



Contents lists available at ScienceDirect

Journal of the American Pharmacists Association

journal homepage: www.japha.org

RESEARCH NOTES

Impact of naloxone education for patients receiving buprenorphine-containing prescriptions indicated for opioid use disorder at an independent community pharmacy

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ARTICLE INFO

Article history:

Received 11 January 2020

Accepted 14 July 2020

Available online 14 August 2020

ABSTRACT

Objectives: A pilot study was conducted to identify whether an opioid education and naloxone distribution (OEND) service affected (1) willingness to accept naloxone; (2) naloxone dispensation; and (3) patient knowledge about opioids, overdose symptoms, and naloxone in patients receiving buprenorphine prescriptions for opioid use disorder (OUD).

Methods: Participants were enrolled from January 2, 2019, to February 15, 2019, in this prospective noncontrolled study when receiving a buprenorphine prescription at the study site. The exclusion criteria included prescriptions being picked up by someone other than the patient and those who were below 18 years of age. The participants completed a written pre- and postsurvey containing "Yes" or "No," "Select all that apply," and open-ended questions assessing (1) willingness to accept naloxone and (2) change in opioid and naloxone knowledge.

Results: Fifty-two participants were enrolled, and all completed the pre- and postsurveys. After the education, there was a not statistically significant change in the proportion of participants willing to accept naloxone from the pharmacy (28.8% vs. 36.5%; $P = 0.31$). In addition, there was an improvement in the proportion of participants believing that they need to carry naloxone with them (15.4% vs. 40.4%; $P < 0.001$). Naloxone dispensing increased 400% after the intervention implementation. Improvements in opioid knowledge also occurred. More participants correctly identified buprenorphine as an opioid (48.1% vs. 86.5%; $P < 0.001$), and correctly identified that methamphetamine (19.2% vs. 3.8%; $P = 0.02$) and cocaine (17.3% vs. 3.8%; $P = 0.03$) are not opioids. Of the 52 participants enrolled, 11.5% correctly identified all opioids on the presurvey, whereas 50% correctly identified all opioids on the postsurvey.

Conclusion: Patients diagnosed with OUD who are prescribed buprenorphine may be at high risk of an overdose if they return to use; yet, few OEND programs specifically target this population. This study suggests that OEND based in community pharmacies may be a strategy to increase naloxone access among these patients.

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Background

In 2017, West Virginia had the highest rate of opioid-related overdose deaths in the United States, with 57.8 deaths per 100,000.¹ Many of these deaths may have been preventable if naloxone was available to and administered in a timely manner by laypeople, first responders, family, friends, or other people who use drugs.^{2,3} Naloxone, a mu-receptor antagonist,

quickly and effectively reverses opioid-induced respiratory depression.⁴ In the absence of opioids, naloxone produces no clinical effect, making it safe to distribute to the lay public and people who use drugs.²⁻⁴ In January 2019, the Food and Drug Administration (FDA) announced efforts to increase availability of naloxone by encouraging development of an over-the-counter (OTC) naloxone product. As of 2019, all 50 states have regulations allowing standing orders or third-party

Disclosure: Mark P. Garofoli has the following conflicts of interest to disclose: he is an expert witness for the U.S. Department of Justice and an advisory board member for Daiichi Sankyo, Inc. The authors declare no other relevant conflicts of interest or financial relationships.

Previous presentation: The results of this study have been reported at the

American Pharmacists Association Annual Meeting and Exposition in Seattle, March 23, 2019.

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prescribing provisions for naloxone.^{5,6} West Virginia pharmacists can dispense naloxone by prescription, statewide standing order, or behind-the-counter protocol. Standing orders eliminate the barrier of needing a provider on site to write a prescription, which may especially be beneficial to Medicaid beneficiaries who struggle with identifying providers who accept Medicaid, or who have transportation issues.⁷

