcare Use Patterns*
- *Problematic Medication Behavior*

The COMM™ will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP®) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future. Since the COMM™ examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment. The COMM™ is:

- A quick and easy to administer patient-self assessment
- 17 items
- Simple to score
- Completed in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The COMM™ is for clinician use only. The tool is not meant for commercial distribution.
- The COMM™ is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with COMM™ scores to decide if and when modifications to particular patient's treatment plan is needed.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

Scoring Instructions for the COMM™

To score the COMM™, simply add the rating of all the questions. A score of 9 or higher is considered a positive

Sum of Questions	COMM Indication
> or = 9	**+**
< 9	**-**

As for any scale, the results depend on what cutoff score is chosen. A score that is sensitive in detecting patients who are abusing or misusing their opioid medication will necessarily include a number of patients that are not really abusing or misusing their medication. The COMM™ was intended to over-identify misuse, rather than to mislabel someone as responsible when they are not. This is why a low cut-off score was accepted. We believe that it is more important to identify patients who have only a possibility of misusing their medications than to fail to identify those who are actually abusing their medication. Thus, it is possible that the COMM™ will result in false positives – patients identified as misusing their medication when they were not.

The table below presents several statistics that describe how effective the COMM™ is at different cutoff values. These values suggest that the COMM™ is a sensitive test. This confirms that the COMM™ is better at identifying who is misusing their medication than identifying who is not misusing. Clinically, a score of 9 or higher will identify 77% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 9 is .95, which means that most people who have a negative COMM™ are likely not misusing their medication. Finally, the Positive likelihood ratio suggests that a positive COMM™ score (at a cutoff of 9) is nearly 3 times (3.48 times) as likely to come from someone who is actually misusing their medication (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 9 will ensure that the provider is least likely to miss someone who is really misusing their prescription opioids. However, one should remember that a low COMM™ score suggests the patient is really at low-risk, while a high COMM™ score will contain a larger percentage of false positives (about 34%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

COMM™ Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 9 or above	.77	.66	.66	.95	3.48	.08

Emerging Solutions in Pain

Pain Medication Questionnaire (PMQ)

Background

1. Survey of 26 self-assessment questionnaire to be completed by patient to assess the risk of opioid medication misuse among chronic pain patients
2. Answers scored on a Likert 5-point scale of 0 (disagree) to 4 (agree), some questions have reverse numeration
3. Further research may be needed to fortify the replicability and validity of the PMQ as a broad-use tool
4. The PMQ can be time consuming to complete

Questions consist of 26 groups of statements. Patients are directed to select the description which best matches their experiences, thoughts, and needs related to their pain medication. Topics include:

- Adjuvant Therapies
- Alcohol
- Anxiety, Depression and Sleep
- Borrowing Medication
- Concentration
- Concomitant Illnesses
- Dependence on Medication
- Discussing Pain with Doctor
- Early Refills
- Education on Medication
- Emergency Room
- GI Effects
- Increased Dosage
- Lost Medication
- Medication Preferences
- Multiple Doctors
- New Treatment Plan
- Obtaining Medication
- Quantity Medication
- Saving Medication
- Self-Medicating

Interpretation

- Higher PMQ scores in the higher third (70 to 104) are associated with history of substance abuse, higher levels of psychosocial distress, and poorer functioning (HPMQ)
- Patients falling in the lower third of scores (0 to 34) constituted the low risk group and are at lower potential for opioid misuse (LPMQ)

Resources: PMQ

1. General
    a. Intended for use by licensed healthcare professionals only
    b. Published by Elsevier
2. Available for purchase from:
    a. http://www.us.elsevierhealth.com

Reference

1. Adams LL, Gatchel RJ, Robinson RC, Polatin P, Gajraj N, Deschner M, Noe C. Development of a self-report screening instrument for assessing potential opioid medication misuse in chronic pain patients. *J Pain Symptom Manage.* 2004; 27:440-459.

