Agenda

1. Overdose in Ohio
2. Opioids in rural areas and populations
3. Practice guidelines
   • Emergency department and acute care facilities
   • Chronic pain
   • Acute pain outside of emergency departments
4. ODH initiatives
Ohio’s Opioid Epidemic

Overdose in Ohio
Death Rates Per 100,000 for Drug Poisoning (All Manner), by Year, Ohio vs. US, 2000-2015

Source: ODH Office of Vital Statistics
Progression of overdose 1999-2014
Unintentional Drug Overdose Deaths of Ohio Residents by Specific Drug(s) Involved, 2000-15*

- Prescription Opioids not including Fentanyl; Fentanyl was not captured in the data prior to 2007 as denoted by the dashed line

Source: ODH Bureau of Vital Statistics; Analysis Conducted by ODH Injury Prevention Program
Number of Fentanyl-related deaths and reported drug seizure cases, Ohio 2013-2015

Source: National Forensic Laboratory Information System (provided by the State of Ohio Board of Pharmacy), and Ohio Department of Health, Bureau of Vital Statistics; Analysis Conducted by ODH Injury Prevention Program.
Proportion of All Unintentional Drug Overdose Deaths Involving Selected Drugs, Ohio, 2015\textsuperscript{1,2}

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple drugs*</td>
<td>57.3%</td>
</tr>
<tr>
<td>All opioids**</td>
<td>84.9%</td>
</tr>
<tr>
<td>Prescription opioids</td>
<td>21.9%</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>37.9%</td>
</tr>
<tr>
<td>Heroin</td>
<td>46.7%</td>
</tr>
<tr>
<td>Methadone</td>
<td>3.5%</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>16.5%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>22.5%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>12.5%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>2.0%</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other/unspecified***</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

* Includes only deaths where the number of substances was specified; number unspecified is 6% of 2015 overdose deaths.

** Includes prescription opioids and heroin.

*** No specific drug was identified as contributing to death.

* Source: ODH Office of Vital Statistics

\textsuperscript{1} Multiple drugs may be listed on the death certificate for one death.
Unintentional drug poisoning – manner of death listed as accidental on death certificate

Ohio Department of Health, Bureau of Vital Statistics; Analysis Conducted by ODH Injury Prevention Program
Average Unintentional Drug Overdose Death Rate By Age Group, Over Time, Ohio Residents, 2001-2015

Source: ODH Bureau of Vital Statistics; Analysis Conducted by ODH Injury Prevention Program
Unintentional Drug Overdose Death Rates for Ohio Residents by County, 2010-2015

Source: ODH Office of Vital Statistics
Prescription drugs led to a larger overdose epidemic than illicit drugs ever have.

舉辦 Overdose Epidemics in Ohio, 1979 - 2015

Heroin & Rx opioids

Heroin

Crack Cocaine
Ohio’s Opioid Epidemic

Opioids in rural Ohio
Unique issues in rural health

- Emergency medical services
- Access to health care
- Availability of prescription opioids
- Rural social networks
- Social determinants of health
- Stigma
Naloxone Use by EMS: Urban vs. Rural

![Graph showing naloxone use and opioid death rates by urbanicity level.](image)

**FIGURE 1**—Overdose rates and odds of naloxone administration by EMS providers by level of urbanicity: National Emergency Medicine Service Information System, United States, 2012.

Note. EMS = emergency medical services.

Recent Federal initiatives

• U.S. Department of Agriculture
  • Secretary Vilsack - rural town hall meeting series
  • Rural Health and Safety Education grants program
  • Distance Learning and Telemedicine (DLT) grant program
  • Community Facilities Direct Loan and Grant Program
Recent Federal initiatives, continued

• Health Resources and Services Administration (HRSA)
  • Rural Opioid Overdose Reversal Grant Program
• Agency for Healthcare Research and Quality (AHRQ)
  • Research demonstration projects to support Medication-Assisted Treatment (MAT) in rural primary care
Unintentional Drug Overdose Death Rates for Ohio Residents by County, 2010-2015

Source: ODH Office of Vital Statistics
Ohio’s Opioid Epidemic

Combating the Opiate Crisis in Ohio
Fighting the Opiate Crisis in Ohio | 2011-2015

2011


SPRING/SUMMER 11 — OCOAT establishes OAP Network to promote family engagement efforts to combat opiate addiction (formerly known as SOLO-ACES).

