January 2024

LIVE.LONG.DC. Stakeholder Summit - *Data Slides*

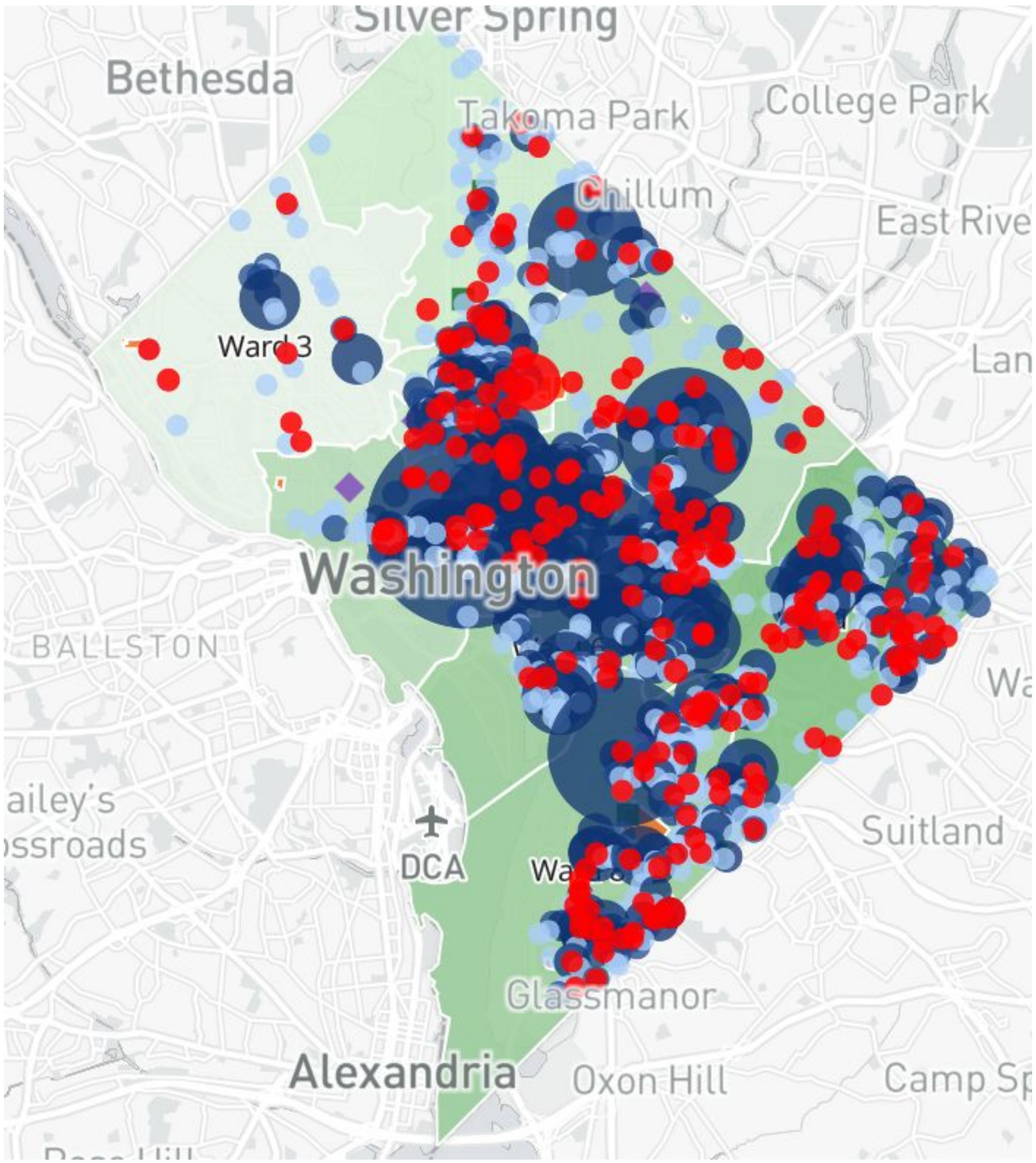
LIVE LONG DC
Saving lives from the opioid epidemic

