

Senate Bill 5195 Emergency Department Implementation Toolkit

Produced by the Washington State Health Care Authority

Division of Behavioral Health and Recovery

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Introduction

Summary of Senate Bill (SB) 5195

The number of opioid overdose-related deaths in Washington State has significantly increased. In response, the legislature passed SB 5195, which requires hospital emergency departments (EDs) to distribute prepackaged opioid overdose reversal medication (i.e., naloxone) to patients at risk of an opioid overdose for individual use after discharge.

The purpose of the new law is to increase community presence of naloxone by ensuring that individuals at-risk of an opioid overdose leave hospitals with prepackaged naloxone in hand. Prescriptions alone for naloxone are not effective as they often remain unfilled. Naloxone in-hand has been proven effective, and used widely, to reverse overdoses in community settings. Emergency departments are also required to provide patients who receive naloxone with overdose prevention and reversal education, information about harm reduction strategies, and resources on medications for opioid use disorder. Impacted organizations are also required to bill insurance for prepackaged naloxone as outlined in the legislation.

*For a bullet point list of ED specific requirements
refer to Appendix A*

Naloxone overview

Naloxone is an opioid antagonist that preferentially binds to opioid receptors. In blocking the opioid receptors, naloxone can temporarily restore respiratory drive to patients who have experienced what may otherwise be a fatal overdose. Naloxone has a duration of 30-90 minutes, and when naloxone wears off overdose symptoms may return as opioid agonists re-bind to receptors. Observation and additional doses may be required following a successful reversal. In people with physical dependence on opioids, naloxone may cause withdrawal symptoms. Naloxone has no effect on a person who has not taken opioids and will not cause harm if administered to people who have not used opioids¹.

Naloxone will not reverse overdoses of non-opioid substances and may restore respiratory drive in a poly-substance overdose that includes opioids. Naloxone can be administered intranasally or intramuscularly and has been proven safe and effective when administered by non-clinical, community members. Naloxone is a critical harm reduction and lifesaving tool for anyone who uses opioids, their family, friends, and individuals at risk of witnessing or responding to an overdose.

¹ WA DOH Overdose Prevention DOH 150-126 August 2019

Harm reduction

Harm reduction is a set of principles, policies, and practices that seek to reduce harm caused by drug use and the stigmatization of people who use drugs. Harm reduction recognizes drug use will always be a part of our society, that not all drug use is harmful, and that much of the harm associated with drug use can be attributed to stigma and bias as opposed to the drug itself². Harm reduction accepts that not everyone is willing or able to practice abstinence and requires that all people are treated with respect and positive regard regardless of their relationship to drug use. Identified by the Department of Health and Human Services, harm reduction is one of the four critical interventions to combat the overdose crisis. Harm reduction is not a new principle and is already integrated into healthcare settings³.

Existing examples of harm reduction include using insulin to manage type-2 diabetes that could be responsive to diet modifications, neutropenic isolation precautions, and antibiotic stewardship programs. Approaching drug use from this perspective is not new either. Syringe exchange programs popularized during the AIDS crisis provided evidence that promoting and distributing clean needles reduced the transmission of HIV and Hepatitis C without increasing drug use or other risk behaviors. Programs and practices designed specifically for people who use drugs have typically taken place in community settings and are not yet standard in hospitals and emergency departments.

The process of standardizing treatment for substance use disorder in ED settings involves developing evidence-based protocols, focusing on treatments that reduce mortality rates, and acknowledging the role of bias toward people who use drugs. Initial approaches to addressing bias in healthcare settings include adopting person-first language when discussing drug use. Below are some examples of ways to modify stigmatizing language to person-first language.

Terms to avoid	Replacement terms
Addict, user, junkie, drug seeker	Person with substance use disorder, patient
Drug abuse, drug addiction, habit	Drug use, drug misuse
Clean	Person in recovery, abstinent

Another important consideration is viewing recovery on a spectrum that is defined by the individual and does not always include or require abstinence or participation in support groups. Recovery is defined by SAMHSA as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”⁴ Recovery from substance use disorder mirrors recovery from any other chronic illness. Recovery starts by making incremental positive changes and can include periods of remission and use. Examples of positive change may include carrying naloxone, practicing safer injection techniques, reducing use, initiating medications for opioid use disorder (MOUD), and developing a trusting relationship with a healthcare provider.

² National Harm Reduction Coalition, 2021

³ Center for Disease Control, 2021

⁴ SAMHSA, 2021

How to use this toolkit

This toolkit provides guidance and offers a standardized approach to creating an initial program that meets the requirements of Senate Bill 5195 and increases community awareness of and access to naloxone. This document is intended to be flexible, and adaptable, for settings starting a new naloxone distribution program and those with existing programs. While this toolkit outlines considerations and suggestions, it recognizes that success comes from leveraging existing program structures and finding the solutions that work best for your hospital. This document includes a summary of the requirements for compliance with SB 5195 along with suggested resources for each program element outlined in the legislation. It also contains an extensive appendix of supportive documents, some of which can be amended and adopted to reflect the needs of local organizations.

Program implementation

It may be helpful to identify a lead person, committee, or program manager to oversee the initial implementation of 5195 requirements. Ideally, this person or group will serve as the primary point of contact for this workstream and be well equipped to identify areas of process improvement and program updates. Initial considerations for program implementation include determining who this program impacts. Examples include frontline staff, risk, regulatory, nursing managers, nursing educators, pharmacy, social work departments, care management, hospitalists, emergency providers and patients.

Developing a plan to communicate information to impacted groups can help to identify and resolve barriers, increase buy in, and support a smooth go-live. Communication techniques can include emails, education sessions, staff meetings, and/or distributing printed information sheets and FAQs.

Dissemination to patients may be done via newsletters, online portal banners, highly visible patient facing signage, or any other means that aligns with your organization's communication strategy.

*For administrative and clinical FAQ documents
refer to Appendices H and I*

Inclusion criteria

SB 5195 requirements

All patients who present to an emergency department with symptoms of the following must be provided with naloxone in hand:

- Opioid overdose,
- Opioid use disorder,
- Other adverse event related to opioid use

The exceptions to naloxone distribution are as follows:

- Patient declines medication
- Provider judgement that it is not appropriate
- Patient has current naloxone

Anyone at risk for opioid overdose may receive naloxone and overdose education. Common risk factors for opioid overdose include:

- Restarting opioid use after a break or change in type/dose. This includes after leaving jail or prison, some types of drug treatment, and hospital admissions.
- Mixing opioids with other sedatives
- Taking prescription pain medication in higher doses and/or more often than prescribed.
- Using heroin or any drug not obtained from a pharmacy or cannabis dispensary, due to unknown purity or origin
- History of opioid overdose
- Using opioids alone and/or in remote, rural, or settings that are not easily accessed by emergency services.

Patients who present with a chief complaint of opioid overdose or opioid withdrawal symptoms meet criteria for inclusion. However, not all chief complaints will immediately identify patients at risk. Common emergency department presentations that may be associated with adverse events secondary to opioid use and merit further screening include the following:

- Soft tissue infections
- Endocarditis
- Suicidality
- Chronic pain
- Vascular injuries
- Peripheral neuropathy
- Osteomyelitis
- Use of other substances

Screening protocols

SB 5195 requirements

The law allows for flexibility on how hospitals screen or determine inclusion.

Your organization may choose to screen patients, or find cases, based on information gathered during health history and clinical contact. This may reduce rigid requirements for clinical staff and feel more natural for patients. This method also has limitations. It may fail to catch all patients who meet inclusion requirements and relies on a thorough medical and social history being completed and documented on all patients. Under the law, social workers, emergency technicians, providers, pharmacists, nurses, and other allied professionals are all able to identify that a patient meets inclusion criteria and communicate that to the treatment team.

A formal screening protocol has the benefit of being universally applied and requiring clinicians to routinely consider applicability of naloxone distribution. If you choose to implement a formal screening tool, know that there is not a validated emergency department screening tool for identifying patients at risk of overdose nor is the use of a screening tool required by legislature. A few options for formal screening tools include the DAST-10, the ORT, or the BSTAD⁵.

Alternatively, you may choose to develop a single question screening tool. An example of a single question screener is “In the past year have you used illegal drugs or prescription medications not prescribed to you?”. An affirmative answer would be followed up by questions that may include following, any of which in the affirmative identifies potential overdose risk:

- “Are any of these substances opioids or painkillers, like heroin, fentanyl, or oxycodone?”
- “Have you ever experienced an overdose?”
- “Has anyone you know using the same substances experienced an overdose?”
- “Do you believe you are at risk of an opioid overdose? Why or why not?”
- “Have you recently increased or decreased your use of these substances?”
- “Do you use more than one type of drug (including medications and alcohol) at the same time?”