Community pharmacies can play an important role in opioid education and naloxone distribution (OEND), and changes in naloxone-prescribing regulations have led to a 79% increase in naloxone dispensed from such pharmacies; nevertheless, the quantity of naloxone dispensed remains relatively low compared with the substantial need.^{5,7} A 2018 Morbidity and Mortality Weekly Report found that 1 naloxone prescription was dispensed for every 69 high-dose opioid prescriptions in the United States.⁸ It is thought that continued barriers to access include cost of the product, stigma, lack of prescribing, and lack of knowledge about the laws and the product itself.⁹ A survey of West Virginia pharmacists found that only 20.4% of the respondents were comfortable with selling naloxone without a prescription, and 71.3% agreed that letting patients buy OTC naloxone would increase opioid overdoses.¹⁰ Conversely, a 2019 study out of Indiana showed that in the 2 years after enacting a statewide standing order, both stocking and dispensing of naloxone greatly increased.¹¹

Research has demonstrated that bystanders can be successfully trained to identify and respond to an overdose, including naloxone administration.¹² Patients receiving FDA-approved medications for an opioid use disorder (OUD), particularly in the early phase of treatment, are a priority population for naloxone distribution because of the potential high risk of overdose mortality if they return to illicit opioid use after a period of abstinence.¹³

Although there is published research on OEND in community pharmacies, this research has primarily targeted patients on high doses of opioids for pain management or patients co-dispensed opioids and benzodiazepines. There is limited research specifically targeting patients receiving buprenorphine prescriptions for OUD.^{14–16}

Objectives

The primary objective of this pilot project was to determine if overdose education for patients receiving a buprenorphine prescription increased their willingness to accept naloxone. The secondary objectives were to assess improvement in patient knowledge and changes in naloxone dispensation from the study site.

Methods

Study design and participants

A cross-sectional study was conducted to determine whether the intervention increased participants' willingness to accept naloxone, knowledge of opioids and overdose, and the quantity of naloxone dispensed. The study participants were recruited between January 2, 2019, and February 15, 2019, at an independent community pharmacy in Morgantown, WV. Individuals were eligible to participate if they were filling a prescription for a buprenorphine (including both buprenorphine

and buprenorphine-naloxone) product approved for the treatment of OUD. The exclusion criteria included (1) the person picking up the prescription was someone other than the person named on the prescription, (2) the person named on the prescription was below 18 years of age, and (3) could not read and write in English. This study was approved by the West Virginia University Institutional Review Board.

Procedures

Participants were recruited for the study when they presented to the pharmacy to drop off or pick up a prescription for a buprenorphine-containing product. At the pharmacy window, customers were asked by a study team member if they would be interested in participating in an overdose education study while they waited for their prescription to be filled. Customers interested in participating were directed to a private counseling area where verbal consent was obtained and study procedures were conducted to protect the participants' privacy. The pre-education knowledge survey was self-administered, and a study team member was available to respond to questions as needed. The presurvey included items on demographic characteristics, receipt of education on overdose and opioid compounds and the provider type that delivered the education, having ever been offered or received naloxone, opioid and naloxone knowledge (compound names, overdose reversal effects, and overdose symptoms), safety considerations (children in the home and keeping naloxone), and willingness to receive naloxone from the pharmacy. The survey instrument was developed for this study, and it was informed by the study team members' experience conducting similar research.¹⁷ A study team member documented the buprenorphine product prescribed to the participant and their health insurance type.

The overdose education was delivered by a pharmacy resident at the site, consistent with the West Virginia naloxone protocol, and the participants were provided with an educational brochure from the protocol (Appendix 1). Importantly, the West Virginia naloxone brochure was not tailored for patients in recovery from OUD, and it does not list buprenorphine as an opioid; therefore, this information gap was addressed in the verbal education delivered. The education included content on the symptoms of an opioid overdose, identification of opioid compounds, appropriate use of naloxone, and how to access naloxone. The education was interactive, and the participants were encouraged to ask questions. The postsurvey reassessed 9 items from the presurvey to measure knowledge improvement associated with the intervention. The survey questions are displayed in the Appendix 2. Naloxone was provided to willing participants by prescription from their provider. The researchers called the providers' offices for these prescriptions when needed. The standing order was not used because at the time of the study the provider on West Virginia's standing order did not have a National Provider Identifier (NPI), and they were not enrolled in West Virginia Medicaid. This has since been resolved, and the standing order can be used.