January 31, 2024

Data Sharing
Fatal and Non-Fatal Overdoses

Laura Heaven, DBH

Fatal vs Suspected Non-Fatal Opioid Overdose Map



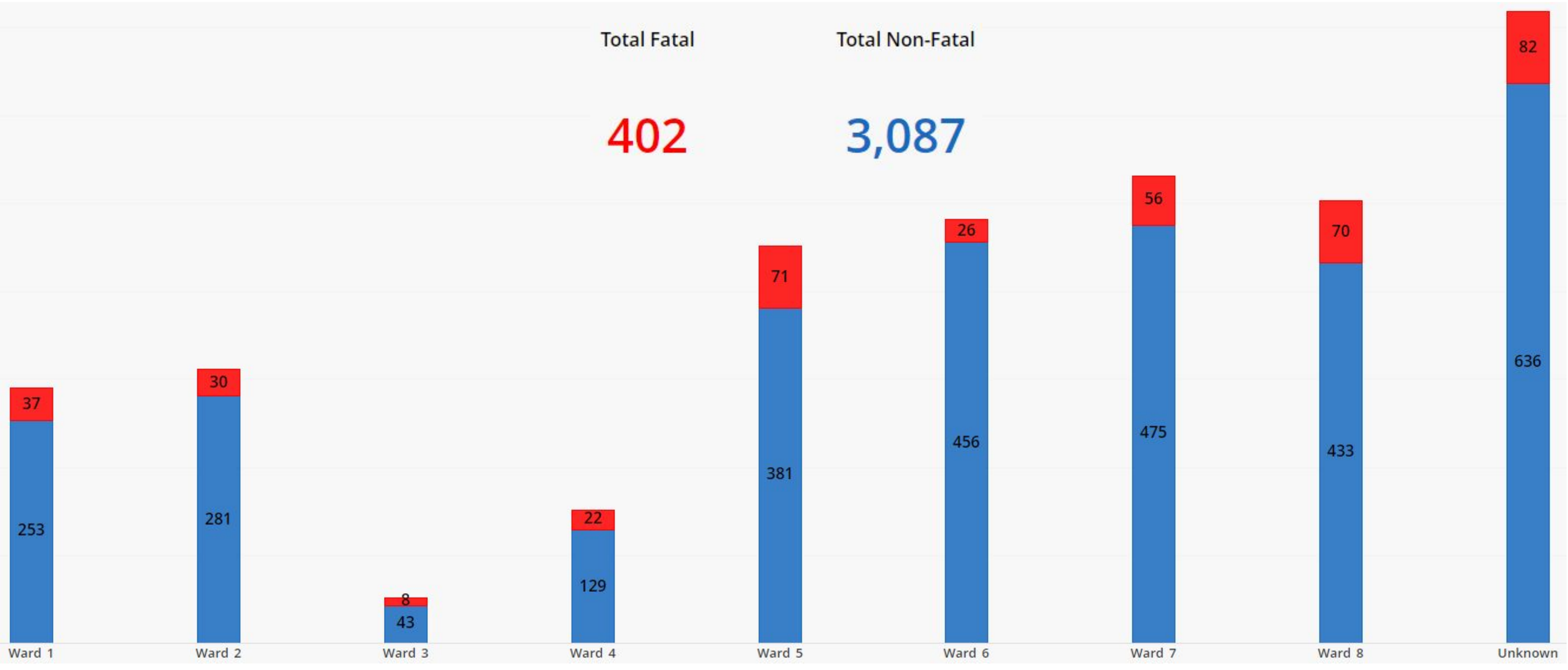
January 1, 2023–September 30, 2023

Notes on the data:

- Ward of injury is reported for both fatal and suspected non-fatal overdoses.
  - Deaths occurring in hospitals skew the fatal overdose Ward data.
- Suspected non-fatal overdose numbers are significantly higher than presented in October.
  - This is due to DBH better aligning the logic to identify suspected non-fatal overdoses with DC Health. This work is ongoing.
- There are unknown Wards in the location breakouts. Work is ongoing to clean address data and map them.