Another option for ensuring that patients who meet inclusion criteria are identified is to create a best practice advisory (BPA) in the electronic health record (EHR). This has the benefit of being standardized and automated and functioning to remind clinical staff of the distribution requirements and supporting clinical decisions. Drawbacks include potential missed patients, potential false positives, and “alarm fatigue”. BPA criteria may include the following:

- Diagnosis of opioid use disorder or any substance use disorder
- Diagnosis of opioid withdrawal
- Current prescription opioids on file
- EDIE regarding opioid medications
- Administration of naloxone during visit
- History of opioid overdose

⁵ Skinner HA, 1982

Distribution

SB 5195 requirements

For a patient to receive naloxone in-hand there must be an active prescription or order in the chart.

The distribution of naloxone may be completed by providers, pharmacists, or nursing staff and must be accompanied by specific education and materials.

Materials provided to the patient must be in an appropriate language or format for that patient, and must include all the following (HCA produced these required documents):

- Overdose reversal instructions
- Information about medications for opioid use disorder
- Resources on harm reduction services and strategies

For the patient to receive naloxone in-hand there must be an active prescription or order in the patient chart. One option for this is to place an order in the medication administration record (MAR) with an administration route of "Dispense to Home". The distribution of naloxone may be completed by providers, pharmacists, or nursing staff. Required patient education includes overdose reversal instructions, information about medications for opioid use disorder, and strategies to reduce drug related harm. English versions of these materials are included in the appendix and translated materials can be accessed from the HCA 5195 webpage. Patient training on naloxone ideally includes the following:

- How to recognize an overdose
- How to respond to an overdose
- Naloxone administration
- Risk for recurrent overdose

Exclusion criteria are intended to be assessed at each unique patient visit, regardless of how recently the patient met one of the above exceptions. The exceptions to distribution are:

- Patient declines medication
- Provider judgement that it is not appropriate
- Patient has naloxone

*For a sample workflow quick sheet refer to Appendix C
For patient education materials refer to Appendices J-M*

Documentation

SB 5195 requirements

The law does not give specific guidance on or requirements for documentation.

The law does not give specific guidance on documentation. It is recommended that your organization's documentation indicates if a patient was screened, the result of the screen, and either the distribution of naloxone and required education or the indications for patient exclusion.

EHR integration can significantly increase the uptake of initiatives by clinical staff and improve compliance with policies and protocols. Ideally, the EHR could be amended to include a screening tool/risk assessment, standard provider and nurse-initiated order sets based on the results of that assessment, and the order sets placed resulting in the population of correct billing codes and required discharge documentation. The administration method in your MAR (such as "dispense to home") could link to specific billing codes. Many of the templates for this program may already exist within your current EHR provider.

In the short-term or absence of full EHR integration, checklist smart phrases can be created adapting screening questions and/or risk assessment tools. Smart phrases can also be created for nurses and providers that cover exclusion criteria and/or discharge requirements so that documentation of these elements exists within the EHR. Some facilities may choose to have a hard copy distribution signature sheet so that the patient can acknowledge receipt of overdose prevention medication in hand and confirm they have received and understood the required education and materials.

*For a sample patient signature sheet refer to Appendix G
For sample smart phrases refer to Appendix D*

Storage and labeling

SB 5195 requirements

The medication must be packaged by, or under the supervision of a licensed pharmacist.

Under SB 5195, the labelling requirements outlined in RCW 69.41.050 and RCW 18.64.246 are waived.

Protocols for the storage and retrieval of naloxone kits require that “prepackaged emergency medications will be kept in a secure location in or near the emergency department in such a manner as to preclude the necessity for entry into the pharmacy”.

The bill specifically allows for naloxone to be dispensed with technology used to dispense medications.

The legislation allows for variation from standard labelling, packaging, and storage standards for prepackaged overdose reversal medication. This can allow for naloxone to be distributed without patient-specific labeling. Protocols for the storage and retrieval of naloxone kits for distribution will need to be developed by pharmacy. The bill specifically allows for naloxone to be dispensed with technology such as a pyxis. Inclusion of a “distribute to home” administration option in the MAR could link to this technology and distribution specific billing codes.

Billing

SB 5195 Requirements

Until the bulk purchasing and distribution program is operational, hospitals must bill as follows:

- For patients enrolled in a medical assistance program, the hospital must bill the patient's Medicaid benefit for the patient's prepackaged naloxone using the appropriate billing codes established by HCA. *This billing code must be separate from and in addition to the payment for the other services provided during the hospital visit.*
- For patients with private or commercial insurance the hospital must bill the patient's health plan for the cost of the prepackaged naloxone.
- For patients who are uninsured the hospital must bill the health care authority for the cost of the patient's prepackaged naloxone.

The law does not prohibit a hospital from dispensing opioid overdose reversal medication (naloxone) to a patient at no cost to the patient or out of the hospital's pre-purchased supply.

The Washington State Health Care Authority (HCA) will establish a long-term mechanism to support naloxone distribution, known as the bulk purchasing and distribution program, as soon as feasible. Until this program is up and running, the hospital will be required to establish billing procedures based upon patient insurance status. Currently, there is no identified state program to assist patients with co-payments. Organizations may elect to use existing charity care, co-payment programs, or dispense at no cost out of a pre-purchased supply.

Policy development

SB 5195 Requirements

All prepackaged emergency medications provided in the ED must be associated with a hospital policy and procedure developed by the pharmacy director in collaboration with hospital medical staff.

Development of a list, preapproved by the pharmacy director, of the types of emergency medications to be prepackaged and distributed

Assurances that prepackaged emergency medications are prepared by a pharmacist or under the supervision of a licensed pharmacist

Development of specific criteria under which emergency prepackaged medications may be prescribed and distributed consistent with the limitations of this section

Assurances that any practitioner authorized to prescribe, or any nurse authorized to distribute prepackaged emergency medication is trained on the types of medications available and the circumstances under which they may be distributed

Procedures to require a valid prescription either in writing or electronically in the patient's records prior to a medication being distributed

Assurances that prepackaged emergency medications will be kept in a secure location in or near the emergency department in such a manner as to preclude the necessity for entry into the pharmacy

distribution of prepackaged emergency medications other than naloxone is allowed under 5195, in appropriate circumstances. While future work may include providing take home insulin, albuterol, or other emergency medications, this toolkit focuses exclusively on naloxone. In addition to the policy elements required by this legislation, it is recommended that the policy outline patient inclusion and exclusion criteria, screening protocols, patient education provided, and the documentation required by the organization.

For a sample policy reference Appendix B

Staff education

SB 5195 Requirements

Senate Bill 5195 requires that hospitals train providers, pharmacists, and nurses on the medications being distributed and the circumstances under which distribution may occur.

All frontline staff that engage in the identified ED naloxone distribution workflow may benefit from training and education. This toolkit includes an editable sample power point that covers training elements and may be adapted by your facility and used in staff meetings, training sessions, or assigned via your learning management system. Records of staff competency may be kept using the sample competency forms. Suggested staff training domains include the following:

- How naloxone works
- Screening protocol and identification: which patients must receive naloxone at the point of care
- General education on signs and symptoms of opioid overdose, opioid use disorder, adverse events related to opioid use
- Documentation
- Patient education requirements for overdose reversal education and hard-copy materials (i.e., medications for opioid use disorder, naloxone administration, and harm reduction services and strategies)
- General education on signs and symptoms of opioid overdose, opioid use disorder, adverse events related to opioid use, and the Good Samaritan Law

Many of your clinical staff will have lived experience with substance use disorder; either themselves or someone close to them. This experience can carry with it complex emotions and deserves recognition as a part of training around substance use disorder assessment and interventions. It is possible to identify unit champions with lived experience who can promote the benefits of naloxone distribution and education.

Training that supports the research behind naloxone, reinforces patients' rights to autonomy, and provides staff with techniques for engaging people who use drugs is recommended. Best practice for educating clinicians follows the general patient or person-first approach of "meeting people where they are at". Approaching the clinician who may experience bias and reluctance to adopt evidence-based practice with compassion, not contempt, is a critical element of supporting adoption these policies and shifting the culture of care.

*For a sample training PPT refer to Appendix E
For a sample staff competency form refer to Appendix F*

Technical assistance

The Health Care Authority will provide technical assistance to assist hospitals in complying with SB 5195. In addition to the provision of this toolkit and appendices, the Health Care Authority has made a webpage to consolidate resources and has identified points of contact for any questions or requests your organization may have.