Progress Note
Pain Assessment and Documentation Tool (PADT™)

Patient Name: _____ Record #:_____

Assessment Date: _____

Patient Stamp Here

Current Analgesic Regimen

Drug Name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)

_____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?

☐ **Yes** ☐ **No**

5. Query to clinician: Is the patient's pain relief clinically significant?

☐ **Yes** ☐ **No** ☐ **Unsure**

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

***If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.**

(Continued on reverse side)

Progress Note

Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever? ☐ Yes ☐ No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	☐	☐	☐	☐
b. Vomiting	☐	☐	☐	☐
c. Constipation	☐	☐	☐	☐
d. Itching	☐	☐	☐	☐
e. Mental cloudiness	☐	☐	☐	☐
f. Sweating	☐	☐	☐	☐
g. Fatigue	☐	☐	☐	☐
h. Drowsiness	☐	☐	☐	☐
i. Other_____		☐	☐	☐
j. Other_____		☐	☐	☐

Potential Aberrant Drug-Related Behavior

This section must be completed by the physician

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ☐ Purposeful over-sedation
- ☐ Negative mood change
- ☐ Appears intoxicated
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Requests frequent early renewals
- ☐ Increased dose without authorization
- ☐ Reports lost or stolen prescriptions
- ☐ Attempts to obtain prescriptions from other doctors
- ☐ Changes route of administration
- ☐ Uses pain medication in response to situational stressor
- ☐ Insists on certain medications by name
- ☐ Contact with street drug culture
- ☐ Abusing alcohol or illicit drugs
- ☐ Hoarding (ie, stockpiling) of medication
- ☐ Arrested by police
- ☐ Victim of abuse
- ☐ Other: _____

_____

_____

2. Patients overall severity of side effects?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ☐ Yes ☐ No ☐ Unsure

Comments: _____

_____

Specific Analgesic Plan:

Comments:_____

- ☐ Continue present regimen
- ☐ Adjust dose of present analgesic
- ☐ Switch analgesics
- ☐ Add/Adjust concomitant therapy
- ☐ Discontinue/taper off opioid therapy

Date:_____ **Physicians Signature:**_____

Addiction Behaviors Checklist (ABC)

Designed to track behaviors characteristic of addiction related to prescription opioid medications in chronic pain patients. Items are focused on observable behaviors noted both during and between visits. ABC is focused on longitudinal assessment and tracking of problematic behaviors.

Addiction Behaviors Checklist

***Instructions*: Code only for patients prescribed opioid or sedative analgesics on behaviors exhibited ''since last visit'' and ''within the current visit'' (NA = not assessed)**

Addiction behaviors—since last visit

1. Patient used illicit drugs or evidences problem drinking*	Y	N	NA
2. Patient has hoarded meds	Y	N	NA
3. Patient used more narcotic than prescribed	Y	N	NA
4. Patient ran out of meds early	Y	N	NA
5. Patient has increased use of narcotics	Y	N	NA
6. Patient used analgesics PRN when prescription is for time contingent use	Y	N	NA
7. Patient received narcotics from more than one provider	Y	N	NA
8. Patient bought meds on the streets	Y	N	NA

Addiction behaviors—within current visit

1. Patient appears sedated or confused (e.g., slurred speech, unresponsive)	Y	N	NA
2. Patient expresses worries about addiction	Y	N	NA
3. Patient expressed a strong preference for a specific type of analgesic or a specific route of administration	Y	N	NA
4. Patient expresses concern about future availability of narcotic	Y	N	NA
5. Patient reports worsened relationships with family	Y	N	NA
6. Patient misrepresented analgesic prescription or use	Y	N	NA
7. Patient indicated she or he ''needs'' or ''must have'' analgesic meds	Y	N	NA
8. Discussion of analgesic meds was the predominant issue of visit	Y	N	NA
9. Patient exhibited lack of interest in rehab or self-management	Y	N	NA
10. Patient reports minimal/inadequate relief from narcotic analgesic	Y	N	NA
11. Patient indicated difficulty with using medication agreement	Y	N	NA

Other

1. Significant others express concern over patient's use of analgesics	Y	N	NA

*Item 1 original phrasing: (''Patient used ETOH or illicit drugs''), had a low correlation with global clinical judgment. This is possibly associated with difficulty in content interpretation, in that if a patient endorsed highly infrequent alcohol use, he or she would receive a positive rating on this item, but not be considered as using the prescription opioid medications inappropriately. Therefore, we include in this version of the ABC a suggested wording change for this item that specifies problem drinking as the criterion for alcohol use.

ABC Score: _____

Score of ≥3 indicates possible inappropriate opioid use and should flag for further examination of specific signs of misuse and more careful patient monitoring (i.e., urine screening, pill counts, removal of opioid).

Checklist developed by Bruce D. Naliboff, Ph.D. with support from VA Health Services Research and Development. Used with permission.

Published in: Wu SM, Compton P, Bolus R, et al. The addiction behaviors checklist: validation of a new clinician-based measure of inappropriate opioid use in chronic pain. *J Pain Symptom Manage*. 2006;32(4):342-351.