Fatal vs Suspected Non-Fatal Opioid Overdoses by Ward

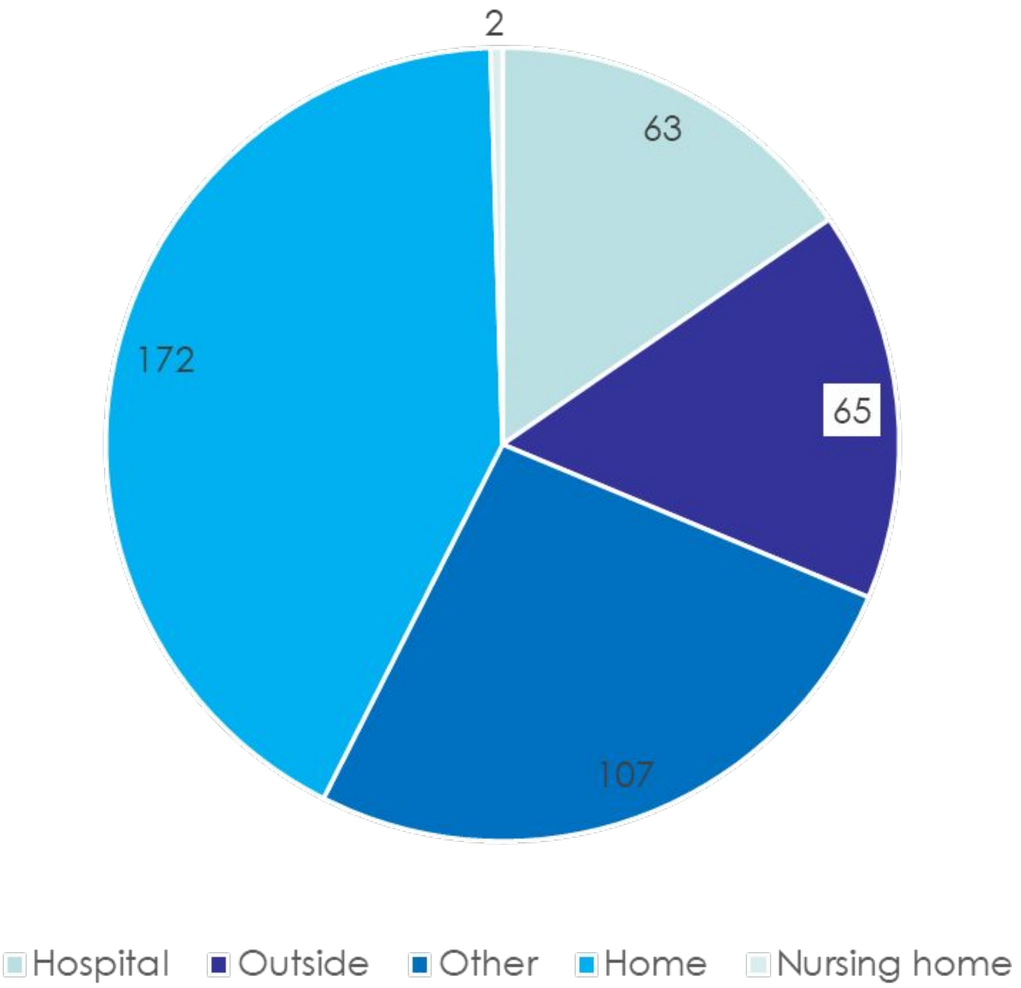
January 1, 2023–September 30, 2023



	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Unknown
% Nonfatal	9%	9%	2%	4%	12%	15%	14%	14%	20%
% Fatal - Injury	9%	8%	2%	6%	18%	6%	14%	17%	20%
% Fatal - Residence	6%	3%	2%	6%	10%	6%	14%	15%	37%

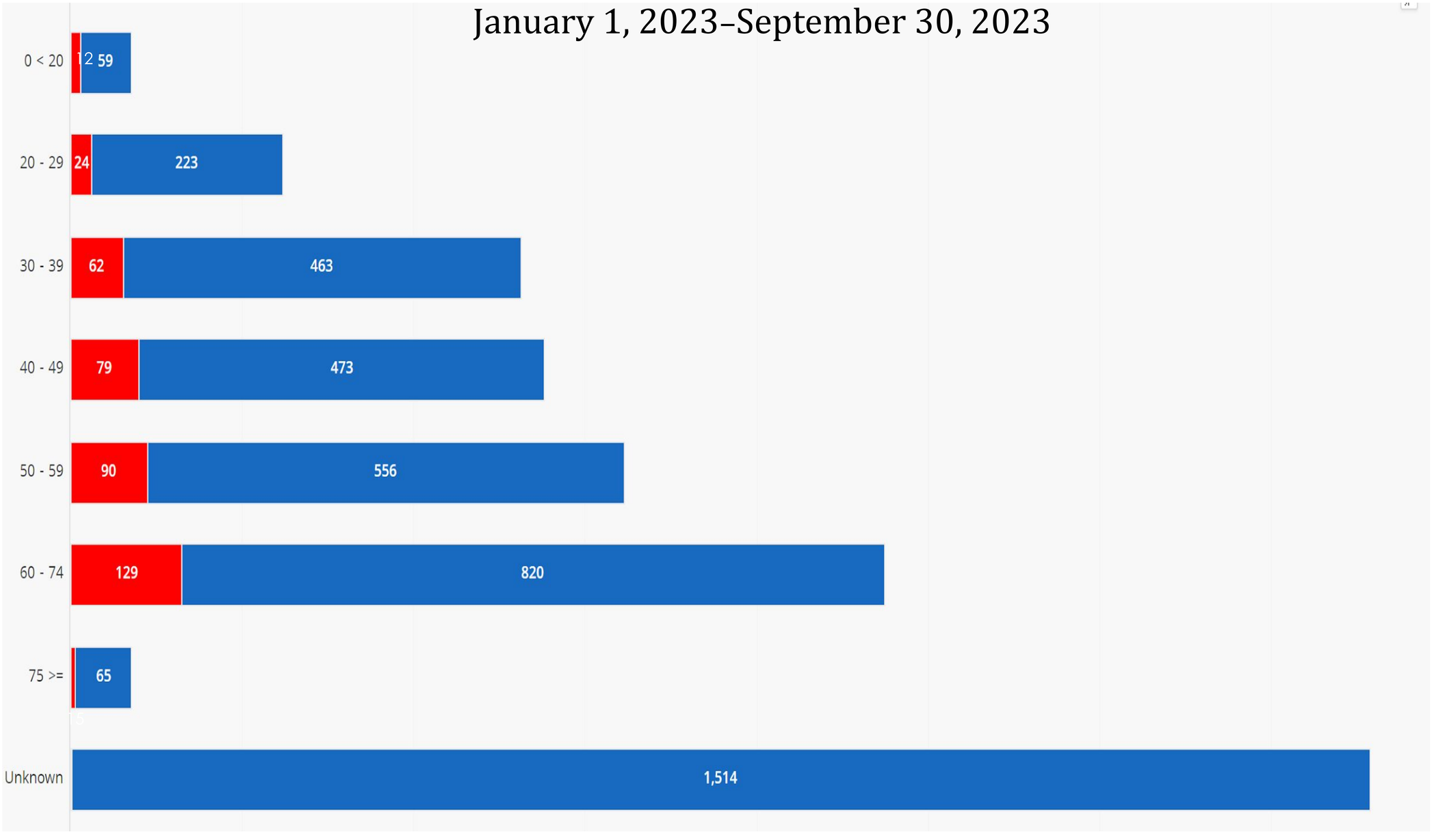
Fatal vs Suspected Non-Fatal Opioid Overdoses by Location