- **Webpage** <https://www.hca.wa.gov/about-hca/behavioral-health-recovery/distributing-opioid-overdose-reversal-medications-2ssb-5195#education-materials>
- **Training, consultation, educational materials, and implementation questions:** laura.meader@hca.wa.gov
- **Billing and pharmacy questions:** applehealthpharmacypolicy@hca.wa.gov

The appendices that follow are intended to support the implementation of a naloxone distribution program in compliance with SB 5195. Appendices B-G are suggestions only. They are meant to be edited and amended to outline the specific processes established by your organization to meet the criteria of the law. Appendices A and H-M are not editable and are to be used as is. The complete toolkit as well as each appendix is available for download on the HCA 5195 webpage.

APPENDIX A – SB 5195 ED REQUIREMENT QUICK SHEET



SB 5195 ED Requirements - Quick Sheet

Inclusion criteria¹

All patients who present to an emergency department with symptoms of the following must be provided with naloxone in hand:

- Opioid overdose,
- Opioid use disorder,
- Other adverse event related to opioid use

The exceptions to naloxone distribution are as follows:

- Patient declines medication
- Provider judgement that it is not appropriate
- Patient has naloxone

Distribution²

For a patient to receive naloxone in-hand there must be an active prescription or order in the chart.

The distribution of naloxone may be completed by providers, pharmacists, or nursing staff and must be accompanied by specific education and materials.

Materials provided to the patient must be in an appropriate language or format for that patient, and must include all the following (HCA produced these required documents):

- Overdose reversal instructions
- Information about medications for opioid use disorder
- Resources on harm reduction services and strategies

Storage and Labeling³

The medication must be packaged by, or under the supervision of a licensed pharmacist.

Under SB 5195, the labelling requirements outlined in RCW 69.41.050 and RCW 18.64.246 are waived.

Protocols for the storage and retrieval of naloxone kits require that "prepackaged emergency medications will be kept in a secure location in or near the emergency department in such a manner as to preclude the necessity for entry into the pharmacy".

The bill specifically allows for naloxone to be dispensed with technology used to dispense medications.

¹ 2SSB 5195 Sec. 3.1

² 2SSB 5195 Sec. 2.3(e)

³ 2SSB 5195 Sec. 2.3(b) and 2.3(g)



Billing⁴

Until the bulk purchasing and distribution program is operational, hospitals must bill as follows:

- For patients enrolled in a medical assistance program, the hospital must bill the patient's Medicaid benefit for the patient's prepackaged naloxone using the appropriate billing codes established by HCA. This billing code must be separate from and in addition to the payment for the other services provided during the hospital visit.
- For patients with private or commercial insurance the hospital must bill the patient's health plan for the cost of the prepackaged naloxone.
- For patients who are uninsured the hospital must bill the health care authority for the cost of the patient's prepackaged naloxone.

The law does not prohibit a hospital from dispensing opioid overdose reversal medication (naloxone) to a patient at no cost to the patient or out of the hospital's pre-purchased supply.

Policy Elements⁵

All prepackaged emergency medications provided in the ED must be associated with a hospital policy and procedure developed by the pharmacy director in collaboration with hospital medical staff.

Development of a list, preapproved by the pharmacy director, of the types of emergency medications to be prepackaged and distributed

Assurances that prepackaged emergency medications are prepared by a pharmacist or under the supervision of a licensed pharmacist

Development of specific criteria under which emergency prepackaged medications may be prescribed and distributed consistent with the limitations of this section

Assurances that any practitioner authorized to prescribe, or any nurse authorized to distribute prepackaged emergency medication is trained on the types of medications available and the circumstances under which they may be distributed

Procedures to require a valid prescription either in writing or electronically in the patient's records prior to a medication being distributed

Assurances that prepackaged emergency medications will be kept in a secure location in or near the emergency department in such a manner as to preclude the necessity for entry into the pharmacy

Staff Training⁶

Senate Bill 5195 requires that hospitals train providers, pharmacists, and nurses on the medications being distributed and the circumstances under which distribution may occur.

⁴ 2SSB 5195 Sec. 3.5 & 3.6

⁵ 2SSB 5195 Sec. 2.3

⁶ 2SSB 5195 Sec. 2.3(d)



APPENDIX B – SAMPLE NALOXONE DISTRIBUTION POLICY

Subject/Title: Distributing Opioid Overdose Reversal Medication in the Emergency Department

Purpose: To reduce opioid overdose deaths through the distribution of prepackaged overdose reversal medication (naloxone) to at risk patients.

Policy:

The hospital shall allow for the distribution of prepackaged emergency medications in accordance with WA Senate Bill 5195. The pharmacy director shall maintain a list of all prepackaged emergency medications approved for distribution to patients in the emergency department, which will include opioid overdose reversal medication (naloxone). This policy and protocol outline specific requirements for prepackaged naloxone distribution.

The hospital must identify all patients who present at the emergency department with symptoms of an opioid overdose, opioid use disorder, or other adverse event related to opioid use. Other adverse event related to opioid use *may include and are not limited to the following*: soft tissue infection, endocarditis, risk of opioid overdose of self, and risk of witnessing or responding to opioid overdose.

The above identified patients must receive the following:

- Opioid reversal medication (naloxone) upon discharge unless there is professional determination that it is not appropriate, or the person already has naloxone; and
- Directions for use; and
- Information and resources about medications for opioid use disorder (MOUD) and harm reduction strategies and services. These materials should be available in all languages relevant to the communities that the hospital serves.

Procedures:

I. Screening and Assessment

- a. Screen patients to determine if they meet requirements as outlined in the policy
 - i. *Determine universal screening process vs. case finding vs. BPA, etc.*
 - ii. *See screening and inclusion criteria recommendations in HCA toolkit for additional guidance*
- b. Exceptions:
 - i. Patient has naloxone
 - ii. Determined not to be appropriate based on professional determination
 - iii. Patient declines naloxone

II. Distribution

- a. **Required:** Nurses, providers, or pharmacists will distribute prepackaged emergency medications to patients only after patient counseling on the medication
- b. **Required:** Education and materials provided in relevant patient languages
 - i. *Depending on ED and hospital workflow, patient education may be provided by allied disciplines (e.g., social workers, SUDP, and peer counselors). Identify roles in your organization's workflow and ensure that included professions review this policy and receive requisite training.*
- c. **Optional:** institution specific tracking or logging protocols

III. Documentation

Required: Procedures to require practitioners intending to prescribe prepackaged emergency medications pursuant to SB 5195 Section 2 to maintain a valid prescription either in writing or electronically in the patient's records prior to a medication being distributed to the patient

- *Determine and outline workflow procedure to ensure compliance*
- a. Document screening and any exceptions
 - i. E.g., Patient decline or AMA
 - b. Document education and materials provided and confirmed patient understanding
 - c. Document delivery of prepackaged naloxone

IV. Providing Competency-Based Staff Education

Any practitioner authorized to prescribe emergency medication, or any nurse authorized to distribute prepackaged emergency medication shall be provided competency-based education about opioid overdose reversal medication, prevention, response, and opioid use disorder. This training will occur on hire (*and annually or in alignment with organization's learning plan*) with documentation of training to be kept in staff files. Education meets the following minimum standards:

- a. Competency domains
- b. Screening and discharge procedure
- c. Documentation requirements as outlined in this policy

V. Pharmacy Requirements

- The prepackaged emergency medication will be prepared by a pharmacist or under the supervision of a pharmacist licensed under 18.64 RCW.
- The labeling requirements (RCW 69.41.050 and RCW 18.64.246) for opioid overdose reversal medication dispensed/delivered is waived
- Medication may be dispensed with technology used to dispense medications (*e.g., automatic drug dispensing devices- "ADDDs"*)

VI. Billing Requirements:

Until the opioid overdoses reversal medication bulk purchasing and distribution program is operational, the hospital must bill as follows:

- For patients enrolled in a medical assistance program
 - The hospital must bill the patient's Medicaid benefit for the patient's prepackaged naloxone using the appropriate billing codes established by HCA.
 - This billing code must be separate from and in addition to the payment for the other services provided during the hospital visit.
- For patients with private or commercial insurance
 - the hospital must bill the patient's health plan for the cost of the prepackaged naloxone
- For patients who are uninsured:
 - the hospital must bill the health care authority for the cost of the patient's prepackaged naloxone.

Existing Prepurchase Naloxone Distribution Channels:

This policy does not prohibit dispensing opioid overdose reversal medication (naloxone) to a patient at no cost to the patient or out of the hospital's prepurchase supply.

Committee Review Required:

Emergency Department Leadership

Pharmacy Leadership

Reference Materials:

[Senate Bill 5195](#)

APPENDIX C – SAMPLE WORKFLOW QUICK SHEET

Program overview

Research indicates that paper prescriptions for naloxone often go unfilled, while naloxone distributed directly to patients is regularly used to reverse potentially fatal overdoses. This indicates that prescriptions do not meet the needs of the community or effectively reduce overdose risk, despite the willingness of community members to use naloxone when indicated. The need for naloxone to be provided in-hand to patients will be met by our organization's naloxone distribution program. Our go-live date will be XX/XX/2022.