Project DAWN (Deaths Avoided with Naloxone) expanded.

2012

MAY 11 — Gov. Kasich announces: Provider guidelines for emergency room and acute care facilities.

Ohio hosts first statewide Opiate Summit, drawing more than 1,000 addiction, criminal justice, policy and medical professionals.

Ohio Medicaid provides coverage of Medication-Assisted Treatment (MAT).

MIR (Mid-Rural Review) includes $3M investment for addiction treatment.

2013


Ohio establishes savings Ohio Treatment Center in Jackson County.

JUL 15 — Gov. Kasich signs HB 376 establishing a naloxone pilot project in Lucas County.

2014

JUL 14 — Medicaid expansion begins — 462,000 Ohioans now have access to treatment services.

Star Talking! statewide youth drug prevention initiative launches.

2015

DEC 14 — HB 567 signed into law requiring school districts to provide education on Rx medication and other opiate abuses.

OSDP reports that 111 more than 30,000 prescription pills (1,386 cases) and 14,179 grams of heroin (984 cases) for calendar year 2014.

Ohio EDs personnel administer naloxone 1,424 times for calendar year 2014.

JUL 15 — SB 533 (Springsteen) further expands availability of naloxone by permitting physicians to license standing orders.

GCOAT publishes Community Health Resource Toolkit for Addressing Opiate Abuse.
Ohio’s Opioid Epidemic

Opioid Prescribing Guidelines
Three Ohio Guidelines

1. Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS Prescribing), April 2012

2. Opioids for the Treatment of Chronic, Non-Terminal Pain 80 mg of a Morphine Equivalent Daily Dose (MED) “Trigger Point”, October 2013


Available at www.mha.ohio.gov
Emergency and Acute Care Facility Guidelines

1. Prescribe OOCS only when appropriate
2. Do not provide replacement doses or extended-release opioids
3. Before prescribing:
   • Search OARRS
   • Request photo ID
   • Perform drug screening
4. Maintain referral list
Emergency and Acute Care Guidelines, continued

5. Consider other options prior to prescribing
   • Contact routine provider
   • Request records or consultations
   • Case review/case management
   • Ask patient to sign pain agreement

6. Use electronic medical resources

7. Limit prescriptions to three-day supply

8. Patient education and clear expectations
Chronic Non-Terminal Pain Guidelines

1. Use non-opioid therapies first
2. Avoid long-term and co-prescribing
3. “Press Pause” at 80 mg MED
   - Re-establish informed consent
   - Review functional status and documentation
   - Review progress toward treatment objectives
   - Check OARRS
   - Consider a pain treatment agreement
   - Consider referral to specialist
Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments

### Acute Pain Prescribing Guidelines

**A companion to Ohio’s Guidelines for the Management of Acute Pain Outside of Emergency Departments. These guidelines are to be used as a clinical tool, but they do not replace clinical judgment.**

#### Patient Presenting with Acute Pain

- Medical history and physical examination, including pain severity.
- Location, intensity, severity, and associated symptoms.
- Quality of pain (corticosteroid or neuropathic).
- Psychological factors, patient/family history of addiction.

#### Develop Pain Management Plan:

- Evaluate patient and refer to necessary specialists.
- Discuss risks/benefits of nonpharmacologic and pharmacologic therapies.
- Set patient expectations for degree of pain and duration of pain.
- SIGOs: Improvement of function to baseline as opposed to complete resolution of pain.

### Options

#### Non-Pharmacologic Treatment

- Ice, heat, positioning, breathing, walking, stretching.
- Massage, touch, relaxation, distraction, coping strategies, cognitive-behavioral therapy.
- Supportive physical therapy, occupational therapy.
- Biofeedback.
- Directed exercise such as physical therapy.