January 1, 2023–September 30, 2023



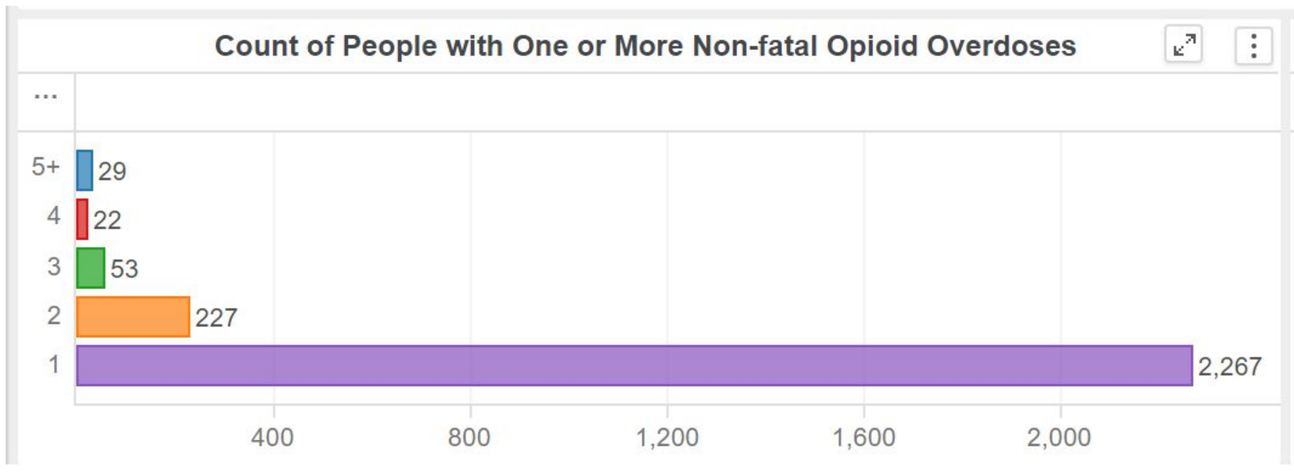
Fatal vs Suspected Non-Fatal Opioid Overdose by Age Group

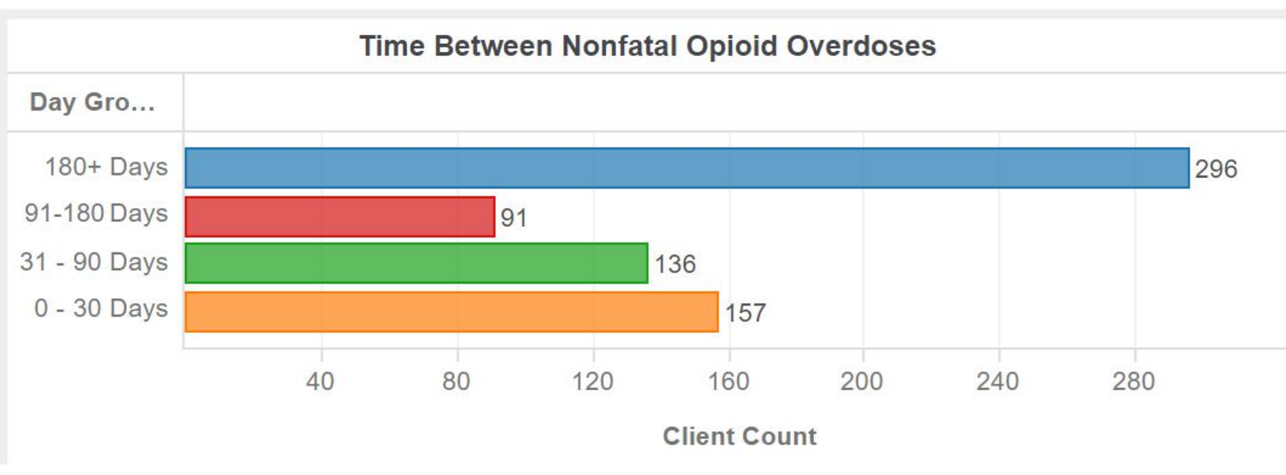
January 1, 2023–September 30, 2023



Repeat Suspected Non-Fatal Opioid Overdoses

In CY23, 331 individuals were identified as having multiple non-fatal overdoses. This number is certainly an undercount, as many individuals are not accurately identified during their interaction with FEMS.