At the completion of the study, the survey results and pharmacy data records were analyzed, and the amount of naloxone dispensed 2 months before the study was compared with the amount of naloxone dispensed during the 2-month study period to determine if an increase in dispensing occurred. Data were manually entered in an Excel spreadsheet

Table 1

Characteristics of participants in the study (n = 52)

Participants' characteristics	Initial survey, n (%)
Male	28 (54.9)
Age, y, mean (SD)	39.2 (10.2)
Insurance payer	
Medicaid	29 (59.2)
Medicare	4 (8.2)
Private	10 (20.4)
None (self-pay)	6 (12.2)
Type of buprenorphine product prescribed	
Buprenorphine-naloxone sublingual film (Suboxone [Indivior])	39 (79.6)
Buprenorphine tablets	9 (18.4)
Buprenorphine-naloxone buccal film (Bunavail [BioDelivery Sciences])	1 (2.0)

(Microsoft Corporation) by 1 of the researchers. The primary outcome was a change in participant willingness to accept naloxone. The secondary outcomes included percent change in naloxone dispensing, and change in knowledge about drugs that were classified as opioids, symptoms of an opioid-related overdose, and naloxone. The sample characteristics were summarized using descriptive statistics, including frequencies and means. Change in willingness to accept naloxone and change in knowledge about opioid medications and overdose were assessed using the Wilcoxon signed-rank test for the following survey questions: (1) Can naloxone reverse an overdose?, (2) Do you think you should keep naloxone with you?, and (3) Are you interested in receiving naloxone from our pharmacy? The McNemar chi-square test was used for the survey questions, "Check all that are opioids" and "Check all that are signs of opioid overdose." A sensitivity analysis of the primary outcome was conducted by (1) excluding the 4 subjects who reported already having naloxone and (2) comparing only the proportion of subjects who wanted naloxone preintervention versus postintervention. The latter was accomplished using the "prtesti" command in Stata (StataCorp LLC). The results were analyzed using Stata/MP 15.1.¹⁸

Results

The pre- and postsurveys were completed by 52 participants. Two declined to participate in the study owing to time constraints. The overdose education took an estimated 5-20 minutes, with the average session lasting 10 minutes. Some participants had questions or wanted to share their experiences, making their education session longer. The participants' mean age was 39.2 years (SD = 10.2). A little more than half of the participants were male (54.9%), and most (59.2%) were insured by West Virginia Medicaid. Buprenorphine-naloxone sublingual film (Suboxone [Indivior]) was the buprenorphine product prescribed most frequently (79.6%); the participants also received buprenorphine tablets (18.4%) and buprenorphine-naloxone buccal film (Bunavail [BioDelivery Sciences]) (2.0%). The participants' demographic characteristics are in Table 1.

Most of the participants (94.2%) reported being familiar with naloxone on the presurvey and knew that naloxone was used for overdose. Regarding previous education, 55.8% had received overdose education, 48% had received naloxone education, and 80.1% had received education on how to take buprenorphine. When asked who provided the previous education ("Select all

Table 2

Change in primary and secondary outcomes (n = 52)

Question	Presurvey (%)	Postsurvey (%)	P value
Primary outcome			
Willingness to accept naloxone today	28.8	36.5	0.31
Secondary outcomes			
Can naloxone reverse the effects of an opioid overdose?			
Yes	78.8	98	0.003
Opioid compounds			
Oxycodone	98.1	98.1	0.999
Fentanyl	82.7	92.3	0.059
Heroin	82.7	92.3	0.059
Buprenorphine	48.1	86.5	< 0.001
Methamphetamine	19.2	3.9	0.021
Cocaine	17.3	3.9	0.035
Codeine	55.8	65.4	0.166
Signs of opioid-related overdose			
Shallow breathing	94.2	96	0.564
Gasping for air	57.7	90.4	< 0.001
Bluish/pale skin/lips	82.7	90.4	0.206
Rapid heartbeat	42.3	17.3	< 0.001
Responds to sternal rub	25	13.5	0.109
Bloodshot eyes	25	13.5	0.058
Slurred speech	77	30.8	< 0.001
Do you think you need naloxone to keep with you?			
Yes	15.4	40.4	< 0.001
Reasons to not keep naloxone with you			
Opioid-abstinent	21.1	9.6	—
Don't need	15.3	7.7	—
Don't understand overdose	9.6	3.8	—
They/someone else already has	3.8	—	—
Miscellaneous	1.9	—	—
Reasons uninterested in receiving naloxone			
Don't need	13.4	11.6	
Have it	7.7	13.5	
Opioid-abstinent	3.8	1.9	
Don't understand overdose	13.5	1.9	
Miscellaneous	3.8	5.8	
What else did you learn from the education session today that wasn't asked about in the questions above?			
Naloxone is available at pharmacies	N/A; only asked on postsurvey	9.6	
What naloxone is used for	—	11.5	
Drugs that are opioids	—	9.6	
Signs of overdose	—	3.8	
Importance of having naloxone	—	3.8	