Criteria for naloxone distribution

All patients who present to the emergency department with symptoms of an opioid overdose, opioid use disorder, or other adverse event related to opioid use disorder.

Purpose of naloxone distribution program

To reduce the risk fatal of opioid overdose by providing naloxone at the point of care. Risk factors for opioid overdose include:

- Restarting opioid use after a break or change in type/dose. This includes after leaving jail or prison, some types of drug treatment, and hospital admissions.
- Mixing opioids with other sedatives
- Taking prescription pain medication in higher doses and/or more often than prescribed.
- Using heroin or any drug not obtained from a pharmacy or cannabis dispensary, due to unknown purity or origin
- History of opioid overdose
- Using opioids alone and/or in remote, rural, or settings that are not easily accessed by emergency services.

Staff roles

- **Case Finding/Screening/Assessment:** *(insert specific protocol here)*
- **Provide prepackaged naloxone and directions for use to patient:** Provider or Registered Nurse with hospital confirmed training.
- **Provide education to patient:** Provider, Registered Nurse, LPN, Social workers, Peer Counselors, and/or SUDP allied professionals as described in hospital policy *(insert name)*.

Discharge materials

- Prepackaged Overdose Reversal Medication (naloxone)
- Patient Education Brochures
- Discharge Education Signature Sheet

Distribution process

1. Identify risk for overdose based on *(insert specific)* screening process and confirm patient willingness to receive naloxone and overdose prevention education.
2. Place standard *(insert name)* provider order set or *(insert name)* NIO set.
3. Obtain naloxone kit from secure storage location *(insert location, process for access, any logging requirements)*
4. Review the overdose reversal quick sheet and patient brochures included in the kit with patient. Complete overdose prevention education as trained in accordance with hospital standards. A pre-recorded training video may be used to support this education.
5. Complete distribution signature sheet with signatures of both patient and staff member providing training and submit to *(insert specific process)*
6. Add *(insert name)* smart phrase(s) to patient chart.

For more information, please refer to hospital policy *(insert name/policy number here)*

APPENDIX D – SAMPLE SMART PHRASES

OUD / OD risk screening

Patient screened for opioid use disorder and/or risk for opioid overdose based on the following questions (*insert screening tool/questions here with check boxes*). This patient screened **in/out** for naloxone distribution. If this patient screened in, the following items were considered as potential exclusion criteria: (*list the following as checkboxes*) patient refusal, patient already has naloxone, and provider judgement. This patient **does/does not** meet criteria for naloxone distribution.

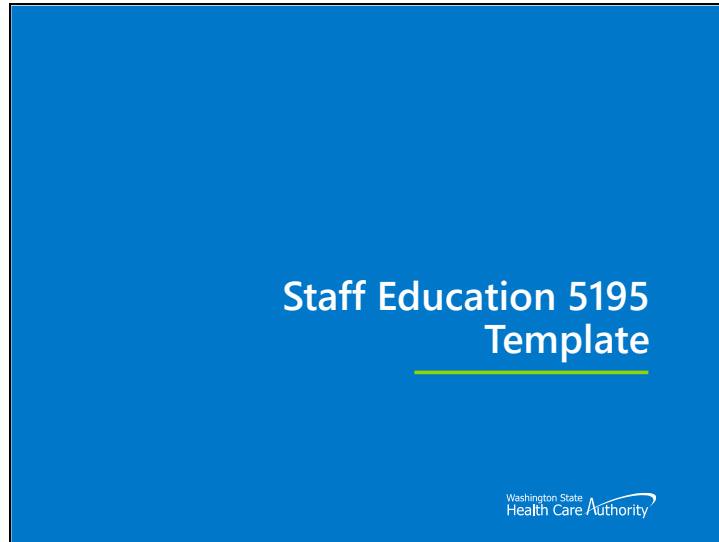
Naloxone distribution and overdose education

Patient was provided a naloxone kit in hand that included 2 doses of naloxone, patient education brochures, and an overdose reversal information sheet. The patient received discharge education from a trained staff member on the below listed topics and verbalizes understanding. Discharge signature sheet completed with patient.

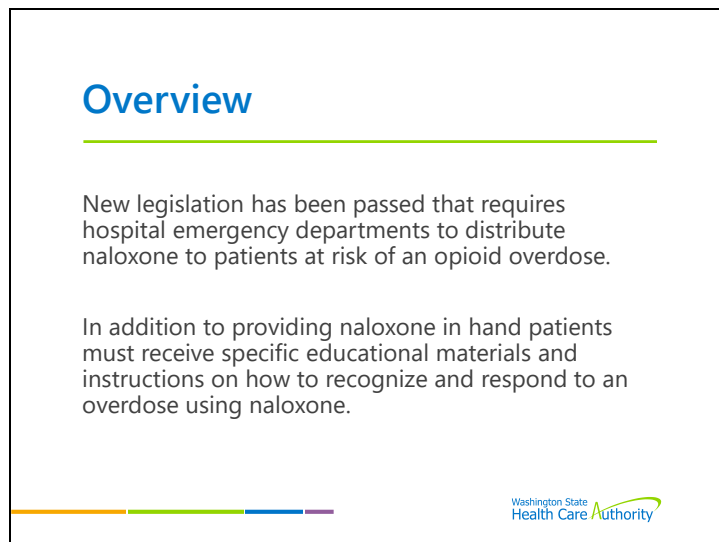
- Risk factors for overdose
- Prevention strategies for overdose
- How to recognize an overdose
- How to respond to an overdose
- Naloxone administration
- Good Samaritan law
- Withdrawal symptoms
- Risk for recurrent overdose

APPENDIX E – SAMPLE STAFF TRAINING PRESENTATION

Slide 1





Slide 2





Learning Objectives

- Define opioid use disorder (OUD)
- Recognize adverse events related to OUD
- Identify risk factors for opioid overdose
- Know the facts about naloxone
- Understand the process for naloxone distribution
- Review patient education requirements
- Develop skills for engaging patients who use drugs



Opioid Use Disorder (OUD)

- OUD is defined as “a problematic pattern of opioid use leading to clinically significant impairment or distress” (CDC, 2021)
 - Can be prescribed, diverted, or illicit opioids
 - People can use opioids without meeting criteria
 - Dependency on opioids is not diagnostic for OUD
 - Recovery from OUD does not require abstinence from opioids
 - OUD can have periods of remission and relapse
 - Patients with OUD are at risk for fatal opioid overdose



Complications of OUD

- Common emergency department presentations secondary to OUD include:
 - Overdose
 - Withdrawal
 - Soft tissue infection
 - Vascular injury
 - Neuropathies
 - Osteomyelitis
 - Endocarditis

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Risk Factors for Opioid Overdose

- Restarting opioid use after a break or change in type/dose. This includes after leaving jail or prison, OUD remission, and hospital admissions
- Mixing opioids with other sedatives
- Misusing and/or diverting prescription pain medication
- Using any drug not obtained from a pharmacy
- Comorbid cardiac, renal, or respiratory disease
- Previous history of overdose
- Using opioids alone

Adapted from stopoverdose.org



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Slide 7

Naloxone Review



- Opioid antagonist that preferentially binds to opioid receptors
- Will precipitate withdrawal symptoms in opioid dependent patients
- Duration of 30-90 minutes
- Overdose symptoms may return as opioid agonists re-bind to receptors
- May require multiple doses
- Can be safely administered IM or IN by trained non-medical community members
- Availability decreases mortality and does not increase opioid use, risk taking behaviors, or other harms.