Project Implicit®

Featured Task: How we think about race/ethnicity

On the next page you'll be asked to complete an Implicit Association Test (IAT).

We ask these questions because the IAT can be more valuable if you also describe your own self-understanding of the attitude or stereotype that the IAT measures. We would also like to compare differences between people and groups.

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Important disclaimer: In reporting to you results of any IAT test that you take, we will mention possible interpretations that have a basis in research done (at the University of Washington, University of Virginia, Harvard University, and Yale University) with these tests. However, these Universities, as well as the individual researchers who have contributed to this site, make no claim for the validity of these suggested interpretations. If you are unprepared to encounter interpretations that you might find objectionable, please do not proceed further. You may prefer to examine general information about the IAT before deciding whether or not to proceed.

You can contact our research team (implicit@fas.harvard.edu) or Harvard's Committee on the Use of Human Subjects (cuhs@harvard.edu) for answers to pertinent questions about the research and your rights, as well as in the event of a research-related injury to yourself.

I am aware of the possibility of encountering interpretations of my IAT performance with which I may not agree. Knowing this, I wish to proceed with the "How we think about race/ethnicity" Implicit Association Task

Project Implicit®

Preliminary Information

On the next page you'll be asked to select an Implicit Association Test (IAT) from a list of possible topics . We will also ask you (optionally) to report your attitudes or beliefs about these topics and provide some information about yourself.

We ask these questions because the IAT can be more valuable if you also describe your own self-understanding of the attitude or stereotype that the IAT measures. We would also like to compare differences between people and groups.

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I am aware of the possibility of encountering interpretations of my IAT test performance with which I may not agree. Knowing this, I wish to proceed

Project Implicit®

Disability IAT — ***Disability*** **('Disabled - Abled' IAT).** This IAT requires the ability to recognize symbols representing abled and disabled individuals.

Religion IAT — ***Religion*** **('Religions' IAT).** This IAT requires some familiarity with religious terms from various world religions.

Transgender IAT — ***Transgender*** **('Transgender People – Cisgender People' IAT).** This IAT requires the ability to distinguish photos of transgender celebrity faces from photos of cisgender celebrity faces.

Age IAT — ***Age*** **('Young - Old' IAT).** This IAT requires the ability to distinguish old from young faces. This test often indicates that Americans have automatic preference for young over old.

Asian IAT — ***Asian American*** **('Asian - European American' IAT).** This IAT requires the ability to recognize White and Asian-American faces, and images of places that are either American or Foreign in origin.

Sexuality IAT — ***Sexuality*** **('Gay - Straight' IAT).** This IAT requires the ability to distinguish words and symbols representing gay and straight people. It often reveals an automatic preference for straight relative to gay people.

Native IAT — ***Native American*** **('Native - White American' IAT).** This IAT requires the ability to recognize White and Native American faces in either classic or modern dress, and the names of places that are either American or Foreign in origin.

Race IAT — ***Race*** **('Black - White' IAT).** This IAT requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for white over black.

Weight IAT — ***Weight*** **('Fat - Thin' IAT).** This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.

Arab-Muslim IAT — ***Arab-Muslim*** **('Arab Muslim - Other People' IAT).** This IAT requires the ability to distinguish names that are likely to belong to Arab-Muslims versus people of other nationalities or religions.

Weapons IAT — ***Weapons*** **('Weapons - Harmless Objects' IAT).** This IAT requires the ability to recognize White and Black faces, and images of weapons or harmless objects.

STATE OF LOUISIANA

Standing Order for the Distribution or Dispensing of Naloxone or Other Opioid Antagonists

Background and Purpose

Naloxone, and other opioid antagonists, is a prescription medication indicated for the reversal of respiratory depression or unresponsiveness due to opioid overdose. Given the current public health emergency relative to the misuse and abuse of opioid derivatives, it has been determind that widespread availability of opioid antagonists to addicts and their caregivers, as well as first responders in the community, would serve the public interest. For as long as naloxone, and other such opioid antagonists, remain classified as prescription drugs by the federal Food and Drug Administration, pharmacists must secure a prescription or order from a prescriber with the legal authority to prescribe said drug products in order to dispense or distribute the drug product. Thus, the Lousiana Legislature has adopted a number of laws designed to facilitate the distribution and dispensing of naloxone, or other opioid antagonists, beyond the person who would need the medication on an emergent basis to manage an opioid-related drug overdose; specifically first responders, caregivers and family/ friends of potential patients.