that apply"), 69.2% answered physician, 30.8% answered pharmacist, and 46.2% answered counselor/therapist, with other answers including nurse, family member, friend, or other.

Primary outcome

There was a not statistically significant change in the proportion of subjects who were willing to accept naloxone (28.8% vs. 36.5%; $P = 0.31$), and the sensitivity analysis was also

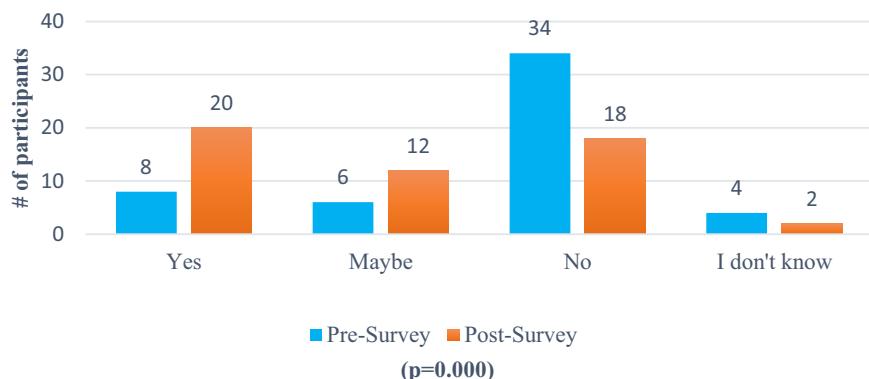


Figure 1. Comparison between pre- and postsurvey results when asked the question: do you think you need naloxone to keep with you?

not statistically significant. Nineteen participants were willing to receive naloxone from our pharmacy; however, only 15 were willing to receive it on the day of the education, and 4 were interested in receiving it in the future.

Secondary outcomes

During the 2 months before the intervention, 2 individuals received naloxone products from the pharmacy. In the subsequent 2 months, 15 individuals were dispensed naloxone products. A prescription from their doctor's office was used for all 15 of these individuals, as stated previously, to bill their insurance for the naloxone. All 15 were participants in the study.

After the education, there was a statistically significant improvement in the proportion of participants who correctly identified buprenorphine as an opioid (48.1% vs. 86.5%; $P < 0.001$) and correctly identified that methamphetamine (19.2% vs. 3.8%; $P = 0.02$) and cocaine (17.3% vs. 3.8%; $P = 0.03$) are not opioids. Regarding identification of opioids, 11.5% correctly identified all opioids on the presurvey, whereas 50% correctly identified all opioids on the postsurvey.

Before the education, 15.4% of the participants said "Yes" to "Do you think you should keep naloxone with you?," whereas 40.4% said "Yes" after receiving the education ($P < 0.001$). In the presurvey, 40% ($n = 21$) said they did not need to keep naloxone with them because they were no longer using opioids, and nor were they around anyone who did (Figure 1).

The results from all the closed-ended survey questions are available in Table 2. In response to the open-ended question regarding what else the participant learned, 9.6% ($n = 5$) responded that naloxone is available at pharmacies, and 11.5% ($n = 6$) responded what naloxone is used for. For example, 1 participant stated "that it [naloxone] is available for people without a prescription from a doctor." Another participant stated, "I learned what it [naloxone] is used for and that it can save a person that has overdosed."