Adapted from WA DOH



Slide 8

Naloxone Distribution Program




Slide 9

Workflow

- ▶ Inclusion Criteria/Screening Protocol
- ▶ Naloxone Storage and Retrieval
- ▶ Patient Education
- ▶ Documentation Requirements

****This slide should bullet point each element of your programs workflow, and may include sections not listed above. Following this slide each bullet point should have it's own slide that outlines the details of your hospitals' policy and protocol. ****




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Slide 10

Inclusion Criteria and Screening

- ▶ Inclusion Criteria
 - ▶ Opioid Overdose
 - ▶ Symptoms of Opioid Use Disorder
 - ▶ Adverse Event r/t OUD
- ▶ Screening Protocol or Tool

****This slide should detail the inclusion criteria and screening process determined by your organization as written in hospital policy****




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Slide 11

Naloxone Storage and Retrieval

- Storage
- Retrieval
- Naloxone Discharge Kit
 - ▶ HCA Overdose prevention and instructions for use
 - ▶ HCA Harm reduction and MOUD patient brochures
 - ▶ Prepackaged naloxone
 - ▶ Patient signature page (optional)

****This slide should detail where naloxone is kept, how to access it, and review the materials in the naloxone kit****




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Slide 12

Patient Education

- Review the overdose reversal instructions and directions for use with the patient and discuss the following topics:
 - ▶ Risk factors for opioid overdose
 - ▶ Strategies to reduce overdose risk
 - ▶ How to recognize and respond to an overdose
 - ▶ How to administer naloxone
 - ▶ Potential for withdrawal symptoms
 - ▶ Potential for return of overdose symptoms
 - ▶ Need for observation and medical care
 - ▶ Importance of not using opioids immediately after naloxone
 - ▶ Good Samaritan laws
- Distribute HCA Harm Reduction and Medications for OUD patient brochure (or have it in AVS)
- Confirm patient understanding and collect patient signature page as appropriate





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Slide 13

Patient Education Video



- WA Department of Health Opioid Overdose video
- [Opioid Overdose - Administering Naloxone on Vimeo](#)
- Short link: <https://vimeo.com/357020563>

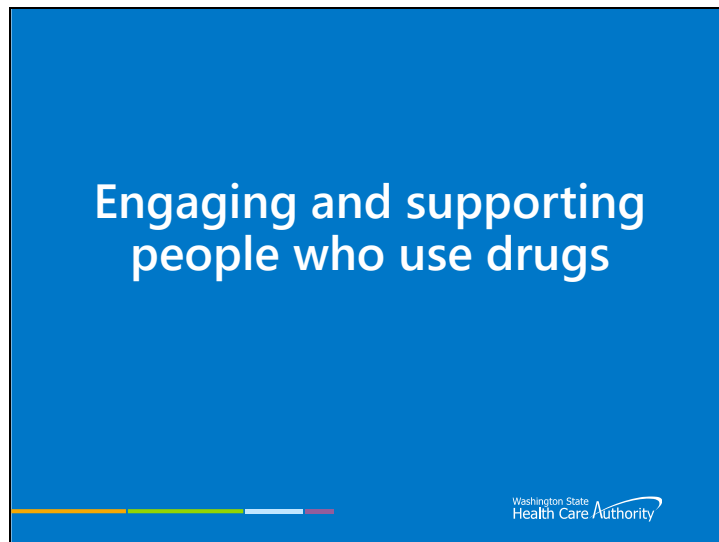


Slide 14

Documentation Requirements

****This slide should include details about your EHR build, smart phrases, paper forms, etc.****

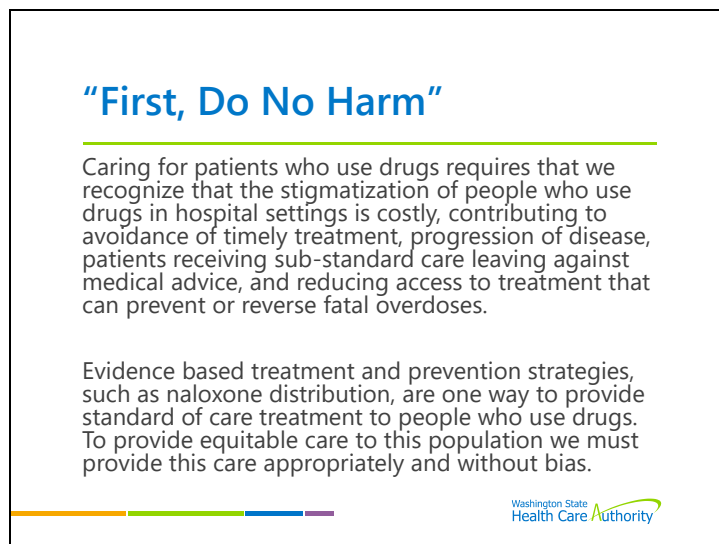




Engaging and supporting
people who use drugs

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A decorative horizontal line with segments in orange, green, white, and purple is located at the bottom left of the slide.



“First, Do No Harm”

Caring for patients who use drugs requires that we recognize that the stigmatization of people who use drugs in hospital settings is costly, contributing to avoidance of timely treatment, progression of disease, patients receiving sub-standard care leaving against medical advice, and reducing access to treatment that can prevent or reverse fatal overdoses.

Evidence based treatment and prevention strategies, such as naloxone distribution, are one way to provide standard of care treatment to people who use drugs. To provide equitable care to this population we must provide this care appropriately and without bias.

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A decorative horizontal line with segments in orange, green, blue, and purple is located at the bottom left of the slide.

Moving Through Judgement

Most people have opinions, thoughts, and feelings about drug use, and that includes healthcare workers. Many people have negative reactions to the idea of drug use based in social norms, personal experience with substance use or loved ones with substance use disorder, or the lack of adequate resources and training provided for the care of people who use drugs.

Accepting and understanding these reactions is an important part of ensuring they do not impact the quality of care that you provide.

Myths about Drug Use

Some of the negative reactions people have to drug use is due to incorrect information that is widely accepted as true. Myths include:

- ▶ People who use drugs have no desire to make positive change or reduce their use
- ▶ People who use drugs lie about their pain
- ▶ People need to “hit bottom” in order to get better, providing compassionate care will only enable them to use more
- ▶ People who use drugs should stop using before being able to receive medical care, housing, or other services
- ▶ Medications for opioid use disorder are not effective treatment, just another way to get high

Adapted from Public Health Seattle - King County

Facts about Drug Use

Correct information about drug use is supported by research and is evidence based. Facts include:

- ▶ Medications for OUD (methadone and suboxone) reduce mortality by 50%*
- ▶ People who receive harm reduction services such as low-barrier housing, syringe exchange, and naloxone are more likely to recover
- ▶ The majority of people who use drugs do not develop substance use disorder
- ▶ The majority of people with substance use disorder recover
- ▶ People who use drugs have a legal and a human right to receive standard care, including access to medication for OUD, naloxone, and effective pain management

*Learnabouttreatment.org

Language Matters

The words you use matter. It is important to see your patient as a person, and not as an illness or a behavior.

You can build rapport by being non-judgmental, asking open ended questions, and respecting your patient's autonomy.



Adapted from Public Health Seattle - King County

Terms to Avoid	Replace with:
Addict, user, junkie, drug seeker	Person who uses drugs, patient
Drug abuse, drug addiction, habit	Drug use, drug misuse
Clean	Person in recovery, abstinent

Defining Recovery

Recovery is defined by SAMHSA as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” (SAMHSA, 2014)



Recovery from substance use disorder mirrors recovery from any other chronic illness. Recovery starts by making incremental positive changes and can include periods of remission (relapses). Positive change includes carrying naloxone, practicing safer injection techniques, reducing use, initiating MOUD, or developing a trusting relationship with a healthcare provider.

Sample Approach

Step 1 - Build rapport	I would like to take some time to talk about your risk of opioid overdose and naloxone. Can you tell me what you know about naloxone and how to use it?
Step 2 - List “Pros and Cons”	What do you do that might put you at risk for overdose? What actions do you currently take to reduce that risk?
Step 3 - Provide information and get feedback	I have some additional information on overdose risk and how naloxone works, can we review it together?
Step 4 - Assess readiness for intervention	So, on a scale of 0 to 10, how prepared do you feel to use naloxone / recognize an overdose / tell other people how to use it on you / etc.
Step 5 - Make an action plan	Based on our conversation, what are some options that might work for you to help you stay healthy and safe? What supports do you have for making this change?
	Those are great ideas. I have a few more that be helpful (link to additional support, programs, telling people where the naloxone is stored, etc)



Adapted from <http://www.bu.edu/bniart/>

Slide 23



Wrap-Up

****summarize, additional staff requirements (test, competency, eval, etc), implementation timeline, other relevant information****



Slide 24

Questions?



APPENDIX F - SAMPLE STAFF COMPETENCY

Competency Domain	Staff Initials	Validator Initials
Staff member can define opioid use disorder and identify common complications		
Staff member verbalizes risk factors for opioid overdose and can name three strategies to reduce opioid overdose risk		
Staff member can describe how naloxone works and the duration of reversal effects, can identify risk factors for refractory / recurrent overdose symptoms, and demonstrates technique for both IM and IN administration		
Staff members verbalizes inclusion criteria for naloxone distribution and understands screening process		
Staff member demonstrates ability to review all patient handouts and provide appropriate patient teaching		
Staff member recognizes the right of patients with opioid use disorder to receive evidence-based care		
Staff member identifies biased language and verbalizes clinically appropriate terminology		
Staff member has completed training on overdose prevention and the naloxone distribution program		

Staff Member Printed Name _____

NPD/UBE/Supervisor Signature _____

Date _____

APPENDIX G – SAMPLE DISTRIBUTION SIGNATURE SHEET

The following staff member has reviewed all critical elements of overdose prevention, recognition, response, and follow up care as outlined below with the patient receiving prepackaged overdose reversal medication.