Data Sharing

Fire and Emergency Services (FEMS)

Dr. Robert Holman, FEMS

EMS Care for Persons with Opioid Use Disorder (OUD) LIVE.LONG.DC. Summit

Robert P. Holman, MD, Medical Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Rev 06062022

Agenda

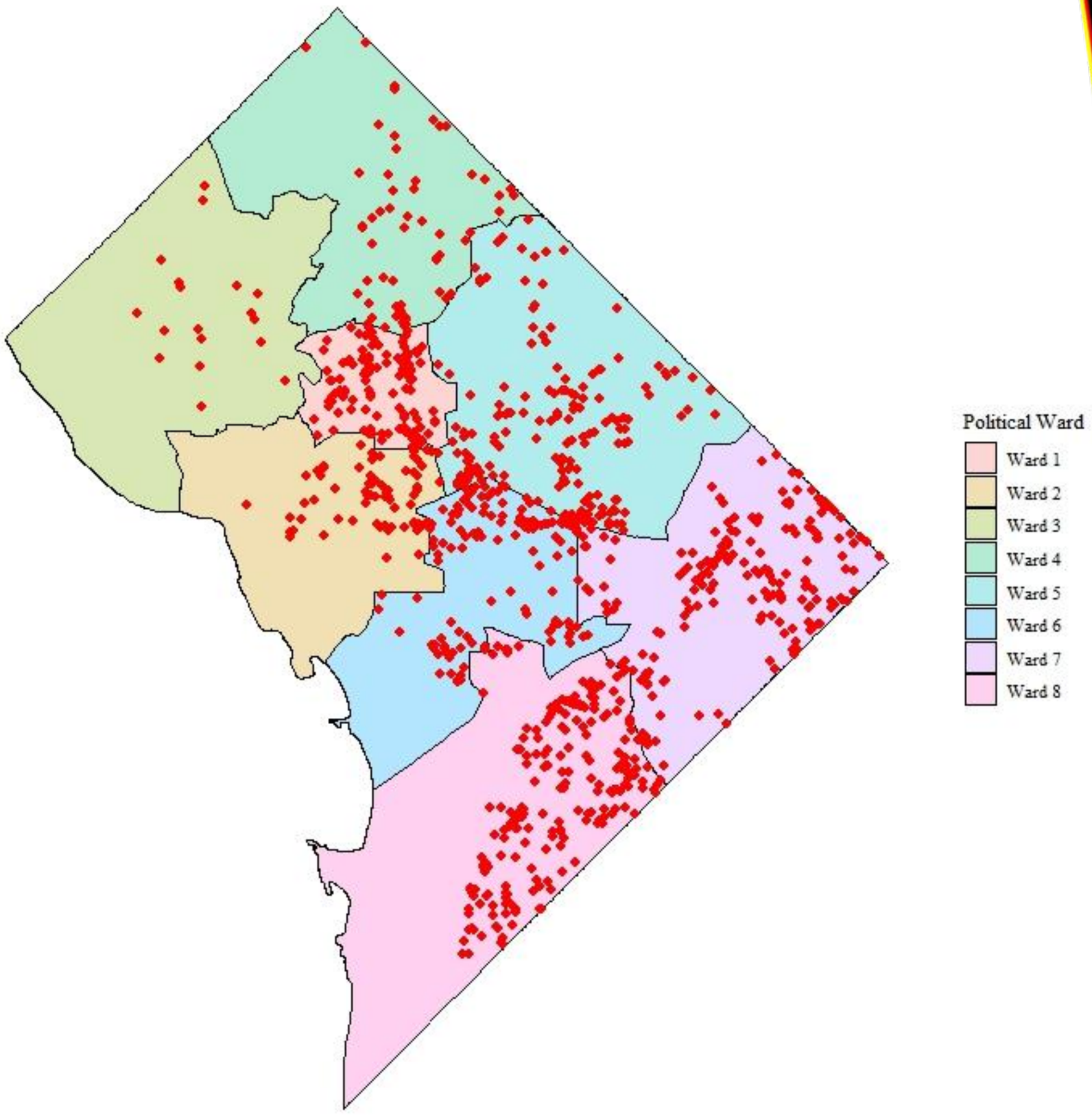
- FEMS Experience with Opiate Overdoses
- The Danger of an Opiate Overdose
- Reducing Morbidity of an Opiate Overdose
- The Emerging Role of EMS in Connecting Patients to Medication for Opioid Use Disorder (MOUD)

FEMS Experience with Opiate Overdoses

- 3,100 Fire and EMS incidents with naloxone administration in 2022
- 40% transport refusal rate after naloxone reversal in 2017-2023

Locations of Narcan Administration by DC Fire and EMS

Date Range: Aug. 1st, 2023 through Jan. 28th, 2024



The Danger of an Opiate Overdose – Massachusetts 2020

- Retrospective analysis of three statewide data bases in Massachusetts
- Only opiate overdoses discharged from an emergency department (ED)
- During the study period, 17,241 patients were treated for opioid overdose
- Of the 11,557 patients who met study criteria, **635 (5.5%) died within 1 year**, 130 (1.1%) died within 1 month, and 29 (0.25%) died within 2 days
- Of the 635 deaths at 1 year, 130 (20.5%) occurred within 1 month and 29 (4.6%) occurred within 2 days