Discussion

Although OEND programs have rapidly expanded in recent years, few have specifically targeted patients with OUD receiving buprenorphine prescriptions in community-based pharmacies.^{13,14} This feasibility study demonstrates 1 way to implement naloxone education in this setting. Existing research has identified persistent barriers in naloxone resulting from high

insurance co-pays, lack of education provided by pharmacists and physicians, and public perception.⁵ Insurance co-pays and lack of education proved to be barriers in this study as well, with 1 participant unable to afford their naloxone co-pay.

Only 38% of the participants in this study had previously received naloxone. Although legislative changes have removed barriers to naloxone access, dissemination and implementation of these changes may be slow. West Virginia Medicaid does allow for third-party prescribing of naloxone, and West Virginia's standing order allows third-party dispensing from pharmacies, which further breaks down the barriers to access. Access to Medicaid in general has shown to result in favorable outcomes for people with OUD, with data showing that Medicaid expansion has been associated with a 6% reduction in overdose deaths.¹⁹ In addition, although there has historically been a lack of naloxone prescribing, we found that some treatment centers in our area are co-prescribing buprenorphine and naloxone. Furthermore, although steps are continually taken to improve naloxone access, individuals at high risk of overdose may not be aware of these changes. For pharmacists practicing in the community, it is important to check local laws and determine which products are covered by insurance companies. Prescribe to Prevent provides information on naloxone products, patient education, and individual state laws.²⁰

Although there was an increase in the number of participants willing to accept naloxone from the study pharmacy, the improvement was not statistically significant and shows that more work needs to be done educating this patient population. Thirteen participants reported on the posttest that they did not need naloxone, and this may not be surprising considering that overdose is primarily associated with active drug use. Patients in recovery may not anticipate returning to use and hence minimize the risk of future overdose. Anecdotally, among those who were willing to receive naloxone, they frequently indicated that they wanted it for loved ones or to keep at work.

Before the study was implemented, the study site did not have any policies or procedures in place for naloxone dispensing. Owing to the success of this intervention, the current pharmacy resident at the site is in the process of developing a business plan to keep it going. Implementing an OEND program may not be feasible in all pharmacies owing to time constraints. Although most sessions lasted less than 10 minutes, this may not be possible depending on pharmacy staffing and prescription volume. Some states have taken notice of this and begun paying pharmacists for these education sessions.

Impact of naloxone education at an independent community pharmacy

Intranasal naloxone (Narcan [Adapt Pharma]) was the only product dispensed to the participants because it was the preferred product on insurance formularies, and it was easier for the site pharmacy to keep 1 naloxone product in stock.²¹ Although intramuscular naloxone formulations are more cost-effective, they are not recommended for layperson use owing to complication of administration. A naloxone auto-injector is available, but use has historically been limited owing to its cost of approximately \$4000 (vs. approximately \$125 for intranasal naloxone). A generic auto-injector has recently been approved with a cash price of approximately \$178; therefore, a potential gain in market share for this product could be seen. A generic intranasal naloxone product is not currently available to the lay public.²⁰

There are several limitations worth noting. First, the intervention was conducted at a single pharmacy in a small metropolitan area, and it is unknown whether the results would generalize to other areas. The study was conducted over a 2-month time period, and it is unknown whether there are any temporal patterns in naloxone dispensing in pharmacies that could have affected the study findings. In addition, a nonvalidated survey was used in the study, and the exclusion criteria limited those enrolled in the study to only a small subset of the population (above 18 years of age receiving a buprenorphine-containing prescription). The study may have been underpowered to detect a statistically significant change in willingness to accept naloxone. Finally, West Virginia's standing order was not used during the study because the provider on the standing order did not have an NPI number, nor were they enrolled in WV Medicaid.

Conclusion

Despite the study limitations, these findings suggest that providing naloxone education to patients prescribed buprenorphine improves their knowledge of opioids, overdose symptoms, and the availability of naloxone without a prescription. In addition, the education resulted in a 400% naloxone dispensing increase postintervention in the pharmacy. This population should be a priority for OEND owing to the potential high risk of overdose mortality should they return to opioid use. Community pharmacists may not want to assume that buprenorphine treatment programs have integrated OEND, or even if they have, patients may still benefit from repeated education.

Future initiatives include providing education on cumulative risk with combining medications from the same class, physician detailing on the need for naloxone in their patients, and increasing naloxone education programs to include other patient populations in community pharmacies. To provide optimal care to patients diagnosed with OUD, a collaboration across all disciplines must exist.