Topic	Staff Initials
Opioids and Overdose	
Risk Factors for Overdose	
Signs of Overdose	
Overdose Response	
Naloxone Administration	
Good Samaritan Law	
Withdrawal Symptoms	
Risk for Recurrent Overdose	

Staff Name:

Date:

I, the patient receiving naloxone, confirm my understanding of how to use naloxone and ways to reduce my risk of overdose.

Signature:

Date:

Patient Label here

Patient education video QR code:



<https://vimeo.com/357020563>

Source: WA Department of Health- Opioid Overdose: Administering Naloxone Video

APPENDIX H – ADMINISTRATIVE FAQ



Naloxone distribution in emergency departments

SB 5195 Frequently Asked Questions

Who is required to receive pre-packaged naloxone in-hand from the ED?

Patients with opioid overdose, symptoms of opioid use disorder, or any adverse event related to opioid use.

Does the law require a specific screening process?

No, your organization can determine what is best for your institution and workflow if patients who meet inclusion criteria are reliably screened in. The toolkit includes a variety of possible screening protocols.

What are the exceptions to the in-hand naloxone distribution requirement?

The patient already has naloxone; provider clinical judgement; and patient refusal.

What are the patient education requirements for patients who receive naloxone in hand?

If patients are given pre-packaged naloxone, they must also be given direct training on the medication and printed educational materials on how to use naloxone, harm reduction strategies, and medications for opioid use disorder.

Is this only for adult patients?

No, the law does not limit distribution to patients over the age of 18.

Will the ED need to give a kit to a known patient on each separate visit?

You will need to assess the need for naloxone at each visit for patients who meet inclusion criteria regardless of how recently you last saw them. If you determine they have naloxone, it is not required to distribute an additional kit.

Can a patient be given a prescription instead of the actual pre-packaged naloxone?

No, the law requires actual in-hand distribution as well as a prescription for distribution in the patient record.

Are we required to provide patients who have short term opioid prescriptions with a kit in hand?

The law does not require naloxone distribution to patients with short term opioid prescriptions unless the patient meets other inclusion criteria. It could be appropriate to provide these patients with a naloxone prescription.

Do patients admitted to acute or critical care units require naloxone distribution on discharge?

The law does not require inpatient medical units to distribute pre-packaged naloxone.

Can my organization utilize grant funded naloxone for this program?

Starting January 1st, 2022, emergency departments may not utilize new grant funded naloxone to meet the requirements of the law. Organizations may prepurchase their own supply or provide kits at no cost to patients.

Is there a state-wide program to address a patient's inability to pay co-pays?

There are no copays for patients with Apple Health Medicaid. There is currently no statewide program to address an inability to meet naloxone co-payments. Organizations may also consider using existing charity care or financial assistance programs toward naloxone co-pays.

Learn more and access implementation toolkits and patient education materials at the [HCA SB 5195 website](#)



Naloxone distribution in emergency departments

SB 5195 Frequently Asked Questions for Clinical Staff

Is naloxone safe and effective when used outside of hospital settings?

Yes, naloxone has been proven to effectively reverse opioid overdoses in community settings administered by people with no medical training. Naloxone will not cause harm if it is administered to someone who is not having an opioid overdose.

Does naloxone distribution encourage drug use?

No, the availability of naloxone does not correlate with an increase in drug use frequency or quantity. In fact, the distribution of naloxone combined with access to harm reduction services has been shown to have a positive impact on substance use behaviors.

Does naloxone help people get better, or does it just allow someone to stay alive and continue using drugs?

Naloxone does both! The value of saving a life is not determined by what we know, assume, like, or dislike about the life saved. Most people who are at risk for an opioid overdose will reduce their risk over time and make positive changes, provided they are alive to do so. By distributing naloxone along with overdose prevention education, you are confirming that the lives of people who experience an opioid overdose are worth saving. Unfortunately, that is not the message that people who use opioids receive. As nurses, we know that caring for people is a part of healing people.

How will this affect me?

Naloxone is a simple way to save lives, which is an ER nurses favorite thing to do. Often, we are struggling with staffing, ratios, COVID... basically not feeling as effective or safe providing care as we should. Having something simple, easy, safe, effective, and lifesaving to do can help reduce burnout and re-establish a sense of purpose.

Offering naloxone and demonstrating you care about people at risk of opioid overdose can immediately shift the relationship you have with that patient. Often people who use opioids experience stigma and shame in their interactions with the healthcare system and may not trust or like us. When you take action to keep them safe you build positive rapport, and that makes their experience more healing and your job more satisfying.

What do I need to do differently?

The education required to dispense naloxone will take about 10-15 minutes and is on top of the other discharge education you must provide. This can be challenging to fit in, especially if you are looking to turn the room over quickly or if the patient is in a hurry to leave. Many patients who need this education will have already received naloxone and may be in withdrawal. Consider discussing offering suboxone for withdrawal management to help the patient continue their medical care and discharge appropriately.

Where can I learn more about reducing the harms related to drug use?

There are a lot of resources out there, and harmreduction.org and stopoverdose.org are two good websites to start learning more. The Washington Department of Health has a drug user health page: <https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth>. You can also connect with your local syringe services program, as they are experts in your community.

What words should I use and what words should I avoid when talking about drug use?

The words you use matter. It is important to see your patient as a person, and not as an illness or a behavior. Words like junky, addict, drug-seeker, clean or dirty, etc. are judgmental and cause harm. Use person first language instead, such as “people who use drugs” or “people who inject drugs”.

Drug addiction and drug abuse are also terms that should be avoided, as they often fail to distinguish between drug use, drug dependence, substance use disorder and always fail to recognize the ways in which people can make positive changes without abstaining from use altogether. Substance use disorder or opioid use disorder are appropriate instead.

What are some effective ways to talk with people about overdose risk?

The most important thing is to be non-judgmental, demonstrate caring, ask open ended questions, include their experiences and existing knowledge, and trust them as the experts on their own use.

If you would like more structure, consider the following approach.

1. Build rapport	I would like to take some time to talk about your risk of opioid overdose and naloxone. Can you tell me what you know about naloxone and how to use it?
2. Pros and Cons	What do you do that might put you at risk for overdose? What actions do you currently take to reduce that risk?
3. Provide information and get feedback	I have some additional information on overdose risk and how naloxone works, can we review it together?
4. Assess readiness	So, on a scale of 0 to 10, how prepared do you feel to use naloxone / recognize an overdose / tell other people how to use it on you / etc.
5. Make an action plan	Based on our conversation, what are some options that might work for you to help you stay healthy and safe? What supports do you have for making this change? Those are great ideas. I have a few more that be helpful (link to additional support, programs, telling people where the naloxone is stored, etc.)

How can I help my patients “get sober”?

Most people who use drugs will end up on a path to recovery. Abstinence is only one way to recover from substance use disorder. It is important to move away from sobriety and abstinence models because they are less effective both in terms of reducing mortality and in terms of long-term retention.

Medications for opioid use disorder, such as suboxone and methadone, are associated with a 50% reduction in mortality. Use of medication treatment is not replacing one drug with another and is one way of recovering from opioid use disorder. Recommending medications and providing information on how to get started on them is a great way to help your patients.

Any positive change in how someone uses drugs is another way to start a recovery process. Patients who carry naloxone and reduce overdose risk are making positive change for themselves and others.

APPENDIX J – OVERDOSE PREVENTION & DIRECTIONS FOR NALOXONE USE PATIENT TRIFOLD

Opioid Overdose Prevention & Directions for Naloxone Use



Anyone who uses opioids can overdose and should carry naloxone




HCA 13-0377 (12/21)

Washington State Health Care Authority

- ### Responding to an Opioid Overdose:
- During an opioid overdose, breathing can stop in a matter of minutes. Knowing the steps to act **FAST** and increase oxygen could help save a life.
1. **Check for a response**
Shake them and call their name, rub your knuckles hard over their chest bone — perform the sternum rub for 10 seconds as hard as possible.
 2. **Call 9-1-1**
Tell the operator that someone isn't breathing and your exact location. You do not have to say anything about drugs or medicines at the scene. The WA State Good Samaritan Law offers protections when you call 9-1-1 for an overdose (RCW 69.50.315).
 3. **Give naloxone**
 4. **Start rescue breathing**
 5. **Repeat steps 3 & 4 if no response**
 6. **You may need to give a second dose if they don't respond after 3 minutes**
 7. **Stay with them until help arrives**
Wait with them if possible until help arrives. If you can't wait, roll them into the recovery position in a safe place where they can be found.
 If the person starts breathing, but they do not wake up, roll them on their side in the recovery position. A person who received naloxone might be agitated, in pain, or experiencing withdrawal symptoms. Keep them from using drugs. Remember, naloxone wears off in 30-90 minutes, after which they could overdose again.

How to use Naloxone




Nasal spray — needs no assembly. Do not test the device. Each device only works once. You may need both devices.