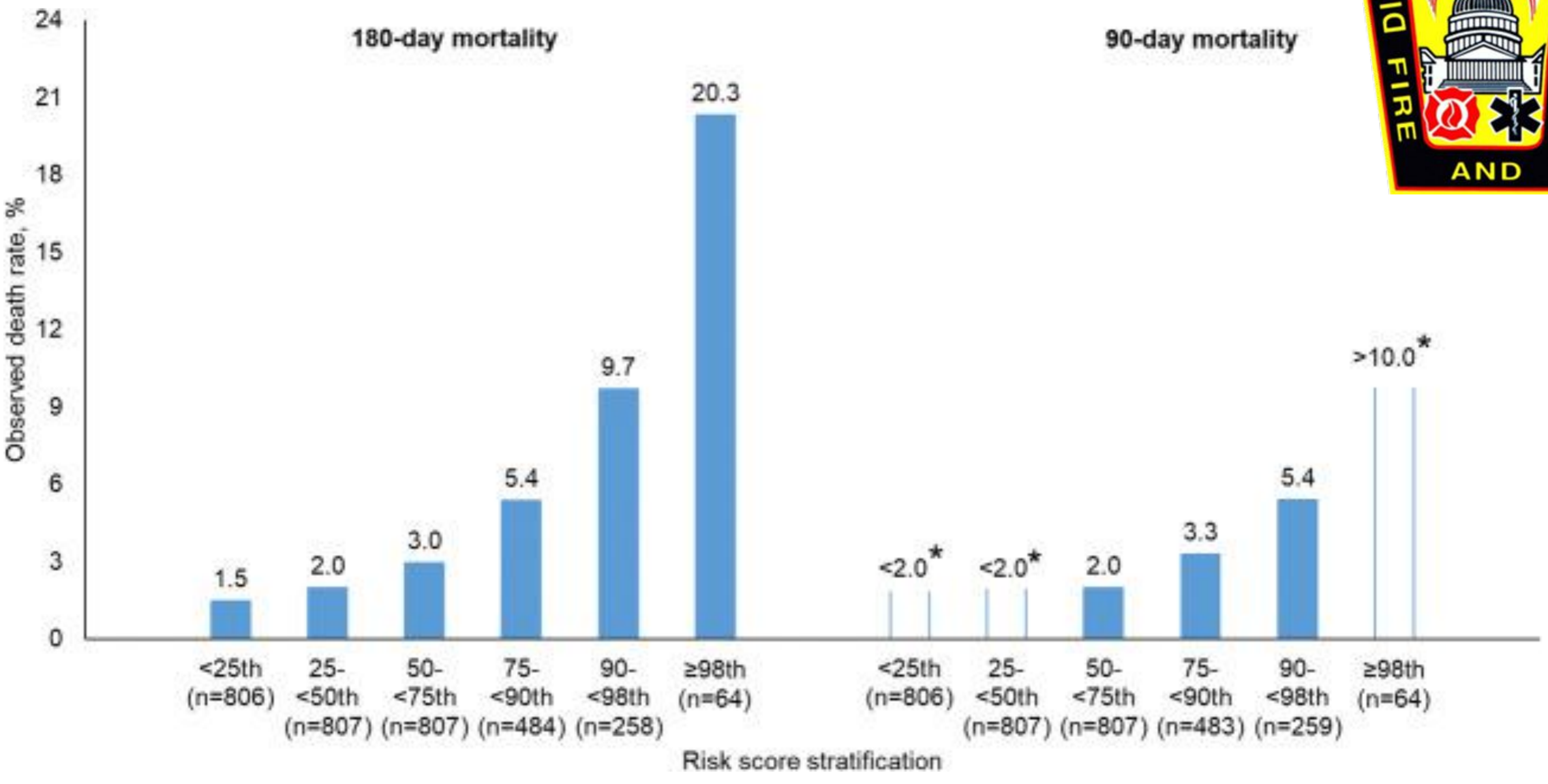
Weiner SG, et al., *One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose*, Ann of Emerg Med 2020, 75; 1:13-17.https://doi.org/10.1016/j.annemergmed.2019.04.020