Acknowledgments

We would like to thank Karl Sommer, BSPharm, for his support in implementing the project. Because this is a small pilot study, the data will not be made publicly available.

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Appendix 1

Senate Bill 335, 16-46-3.d
 Any person who possess an opioid antagonist and administers it to a person whom they believe to be suffering from an opioid related overdose and who is acting in good faith is not, as a result of his or her actions or omissions, subject to criminal prosecution arising from the possession of an opioid antagonist or subject to any civil liability with respect to the administration of or failure to administer the opioid antagonist unless the act or failure to act was the result of gross negligence or willful misconduct.

Senate Bill 335, 16-46-3.e
 Any person who administers an opioid antagonist to a person whom they believe to be suffering from an opioid related overdose is required to seek additional medical treatment at a medical facility for that person immediately following the administration of the opioid antagonist to avoid further complications as a result of the suspected opioid related overdose.

Naloxone Intranasal Administration

I HAVE NARCAN

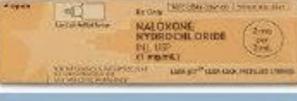
PLEASE
ASK FOR
MY HELP!

I AM TRAINED TO
HELP WITH AN
OVERDOSE

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Department of
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BUREAU FOR PUBLIC HEALTH

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Charleston, WV 25301
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West Virginia Department of Health and Human Resources
Office of Emergency Medical Services



Access to Opioid Antagonist Act
Senate Bill 335
Naloxone Intranasal Administration

Impact of naloxone education at an independent community pharmacy

How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
- Call a doctor if your pain gets worse
- Never mix pain medications with alcohol
- Avoid sleeping pills when taking pain medications

When to Administer Naloxone

Are they breathing? → Call 911 for help



Signs of an overdose:
 • Slow or shallow breathing
 • Gasp for air when sleeping or weird snoring
 • Pale or bluish skin
 • Slow heartbeat, low blood pressure
 • Won't wake up or respond (rub knuckles on sternum)

Airway → **Rescue breathing**



Make sure nothing is inside the person's mouth.

Prepare Naloxone



Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?

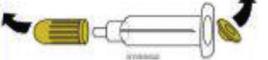
Evaluate + support



- Continue rescue breathing
- Give another 2 sprays of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opioids right away
- Encourage survivors to seek treatment if they feel they have a problem

How to Administer Naloxone

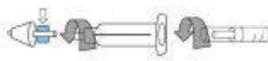
Step 1: pull or pry off yellow caps



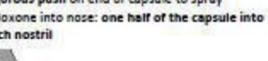
Step 2: pry off red cap



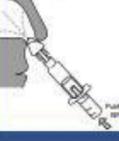
Step 3: grip clear plastic wings



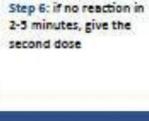
Step 4: gently screw capsule of naloxone into barrel of syringe



Step 5: insert white cone into nostril; give a short vigorous push on end of capsule to spray naloxone into nose: one half of the capsule into each nostril



Step 6: if no reaction in 2-5 minutes, give the second dose



Signs of an overdose include:

- Pale and clammy face
- Limp body
- Blue lips and/or fingernails
- Vomiting or gurgling sounds
- Will not wake up
- Not able to speak
- Slow or stopped breathing
- Slow or stopped heartbeat

If you suspect an overdose, **CALL 911** immediately.

How to avoid an overdose:

- Only take your own medication
- Follow the medication directions
- Call your doctor if pain gets worse
- Never mix medicine with alcohol
- Keep medicine out of the reach of children
- Learn the signs of an overdose

Office of Emergency Medical Services
 350 Capitol Street
 Room 423
 Charleston, WV 25301
www.wvems.org
 1-888-747-8367

West Virginia Department of Health and Human Resources
Office of Emergency Medical Services



Access to Opioid Antagonist Act
Senate Bill 335

e211

What are opioids/opiates?

Chemicals that act in the brain to:

- Decrease feeling of pain
- Decrease reaction to the pain
- Provide comfort

Opioids/opiates may be used to reduce pain resulting from injury or medical procedures, or as part of long-term care for cancer or other painful diseases that cause constant pain.