According to La R.S. 40:978.2, a licensed medical practioner may, directly or by **standing order** (emphasis added), prescribe or dispense the drug naloxone or another opioid antagonist without having examined the individual to whom it may be administered if two conditions are met. First, the licensed medical practitioner must provide the individual receiving and administering the naloxone or other opioid antagonist all training required by the Louisiana Department of Health (LDH) for the safe and proper administration of naloxone or another opioid antagonist to individuals who are undergoing, or who are belived to be undergoing, an opioid-related drug overdose. According to the statute, the training, at a minimum, shall address (1) techniques on how to recognize signs of opioid-related overdose, (2) standards and procedures for the storage and administration of naloxone or another opioid antagonist and (3) emergency follow-up procedures including the requirement to summon emergency services either immediately before or immediately after administering the naloxone or other opioid antagonist to an individual apparently experiencing an opioid-related overdose. Second, the naloxone, or other opioid antagonist, must be prescribed or dispensed in such a manner that it shall be administered through a device approved for this purpose by the United States Food and Drug Administration.

Authorization

The standing order is issued in compliance with, and under the authority of, La. R.S. 40:978.2 and shall be deemed as a medical order for naloxone, or other opioid antagonist, as long as the conditions of the statute are met. This standing order shall be valid for one year from the date of issue below.

Training and Instructional Materials

In accordance with the Louisiana Board of Pharmacy's regulations (LAC 46:LIII.2541), the pharmacist distributing the naloxone, or other opioid antagonist, must verify the recipient's knowledge and understanding of the proper use of the drug product. At a minimum, this must include (1) techniques on how to recognize signs of an opioid-related drug overdose, (2) standards and procedures for the storage

and administration of the drug product, and (3) emergency follow-up procedures, including the requirement to summon emergency service either immediately before or immediately after administering the drug product to the individual experiencing the overdose.

Dosage and Refills

Further, refills may be obtained as needed pursuant to this order. Do not administer naloxone for usage on an individual with known hypersensitivity to naloxone, or to any other ingredient that may be referenced in the package insert of naloxone, or any other opioid antagonist prescribed and/or dispensed.

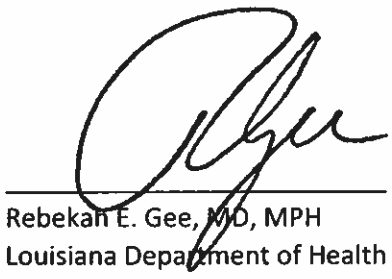
Reimbursement

For reimbursement purposes, it may be necessary to have the medication dispensed in the name of the insured. This standing order authorizes the pharmacist to prepare a prescription for naloxone or other opioid antagonist, with refills authorized, in the name of the insured, and then dispense that product. This standing order, in and of itself, should not be relied upon as a guaranty or reimbursement from any payer source.

Recordkeeping

In order to comply with the recordkeeping requirements found in the Board of Pharmacy rules and regulations, the pharmacist shall attach a copy of this standing order to the invoice, or other record of sale of distribution. Further, the pharmacist shall store these transaction documents with the other distribution records in the pharmacy.

I hereby declare this standing order as a statewide medical order for the dispensing of naloxone, or opioid antagonist product, as long as the requirements of La. R.S. 40:978.2 and LAC 46:LIII.2541 are satisfied. Any pharmacy licensed by the Louisiana Board of Pharmacy may rely on this standing order for the distribution or dispensing of naloxone or other opioid antagonist to any Louisiana resident.



Rebekah E. Gee, MD, MPH
Louisiana Department of Health

Date of Issue: 1/7/19

Louisiana Good Samaritan Law- ACT 392

2014 Louisiana Laws
Revised Statutes
TITLE 14 - Criminal Law
RS 14:403.10 - Drug-related overdoses; medical assistance; immunity from prosecution

Universal Citation: LA Rev Stat § 14:403.10

§403.10. Drug-related overdoses; medical assistance; immunity from prosecution

A. A person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized for possession of a controlled dangerous substance under the Uniform Controlled Dangerous Substances Law if the evidence for possession of a controlled dangerous substance was obtained as a result of the person's seeking medical assistance, unless the person illegally provided or administered a controlled dangerous substance to the individual.

B. A person who experiences a drug-related overdose and is in need of medical assistance shall not be charged, prosecuted, or penalized for possession of a controlled dangerous substance under the Uniform Controlled Dangerous Substances Law if the evidence for possession of a controlled substance was obtained as a result of the overdose and the need for medical assistance.