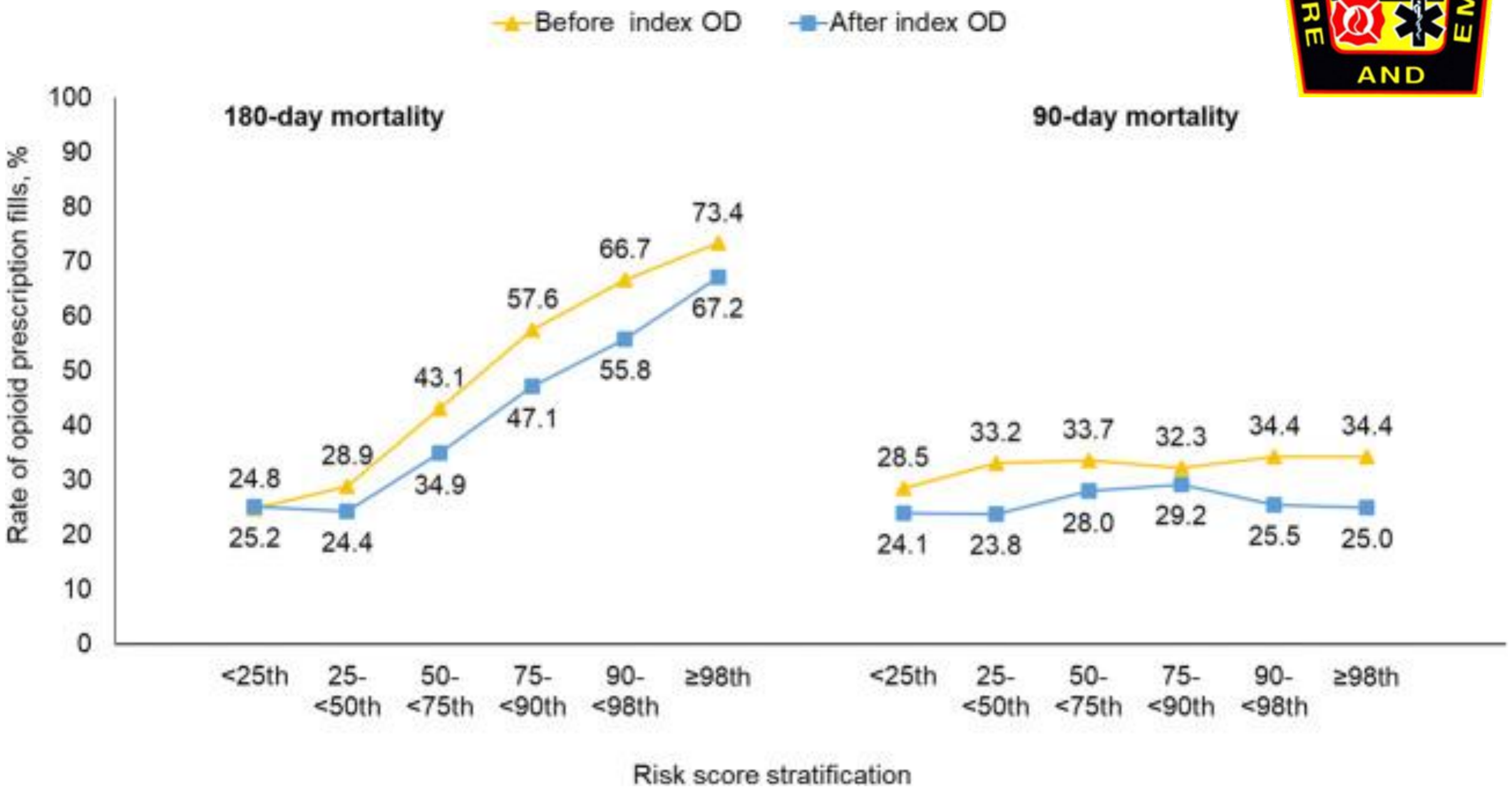
The Danger of an Opiate Overdose – Pennsylvania 2021

- Reviewed Pennsylvania Medicaid records 2014 – 2016
- Calculated 180-days mortality rate of **3.6%**
- Stratified the risk into six subgroups with the lowest rate of 1.5% while the highest rate was 20.3%

Guo J, et al., *Predicting Mortality Risk After a Hospital or Emergency Department Visit for Nonfatal Opioid Overdose.* J Gen Intern Med. 2021 Apr;36(4):908-915. doi: 10.1007/s11606-020-06405-w.

The Danger of an Opiate Overdose – Pennsylvania 2021





Proportion of beneficiaries with opioid prescription fills before and after index opioid overdose, by risk subgroup. OD, overdose. Chi-square test for overall trend across risk groups. For 180-day mortality, both before and after the index OD had $p < .001$; for 90-day mortality, both before ($p = .231$) and after ($p = .161$) the index OD had $p > 0.15$.

Reducing Morbidity for Patients with an Opiate Overdose

- Retrospective analysis of Medicare Advantage points January 2015 to September 2017

- 40,885 individuals with OUD (mean age 47 years; 54.2% male; 74.2% white) were identified

Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open.* 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622

Reducing Morbidity for Patients with an Opiate Overdose

Frequency of OUD treatments:

- Non-intensive behavioral health, 59.3%
- Inpatient detoxification or residential services, 15.8%
- MOUD treatment with buprenorphine or methadone, 12.5%
- Intensive behavioral health, 4.8%
- MOUD treatment with naltrexone, 2.4%.
- During 3-month follow-up, 707 participants (1.7%) experienced an overdose, and 773 (1.9%) had serious opioid-related acute care use.

Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open.* 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622

Reducing Morbidity for Patients with an Opiate Overdose

- Only treatment with buprenorphine or methadone was associated with a **reduced risk of overdose** during **3-month** (adjusted hazard ratio [AHR], 0.24; 95% CI, 0.14-0.41) and **12-month** (AHR, 0.41; 95% CI, 0.31-0.55) follow up.
- Treatment with buprenorphine or methadone was also associated with **reduction in serious opioid-related acute care use** during **3-month** (AHR, 0.68; 95% CI, 0.47-0.99) and **12-month** (AHR, 0.74; 95% CI, 0.58-0.95) follow up.

Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Netw Open.* 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622

EMS Doing “Bupe in the Field”

Contra Costa County, CA published initial pilot.

- 36 patients in first year, no precipitated withdrawal
- All patients taken to the ED
- 50% enrolled in MOUD at 7 days
- 36% enrolled in MOUD at 30 days

H. Gene Hern, Vanessa Lara, David Goldstein, M. Kalmin, S. Kidane, S. Shoptaw, Ori Tzvieli & Andrew A. Herring (2023) Prehospital Buprenorphine Treatment for Opioid Use Disorder by Paramedics: First Year Results of the EMS Buprenorphine Use Pilot, Prehospital Emergency Care, 27:3, 334-342, DOI: 10.1080/10903127.2022.2061661

EMS Doing “Bupe in the Field”

Camden, NJ

- 18 patients; none had precipitated withdrawal

- Dosing buprenorphine after opiate OD reversal with naloxone

Gerard G. Carroll , Deena D. Wasserman , Aman A. Shah , Matthew S. Salzman , Kaitlan E. Baston , Rick A. Rohrbach , Iris L. Jones & Rachel Haroz (2021) Buprenorphine Field Initiation of ReScue Treatment by Emergency Medical Services (Bupe FIRST EMS): A Case Series, Prehospital Emergency Care, 25:2, 289-293, DOI: 10.1080/10903127.2020.1747579

Opioid overdose requiring administration of naloxone

Any exclusion criteria present?