The frequent misuse of both opiates and opioids often result in danger.



Effects of opioids/opiates

Tolerance develops when someone uses an opioid/opiate drug regularly, so that their body becomes accustomed to the drug and needs a larger or more frequent dose to continue to experience the same effect.

Loss of Tolerance occurs when someone stops taking an opioid after long-term use. When someone loses tolerance and takes the opioid drug again, they can experience serious adverse effects, including overdose, even if they take an amount that caused them no problem in the past.



Recovering from an opioid overdose

Find a network of support, which may include:

- Family and friends
- Health care and behavioral health providers
- Peer-to-peer support groups
- Faith-based organizations
- Educational institutions
- Neighborhood groups
- Government agencies
- Family and community support groups



Appendix 2

Pre-Training Survey

1. **Age:** _____

2. Gender:

Male
 Female
 Prefer to self describe _____
 Prefer not to specify

3. Race:

White/Caucasian
 Black/African American
 Other (Please list: _____)

4. Are you familiar with naloxone (Narcan)?

Yes
 No

4a. If you answered "yes" to 4, please explain what it is?

5. Have you ever received education on (check all that apply):

Overdose prevention
 Using naloxone to reverse a drug overdose
 How to properly take your buprenorphine
 None of the above

5a. If you received education, who provided it (check all that apply)?

Physician
 Pharmacist
 Nurse
 Counselor/therapist
 Family member
 Friend
 Other (Please list _____)

6. Have you ever received take-home naloxone to use in the future (exclude times when someone had to administer it to you)?

Yes
 No
 I'm not sure

6a. If you answered "no" to 6, was it offered to you?

Yes -> Is there a reason why you chose not to get naloxone when it was offered to you?

No

7. Can naloxone reverse the effects of an opioid overdose?

Yes
 No
 I'm not sure

8. Which of the following are opioids (check all that apply)?

Oxycodone (Oxycontin, Percocet)
 Fentanyl (Duragesic)
 Heroin
 Buprenorphine (Suboxone, Subutex, Bunavail, Zubsolv)

Methamphetamine
 Cocaine
 Codeine

9. Which of the following are signs of an opioid overdose (check all that apply)?

Shallow or slow breathing
 Gasping for air when sleeping
 Bluish or pale skin or lips
 Rapid heartbeat
 Responds to a sternal rub (rubbing their chest)
 Bloodshot eyes
 Slurred speech

10. Do you think you need naloxone to keep with you?

Yes
 Maybe
 No
 I don't know

10a. If you answered "no" to 10, why not?

11. Do you have children in your home?

Yes
 No
 I don't know

12. Are you interested in receiving naloxone from our pharmacy?

Yes
 No
 I don't know

12a. If you answered "no" to 12, why?

12b. If you answered "yes" to 12, would you like the pharmacist to provide a prescription for naloxone for you today? (This prescription would be provided under a standing order by the State of West Virginia)

Yes
 No

Administrative Use Only

What buprenorphine-containing medication is the participant taking?

What prescription insurance does the participant have? If none, write none _____

Post-Training Survey

1. Can naloxone reverse the effects of an opioid overdose?

Yes
 No
 I'm not sure

2. Which of the following are opioids (check all that apply)?

Oxycodone
 Fentanyl
 Heroin
 Buprenorphine
 Methamphetamine
 Cocaine
 Codeine

3. Which of the following are signs of an opioid overdose
(check all that apply)?

- Shallow or slow breathing
- Gasping for air when sleeping
- Bluish or pale skin or lips
- Rapid heartbeat
- Responds to a sternal rub (rubbing their chest)
- Bloodshot eyes
- Slurred speech

4. Do you think you need naloxone to keep with you?

- Yes
- Maybe
- No
- I don't know

4a. If you answered "no" to 10, why?

5. Are you interested in receiving naloxone from our
pharmacy?

- Yes
- No
- I don't know

5a. If you answered "no" to 5, why?

5b. If you answered "yes" to 5, would you like the pharmacist to provide a prescription for naloxone for you today? (This prescription would be provided under a standing order by the State of West Virginia)

- Yes
- No

6. What else did you learn from the education session
today that wasn't asked about in the questions above?