C. Protection in this Section from prosecution for possession offenses under the Uniform Controlled Dangerous Substances Law may not be grounds for suppression of evidence in other criminal prosecutions.

Acts 2014, No. 392, §1.

2014 Louisiana Laws
Revised Statutes
TITLE 14 - Criminal Law
RS 14:403.11 - Administration of opiate antagonists; immunity

Universal Citation: LA Rev Stat § 14:403.11

§403.11. Administration of opiate antagonists; immunity

A. First responders shall have the authority to administer, without prescription, opiate antagonists when encountering an individual exhibiting signs of an opiate overdose.

B. For the purposes of this Section, a first responder shall include all of the following:

(1) A law enforcement official.

(2) An emergency medical technician.

(3) A firefighter.

(4) Medical personnel at secondary schools and institutions of higher education.

C.(1) Before administering an opioid antagonist pursuant to this Section, a first responder shall complete the training necessary to safely and properly administer an opioid antagonist to individuals who are undergoing or who are believed to be undergoing an opioid-related drug overdose. The training, at a minimum, shall cover all of the following:

(a) Techniques on how to recognize symptoms of an opioid-related overdose.

(b) Standards and procedures for the storage and administration of an opioid antagonist.

(c) Emergency follow-up procedures.

(2) Any first responder administering an opiate antagonist in a manner consistent with addressing opiate overdose shall not be liable for any civil damages as a result of any act or omission in rendering such care or services or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the person involved in said emergency, unless the damage or injury was caused by willful or wanton misconduct or gross negligence.

D. The deputy secretary of public safety services of the Department of Public Safety and Corrections shall develop and promulgate, in accordance with the Administrative Procedure Act, a set of best practices for use by a fire department or law enforcement agency in the administration and enforcement of this Section including but not limited to the training necessary to safely and properly administer an opioid antagonist to individuals who are undergoing or who are believed to be undergoing an opioid-related drug overdose, the standards and procedures for the storage and administration of an opioid antagonist, and emergency follow-up procedures.

Acts 2014, No. 392, §1.

2018 Louisiana Laws
Revised Statutes
TITLE 40 - Public Health and Safety
RS 40:1006 - Reporting of prescription monitoring information

Universal Citation: LA Rev Stat § 40:1006 (2018)

§1006. Reporting of prescription monitoring information

A. Each dispenser shall submit to the board information regarding each prescription dispensed for a controlled substance or drug monitored by the program. The information submitted for each prescription shall include, at a minimum, data relative to the identification of the following elements of the transaction:

(1) Prescriber information.

(2) Patient information.

(3) Prescription information.

(4) Controlled substance or drug information.

(5) Dispenser information.

B. Each dispenser shall submit the required information in accordance with transmission methods and frequency established by the board. Each eligible prescription transaction shall be reported no later than the next business day after the date of dispensing.

C. The board may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver shall state the format and frequency with which the dispenser shall submit the required information. The board may issue an exemption from the reporting requirement to a dispenser whose practice activities are inconsistent with the intent of the program. The board may rescind any previously issued exemption without the need for an informal or formal hearing.

D. Any person or entity required to report information concerning prescriptions to the board or to its designated agent pursuant to the requirements of this Part shall not be liable to any person or entity for any claim of damages as a result of the act of reporting the information and no lawsuit may be predicated thereon. Any person or entity who submits report information in good faith containing prescription information that is not the subject of the PMP shall not be liable to any person or entity for any claim of damages and no lawsuit may be predicated thereon.

E. The prescription monitoring program's agents, a dispenser, or a prescriber may report suspected violations of this Section or violations of any law to any local, state, out-of-state, or

federal law enforcement agency, or the appropriate prosecutorial agency for further investigation or prosecution.

F. No agent, dispenser, or prescriber who in good faith reports suspected violations as provided for in Subsection E of this Section shall be liable to any person or entity for any claim of damages as a result of the act of reporting the information, and no lawsuit may be predicated thereon.

G. The board shall establish by rulemaking standards for the retention, archiving, and destruction of prescription monitoring information.

Acts 2006, No. 676, §1, eff. July 1, 2006; Acts 2009, No. 129, §1; Acts 2009, No. 314, §1; Acts 2010, No. 488, §1, eff. June 22, 2010; Acts 2014, No. 472, §1; Acts 2016, No. 189, §1; Acts 2018, No. 206, §4.