- Unwilling to give name AND date of birth
- Under 18 years of age
- Pregnant
- Methadone dose <48 hours
- Altered mental status and unable to give consent

YES

Not eligible for prehospital treatment

Give MAT brochure; transport to hospital or RMA

NO

Clinical Opioid Withdrawal Scale (COWS) >7

NO

Was the patient sober for 72 hours prior to overdose?

YES

NO

CONTACT MEDICAL COMMAND; REQUEST BUP BUNDLE

YES

Provide counseling and assess patient interest in buprenorphine

Is patient agreeable to treatment?

NO

YES

"Bup Bundle"

16-24mg buprenorphine + 4mg ondansetron

Give water to moisten mucous membranes
Administer 16mg buprenorphine SL
4mg ondansetron PRN nausea
Reassess after 10min

Symptoms improved

MIHC to provide clinic appointment; transport to hospital or RMA

Symptoms worsen/persist

Redose with 8mg SL buprenorphine
Max total 24mg

Camden and Contra Costa County – Unpublished Combined Experience

~225 patients combined

2/3 of their OUD calls to EMS are for **opiate withdrawal not overdose.**

They have changed the need to call the medical director for orders by expanding the Medic's scope of practice to include Bupe.

30-day MOUD retention is 23.2%

Contra Costa County will Rx pregnant and teenagers.

Other Models

- Austin/Travis county Bupe induction 24/7 entails five days of EMS visits with dosing
- After these five days of engagement their 30-day engagement in MOUD is 90%

What EMS Would Need to Do

- DC Health would have to expand the Paramedic scope of practice
- We would have to train our Street Calls/ MIH team initially
- Roll out training by unit crew
- Saturate the users with information on EMS field induction of Bupe
- Partner with DC Stabilization Center (DCSC)

Now It’s Your Turn…

Please provide questions and input!

DC Stabilization Center

Anna Jones, DCSC
Mary Page, DCSC
Dr. Robert Holman, FEMS
Tracey Wright, Federal City

DISTRICT OF COLUMBIA STABILIZATION CENTER (DCSC)

LIVE.LONG.DC. Summit
January 31, 2024, Updates

Anna Jones, DCSC Community Liaison
Mary Page, DCSC Clinical Director

Introduction

- The District of Columbia Stabilization Center (DCSC) exemplifies Mayor Bowser's priority and commitment to provide District residents with the opportunity to receive the right care, at the right time, in the right place to address their substance use needs.
- The Department of Behavioral Health (DBH) developed the DCSC in partnership with Community Bridges, Inc. (CBI), as a new, critical enhancement to our existing Substance Use Continuum of Care.
- Community Bridges, Inc. operates the facility, which is under the close monitoring and oversight of the DBH.

District of Columbia Stabilization Center (DCSC)

35 K Street NE, Washington, DC 20002

Direct Line: (202) 839-3500

https://dbh.dc.gov/service/dc-stabilization-center

DCSC Services

- Medical Screening and Clearance / Stabilization / Support Services
- Consumers' immediate personal needs being met
- Comprehensive diagnostic assessment for mental health, substance use disorders, and co-occurring conditions
- Referrals to appropriate ASAM level of treatment and recovery and harm reduction services in the community to meet consumer needs and their readiness to change
- Care management and coordination to support consumers post discharge
- Navigation, linkages, and referrals to housing, transportation, social services, and other supports
- Recovery coaching and consumer engagement services to address immediate personal needs
- Providing alternative disposition to first responders for people under the influence of substances and persons presenting in crisis

DC Stabilization Center Updates

- Low barrier access to therapeutic substance use disorder (SUD) treatment and crisis stabilization services to adults 18 years and older
- No costs, insurance, or residency requirements
- Individuals can be referred by community providers, family/friends, or walk ins
- The center can support up to 22 individuals at one time
- 16 recliners for people staying up to 23 hours
- 6 beds for patients staying up to 72 hours with acute SUD needs that need to be observed and monitored
- The DCSC is a 24/7 naloxone distributor for the community

DCSC By The Numbers

Program opened on 10/31/23

929 of Admissions to Date (1/29/24)

In Development - Public dashboard with additional data on the Stabilization Center

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DC Stabilization Center – Post Discharge

- Tracking Consumers post discharge
  - All referrals are reflected in the patient discharge transition plan found in the Electronic Health Record.
  - CBI is using the CRISP HIE for follow-up treatment.
- Treatment Providers
  - Pre-arranged agreements (MOAs) that allows feedback if patient attended intake, engaged in services, if the patient completed treatment or how long the patient stayed in treatment.
  - Review process for referrals that had barriers or gaps to improve transition to care.

Contact Information

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