- 1 
- 2 
- 3 

Place and hold the tip of the nozzle in either nostril.

Press the plunger firmly to release the dose into nose.

Injectable — This requires assembly.

- 1 
- 2 
- 3 


Remove cap from naloxone vial and uncover the needle.

Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.

Inject 1 ml of naloxone into an upper arm or thigh muscle.

Rescue Breathing

1. Lay the person flat on their back.
2. Gently tilt their head. Pinch their nose.
3. Give 2 quick breaths into their mouth. The chest (not stomach) should rise.
4. Give 1 slow breath every 5 seconds until they start breathing or wake up.



Opioids and Opioid Overdose

Opioids include some prescription pain medications, heroin, and fentanyl. Opioids can cause a person's breathing to slow down or stop. If someone takes more opioids than their body can handle, they can lose consciousness, stop breathing, and die. This is called an opioid overdose. An overdose can happen at once or over time.



Opioid Overdose Risks

- **Restarting opioid use after a break or change in type/dose.** This includes after leaving jail or prison, some types of drug treatment, and hospital admissions. *Tolerance can decrease quickly, even in a matter of days.*
- **Mixing opioids with other sedating substances** such as *alcohol, sleep aids, or benzodiazepines* ("benzos" like Valium and Xanax). Use one drug at a time or use less of each drug. Start low and go slow.
- **Taking prescription pain medication in higher doses and/or more often than prescribed**
- **Taking someone else's pain medication**
- **Using heroin or any drug not obtained from a pharmacy or cannabis dispensary**, due to unknown purity or origin
- **Heart, kidney, or lung disease**, which may affect the body's ability to fight back against an overdose
- **Having overdosed in the past**
- **Using alone;** you can't give yourself naloxone during an overdose. Try to use with a friend or around other people.



Signs of Opioid Overdose

- Slow or no breathing, they may look like they are sleeping
- Gurgling, gasping, or snoring
- Pale, gray, or blue fingernails or lips
- Ashen, white lips on a person of color
- Cool, clammy skin
- Unresponsive to external stimuli

If the person shows signs and symptoms of an opioid overdose, give naloxone even if you don't know what substance the person took.

Naloxone is a safe medication that can temporarily stop the effects of opioids and help a person start breathing again.

Naloxone only works on opioids and will have no effect on someone who has taken a different substance.

In Washington State, anyone can obtain naloxone at retail pharmacies, even if you don't have a prescription from a doctor. You can use the WA State Standing Order to dispense naloxone in lieu of a prescription from a primary care provider.



Watch a training video on overdose reversal
<https://vimeo.com/357020563> or
stopoverdose.org/section/take-the-online-training/



Share this resource with a friend or family member

Take a picture with your cell phone, keep a quick sheet with the naloxone, and learn more at stopoverdose.org or bit.ly/naloxoneinstructions.

If you take anything not prescribed to you or obtained from a pharmacy or purchased at a cannabis dispensary:

Assume that what you're taking likely has fentanyl in it, which may significantly increase opioid overdose risks.

This is not a substitute for more complete overdose response training from a medical provider or health educator. Some content in this publication is adapted from WA Department of Health and ADAL. Naloxone nasal spray instructions are adapted from Adapt Pharma/Emergent BioSolutions.

APPENDIX K – PATIENT EDUCATION HARM REDUCTION & MOUD PATIENT TRIFOLD



What is Harm Reduction?

There are lots of ways to get and stay healthy if you use drugs. If you don't want to quit, or are not sure if you want to quit, harm reduction practices can help. In harm reduction the focus is on "any positive change" and you decide what that means.



Substance Use Disorder Peers

Substance Use Disorder (SUD) peers can help you find treatment, or help you improve your health and quality of life. They also have experience with substance use disorder and are usually in recovery. SUD Peers support you in making positive changes. Locate SUD Peers on the MOUD Locator by following this link: warecoveryhelpline.org/moud-locator/



Syringe Service Programs (SSPs)

Programs can help people who use drugs stay healthy. SSPs provide clean syringes and injection equipment, syringe disposal, naloxone, and access to healthcare. These programs often have free HIV and hepatitis C testing. Find out more about SSPs and find a local site at doh.wa.gov/SSPDirectory.

If you inject drugs there are injection strategies that can reduce your risk of harm. You can read about them here: nextdistro.org/saferinjection

Treatment for Hepatitis C

In Washington State, anyone with Medicaid can get free treatment for hepatitis C. Newer treatments are usually two months long, have no or few side effects, and work — almost everyone who is treated is cured!

To get help accessing treatment visit this website: hepeducation.org/what-we-do/medical-case-management



HIV Testing and Prevention

For locations that offer HIV testing you can search this web address: bit.ly/hiv_testing

There are medications that can prevent HIV before or after a potential exposure. Learn more on the DOH website at: Pre-Exposure Prophylaxis (PrEP) bit.ly/DOH_PREP and PrEP Drug Assistance Program (PrEPDAP) bit.ly/DOH_PrEPDAP

Want to quit, cut back, or make a change?

There are treatment and support options available in Washington State.



HCA 13-0377 (12/21)

Content adapted and linked from the National Harm Reduction Coalition, UW/ADAI, stopoverdose.org, and WA Department of Health

Lower your risk of dying from an overdose by carrying naloxone

- Tell people where you keep the naloxone
- Learn how to respond to an opioid overdose and share overdose training with friends
- **Instructions for using naloxone** (written) or bit.ly/Naloxone_Instructions
- **Instructions for using naloxone** (video) vimeo.com/357020563
- **Find naloxone near you** or bit.ly/Find_Naloxone

Lower your risk of having an overdose by testing your dose and not using alone

If you use pills or other drugs from the street, the internet, or a friend, you should assume they contain fentanyl. Fentanyl is 50-100x stronger than heroin. Overdose with fentanyl can be fast. If you use any drugs, set safer conditions when possible.

Start low and go slow:

- Use a small amount or tester. If you are using more than one drug, use one drug at a time or use less of each drug.

Use the buddy system:

- If you can, avoid using drugs alone and make sure someone near you has naloxone.
- Have a friend or someone you trust check on you (test, call, or come by)
- Use in a place where someone is more likely to find you if you need help
- Set an alarm or time that other people can hear and will respond to if you overdose
- Use a confidential service like neverusealone.com, by calling (800) 484-3732, or the Brave app

Medications for Opioid Use Disorder (MOUD)

Opioid use disorder (OUD) is a treatable, long-term medical condition. Medications for opioid use disorder are effective and are a part of recovery for many people. There are three medications approved to treat OUD. See below.

Approved opioid treatment medications		
Buprenorphine	Methadone	Naltrexone
How does it work?		
Manages cravings and withdrawal symptoms by binding to the opioid receptors	Manages cravings and withdrawal symptoms by binding to the opioid receptors	An opioid blocker, you won't feel the opioids effects. Manages cravings for some people
Does it reduce harm and lower my risk of dying? Based on research that tracked outcomes in the real world		
Lowers risk of death by about 50%	Lowers risk of death by about 50%	Has not been shown to lower the risk of death
How long does it last and how do I take it?		
Lasts about 24 hours, usually taken by mouth (implant or injection possible)	Lasts about 24 hours, taken by mouth	Injection lasts for about 28 days. You can't take any opioids for 7-10 days before starting
Where can I get it, and what is the process?		
Primary care, medical office, community program, and some OTPs Low barrier, same day start options available. Visits vary from daily to monthly and may require scheduled appointments depending on where you go.	Only dispensed at opioid treatment programs (OTPs) Highly structured program, you may need to start going to clinic multiple days each week, but frequency can decrease over time	Prescribed and given by a medical provider and at some OTPs Visits vary from weekly to monthly
Will I need counseling or drug testing?		
Most providers require urine drug testing, some require counseling.	Requires regular urine drug testing and counseling	Some providers require urine drug testing and counseling

(Adapted from UW ADA) To learn more about these medications, visit: learnabouttreatment.org/

Find medications near you at this website: warcoveveryhelpline.org/moud-locator/ or call 1-866-789-1511.

APPENDIX L – OVERDOSE PREVENTION & DIRECTIONS FOR NALOXONE USE EHR VERSION

Opioid Overdose Prevention & Directions for Naloxone Use



Anyone who uses opioids can overdose and should carry naloxone

Opioids and Opioid Overdose

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Opioid Overdose Risks

- **Restarting opioid use after a break or change in type/dose.** This includes after leaving jail or prison, some types of drug treatment, and hospital admissions. *Tolerance can decrease quickly, even in a matter of days.*
- **Mixing opioids with other sedating substances** such as *alcohol, sleep aids, or benzodiazepines* ("benzos" like Valium and Xanax). Use one drug at a time or use less of each drug. Start low and go slow.
- **Taking prescription pain medication in higher doses and/or more often than prescribed**
- **Taking someone else's pain medication**
- **Using heroin or any drug not obtained from a pharmacy or cannabis dispensary,** due to unknown purity or origin
- **Heart, kidney, or lung disease,** which may affect the body's ability to fight back against an overdose
- **Having overdosed in the past**
- **Using alone:** you can't give yourself naloxone during an overdose. Try to use with a friend or around other people.

