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EXPERIENCE

Implementing take-home naloxone in an urban community pharmacy

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ABSTRACT

Objective: Morbidity and mortality associated with opioid use have increased across the nation, growing into what can only be described as an epidemic.
Setting: In Washington State between 2002 and 2004, the statewide death rate attributed to any opioid was 6.6 per 100,000 people, but between 2011 and 2013 it increased to 8.6 per 100,000 people. Pharmacies provide a unique access point for harm reduction services to patients due to their ease of accessibility in the community.
Practice description: In development of a take-home naloxone (THN) program, there were multiple areas that needed to be considered. These included product selection, collaborative practice agreements, training format and materials, managing patient and provider expectations, partnerships, and community perception of the service.
Practice innovation: Initial demographics from our experience of people obtaining THN showed a significant difference in the median age from other available programs in the area (57 years vs. 34, 35, and 31). These people tended to be bystanders, instead of end users of opioids, which led to redirecting marketing of our program. We provided community and group trainings for various organizations around the greater Seattle area. We have trained approximately 1400 unique individuals on how to recognize and respond to an opioid overdose, and how to administer naloxone.
Evaluation: One organization reports 20 successful overdose rescues from 99 kits (100% intranasal route) dispensed by our pharmacy (20.2% rescue rate).
Results: Since 2012 when our THN program began, we have seen growth of these programs across the state. Based on data through 2015, deaths from heroin in King County have decreased for the first time in the last 7 years, and the number of people seeking treatment for heroin addiction has increased.
Conclusion: Take-home naloxone programs can be successfully implemented into community pharmacies to increase access and awareness of opioid overdose recognition and response.

Morbidity and mortality associated with opioid use have increased across the nation, growing into what can only be described as an epidemic.[1] This trend has occurred in Washington State as it has across the country. In Washington State from 2002 to 2004, the statewide death rate attributed to any opioid was 6.6 per 100,000 people, but in 2011 to 2013 it increased to 8.6 per 100,000 people.[2] For the first time in history, deaths from drug overdose have become the number one cause of accidental death in Washington and the nation, eclipsing motor vehicle accidents.[3] Although this change is partly explained by the overall decrease in motor vehicle accidents, the growth in drug overdoses is alarming and represents a clear and immediate threat to public health.

Naloxone (Narcan) has been available and used in hospitals and by emergency response teams since it was first approved in 1971 as an opioid receptor antagonist to reverse the effects of opioids. In the health care setting, the use is most common in helping patients recover from respiratory depression (overdose). Take-home naloxone (THN) is a relatively new application of this medication, which is intended for use outside of the traditional health care setting. It is used by bystanders witnessing someone experiencing an opioid

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Key Points

Background:

- Morbidity and mortality associated with opioid use have increased across the nation, growing into what can only be described as an epidemic. In Washington State between 2002 and 2004, the statewide death rate attributed to any opioid was 6.6 per 100,000 people, but between 2011 and 2013 it increased to 8.6 per 100,000 people.
- The practice of distributing take-home naloxone (THN) developed in needle-exchange programs in various parts of the country for people who were injection drug users in the late 1990s and early 2000s.
- Pharmacies provide a unique access point for harm reduction services to patients due to their ease of accessibility in the community.

Findings:

- In development of a THN program, there were multiple areas that needed to be considered. These included product selection, collaborative practice agreements, training format and materials, managing patient and provider expectations, community partnerships, and community perception of the service.
- We estimate that we have trained ~1400 unique individuals on how to recognize and respond to an opioid overdose and how to administer naloxone.
- One organization reports 20 successful overdose rescues from 99 kits (100% intranasal route) dispensed by our pharmacy (20.2% rescue rate).
- Since 2012 when we began our THN program, we have seen growth of these programs across the state. While we were the first pharmacy program in Washington, there are now over 50 unique pharmacy programs across the state.

overdose as a first-line response. The practice of distributing THN developed in needle-exchange programs in various parts of the country for people who were injection drug users in the late 1990s and early 2000s.[4] Initially only intramuscular (IM) options were available, but owing to concerns about potential for inadvertent needle-sticks and blood-borne pathogen (BBP) exposure, intranasal (IN) options were explored.[4]

Pharmacies provide a unique access point for harm reduction services to patients owing to ease of accessibility in the community. Kelley-Ross Pharmacy Group (Seattle, WA) serves patients across the continuum of care through a community pharmacy located in a multispecialty clinic, a long-term care pharmacy serving a day health program for high-risk individuals, and a nondispensing community outreach division. In 2012, Kelley-Ross collaborated with the University of Washington Alcohol and Drug Abuse Institute (ADAI) regarding the opioid epidemic. We believed we could empower our pharmacists to provide education and training to both opioid users and potential bystanders on how to properly respond to an opioid overdose and administer THN to potentially save a life.

The regulatory environment in Washington State was unique in allowing pharmacists a very progressive practice opportunity specifically related to naloxone. In Washington, pharmacists are allowed to prescribe through a collaborative drug therapy agreement (CDTA) with a physician to initiate or modify therapy (WAC 246-863-100).[5] Kelley-Ross worked with ADAI to develop a CDTA that would allow pharmacists to prescribe and dispense naloxone to anyone at risk of having an overdose as well as anyone at risk of witnessing an overdose. In addition to the CDTA allowing this practice, Washington State also has a "Good Samaritan" law (RCW 69.50.315), which protects a person acting in good faith who seeks medical assistance for someone experiencing a drug-related overdose.[6] Both of these laws were then further reinforced to help increase access to naloxone with the enactment in 2015 of the Opioid Overdose Medication law (RCW 69.41.095).[7] The intent of this law was "to reduce the number of lives lost to drug overdoses by encouraging the prescription, dispensing, and administration of opioid overdose medications."[7] Essentially, it encouraged prescribing of naloxone not just to opioid users, but to any person or entity that may be in a position to respond to someone experiencing an opioid-related overdose.

Program development

In development of a THN program, there were multiple areas that needed to be considered. To craft a CDTA for naloxone, the route of administration (IM vs. IN) needed to be determined. In reviewing available data, we found that efficacies between these routes were equivalent.[8,9] We opted to have both forms available for patients, with emphasis on providing the IN version for ease of administration (training provided in the pharmacy) and less risk of BBP exposure. Since initial implementation, multiple options for providing naloxone have become available (naloxone IM, naloxone pre-filled syringe for IN, Evzio IM autoinjector, Narcan nasal spray).

Our program was prepared by reviewing necessary components for an appropriate overdose response. Thus our program was not limited to only dispensing THN, but also provided general opioid overdose education. This was developed into a checklist to standardize the training, which included:

- Risk factors for opioid overdose
- Recognizing an opioid overdose (i.e., "what is an overdose?")
- Activation of emergency medical response (911)
- Providing basic life support (rescue breathing)
- Naloxone administration
- Recovery position
- Post-overdose monitoring and expectations
- Good Samaritan law review

Materials for this program were developed internally, adapted from the Substance Abuse and Mental Health Services Administration toolkits.[10] We also included using online demonstration videos to ensure repetition of the information, the ability to review the training provided, and allowing