Signs of Opioid Overdose

- Slow or no breathing, they may look like they are sleeping
- Gurgling, gasping, or snoring
- Pale, gray, or blue fingernails or lips
- Ashen, white lips on a person of color
- Cool, clammy skin
- Unresponsive to external stimuli

If the person shows signs and symptoms of an opioid overdose, give naloxone even if you don't know what substance the person took.

Naloxone is a safe medication that can **temporarily** stop the effects of opioids and help a person start breathing again.

Naloxone only works on opioids and will have no effect on someone who has taken a different substance.

In Washington State, anyone can obtain naloxone at retail pharmacies, even if you don't have a prescription from a doctor. You can use the WA State Standing Order to dispense naloxone in lieu of a prescription from a primary care provider.

If you take anything not prescribed to you or obtained from a pharmacy or purchased at a cannabis dispensary:

Assume that what you're taking likely has fentanyl in it, which may significantly increase opioid overdose risks.

This is not a substitute for more complete overdose response training from a medical provider or health educator. Some content in this publication is adapted from WA Department of Health and ADAI. Naloxone nasal spray instructions are adapted from Adapt Pharma/Emergent BioSolutions.

How to use Naloxone

Nasal spray — needs no assembly. Do not test the device. Each device only works once. You may need both devices.

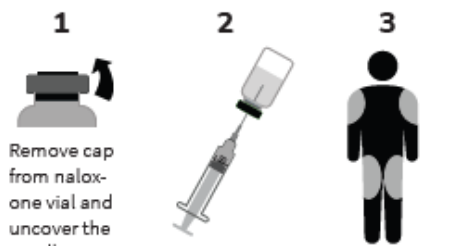


1
Peel back the package to remove the device.

2
Place and hold the tip of the nozzle in either nostril.

3
Press the plunger firmly to release the dose into nose.

Injectable — This requires assembly.



1
Remove cap from naloxone vial and uncover the needle.

2
Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.

3
Inject 1 ml of naloxone into an upper arm or thigh muscle.

Rescue Breathing

1. Lay the person flat on their back.
2. Gently tilt their head. Pinch their nose.
3. Give 2 quick breaths into their mouth. The chest (not stomach) should rise.
4. Give 1 slow breath every 5 seconds until they start breathing or wake up.



Responding to an Opioid Overdose:

During an opioid overdose, breathing can stop in a matter of minutes. Knowing the steps to act **FAST** and increase oxygen could help save a life.

1. Check for a response

Shake them and call their name, rub your knuckles hard over their chest bone — perform the sternum rub for 10 seconds as hard as possible.

2. Call 9-11

Tell the operator that someone isn't breathing and your exact location. You do not have to say anything about drugs or medicines at the scene. The WA State Good Samaritan Law offers protections when you call 9-1-1 for an overdose (RCW 69.50.315).

3. Give naloxone

4. Start rescue breathing

5. Repeat steps 3 & 4 if no response

6. You may need to give a second dose if they don't respond after 3 minutes

7. Stay with them until help arrives

Wait with them if possible until help arrives. If you can't wait, roll them into the recovery position in a safe place where they can be found.

If the person starts breathing, but they do not wake up, roll them on their side in the recovery position.

A person who received naloxone might be agitated, in pain, or experiencing withdrawal symptoms. Keep them from using drugs. Remember, naloxone wears off in 30-90 minutes, after which they could overdose again.



Watch a training video on overdose reversal

<https://vimeo.com/357020563> or stopoverdose.org/section/take-the-online-training/



Share this resource with a friend or family member

Take a picture with your cell phone, keep a quick sheet with the naloxone, and learn more at stopoverdose.org or bit.ly/naloxoneinstructions.

APPENDIX M – PATIENT EDUCATION HARM REDUCTION & MOUD EHR VERSION

Harm Reduction Strategies



Want to quit, cut back, or make a change?

There are treatment and support options available in Washington State.

What is Harm Reduction?

There are lots of ways to get and stay healthy if you use drugs. If you don't want to quit, or are not sure if you want to quit, harm reduction practices can help. In harm reduction the focus is on "any positive change" and you decide what that means.



Substance Use Disorder Peers

Substance Use Disorder (SUD) peers can help you find treatment, or help you improve your health and quality of life. They also have experience with substance use disorder and are usually in recovery. SUD Peers support you in making positive changes. Locate SUD Peers on the MOUD Locator by following this link: warecoveryhelpline.org/moud-locator/



Syringe Service Programs (SSPs)

Programs can help people who use drugs stay healthy. SSPs provide clean syringes and injection equipment, syringe disposal, naloxone, and access to healthcare. These programs often have free HIV and hepatitis C testing. Find out more about SSPs and find a local site at doh.wa.gov/SSPDirectory.

If you inject drugs there are injection strategies that can reduce your risk of harm. You can read about them here: nextdistro.org/saferinjection



Treatment for Hepatitis C

In Washington State, anyone with Medicaid can get free treatment for hepatitis C. Newer treatments are usually two months long, have no or few side effects, and work — almost everyone who is treated is cured!

To get help accessing treatment visit this website: hepeducation.org/what-we-do/medical-case-management



HIV Testing and Prevention

For locations that offer HIV testing you can search this web address : bit.ly/hiv_testing

There are medications that can prevent HIV before or after a potential exposure. Learn more on the DOH website at: Pre-Exposure Prophylaxis (PrEP) bit.ly/DOH_PrEP and PrEP Drug Assistance Program (PrEPDAP) bit.ly/DOH_PrEPDAP

Lower your risk of dying from an overdose by carrying naloxone

- Tell people where you keep the naloxone
- Learn how to respond to an opioid overdose and share overdose training with friends
- **Instructions for using naloxone** (written) or bit.ly/Naloxone_Instructions
- **Instructions for using naloxone** (video) vimeo.com/357020563
- **Find naloxone near you** or bit.ly/Find_Naloxone

Lower your risk of having an overdose by testing your dose and not using alone

If you use pills or other drugs from the street, the internet, or a friend, you should assume they contain fentanyl. Fentanyl is 50-100x stronger than heroin. Overdose with fentanyl can be fast. If you use any drugs, set safer conditions when possible.

Start low and go slow:

- Use a small amount or tester. If you are using more than one drug, use one drug at a time or use less of each drug.

Use the buddy system:

- If you can, avoid using drugs alone and make sure someone near you has naloxone.
- Have a friend or someone you trust check on you (test, call, or come by)
- Use in a place where someone is more likely to find you if you need help
- Set an alarm or time that other people can hear and will respond to if you overdose
- Use a confidential service like neverusealone.com, by calling (800) 484-3732, or the Brave app

Medications for Opioid Use Disorder (MOUD)

Opioid use disorder (OUD) is a treatable, long-term medical condition. Medications for opioid use disorder are effective and are a part of recovery for many people. There are three medications approved to treat OUD. See below.

Approved opioid treatment medications		
Buprenorphine	Methadone	Naltrexone
How does it work?		
Manages cravings and withdrawal symptoms by binding to the opioid receptors	Manages cravings and withdrawal symptoms by binding to the opioid receptors	An opioid blocker, you won't feel the opioids effects. Manages cravings for some people
Does it reduce harm and lower my risk of dying? Based on research that tracked outcomes in the real world		
Lowers risk of death by about 50%	Lowers risk of death by about 50%	Has not been shown to lower the risk of death
How long does it last and how do I take it?		
Lasts about 24 hours, usually taken by mouth (implant or injection possible)	Lasts about 24 hours, taken by mouth	Injection lasts for about 28 days. You can't take any opioids for 7-10 days before starting
Where can I get it, and what is the process?		
Primary care, medical office, community program, and some OTPs Low barrier, same day start options available. Visits vary from daily to monthly and may require scheduled appointments depending on where you go.	Only dispensed at opioid treatment programs (OTPs) Highly structured program, you may need to start going to clinic multiple days each week, but frequency can decrease over time	Prescribed and given by a medical provider and at some OTPs Visits vary from weekly to monthly
Will I need counseling or drug testing?		
Most providers require urine drug testing, some require counseling.	Requires regular urine drug testing and counseling	Some providers require urine drug testing and counseling

(Adapted from UW ADAI) To learn more about these medications, visit: learnabouttreatment.org/

Find medications near you at this website: warecoveryhelpline.org/moud-locator/ or call 1-866-789-1511.

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