#### Non-Opioid Pharmacologic Treatment

<table>
<thead>
<tr>
<th>Role in Therapy</th>
<th>First Line</th>
<th>Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Naratriptan</td>
<td>Gabapentin (pregabalin) TCA (SNRIs)</td>
</tr>
<tr>
<td>Suppository Medication</td>
<td>Sumatriptan</td>
<td>Anti-epileptic, serotonin, lower concentration opioid, SSRIs, topical lidocaine</td>
</tr>
</tbody>
</table>

#### Opioid Pharmacologic Treatment

- For all opioids:
  - Complete risk screening (e.g., pregnancy, high-risk physical environment, personal/family history of substance abuse).
  - Provide the patient with the least patient-activated, effective measure of pain (e.g., IV morphine instead of oxycodone). Refer to Morphine Equivalency Table.
  - Prescribe the minimum quantity needed with no refills.
  - Consider checking NAPS for patients who will require an opioid prescription.
  - Opioid taper is supplied for most prescriptions of 7 days or more.
  - Avoid prescribing long-acting opioids for acute pain (e.g., methadone, oxycodone).
  - Use caution when prescribing opioids with patients on bismuth/iron or other bismuth products to use alcohol.
  - Discuss how to safely and effectively wean patients off opioid medications.
  - Remind that it is unsafe and unwise to give away or sell their opioids.
  - Discuss proper storage and disposal of opioid medications.
  - Coordinate care and communication of opioid patients with other clinicians.

- 14 Days (Key Checkpoint)
  - Doesn’t patient within an appropriate time NOC exceeding 14 days.

- 6 Weeks (Key Checkpoint)
  - If pain is unresolved, reasons:
    - Pain: consider standardized tool (e.g., Oswestry Disability Index for back pain).
    - Treatment methods
    - Follow-up care for continued pain
    - Additional treatment options, including consultation.
Acute Pain Outside of Emergency Dept Guidelines

1. Assessment and diagnosis

2. Develop a plan
   • Measurable goals with a focus on function
   • Clear treatment expectations and progression of treatment

3. Reevaluation checkpoints
   • If opioid therapy will continue after 14 days
   • If pain is unresolved after 6 weeks
   • If pain becomes chronic (≥12 weeks)
3. Treatment of Acute Pain
   - Non-pharmacologic therapy
   - Non-opioid pharmacologic therapy
   - Opioid therapy
     - Screen for risk
     - Provide the minimum needed quantity at the lowest effective dose
     - Check OARRS
     - No refills or extended-release opioids
     - Discuss weaning, storage and disposal, and implications of selling/giving away medication
## Summary: Progressive Opioid Prescribing Guidelines for a Safer Ohio

<table>
<thead>
<tr>
<th>From Emergency Department &amp; Acute Care Facilities</th>
<th>For Chronic, Non-Terminal Pain</th>
<th>For Acute Pain Outside of Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Release Date</strong></td>
<td>April 2012</td>
<td>October 2013</td>
</tr>
<tr>
<td><strong>Specific Goals</strong></td>
<td>Stop inappropriate prescribing from ED &amp; Urgent Care Centers</td>
<td>Ensure long-term patient safety</td>
</tr>
<tr>
<td><strong>Prescribing Limitations</strong></td>
<td>• No more than 3 days</td>
<td>• “Press pause” at ≥ 80 mg MED</td>
</tr>
<tr>
<td></td>
<td>• No long-acting opioids</td>
<td>• Caution with co-prescribing of benzodiazepines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OARRS Recommendations</strong></td>
<td>Check prior to prescribing</td>
<td>Check every patient at ≥ 80mg MED By law, OARRS check required for &gt;12 weeks</td>
</tr>
<tr>
<td><strong>Key Additional Clinical Steps</strong></td>
<td>Referral to Primary Care</td>
<td>12 weeks a trigger for re-evaluation of pain, function, medication effectiveness &amp; SBIRT</td>
</tr>
<tr>
<td><strong>Associated Metrics</strong></td>
<td>TBD: Survey by ODH; Additional data &amp; trends through OARRS</td>
<td>• # patients at ≥ 80mg MED</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proportion of prescriptions ≥ 120 pills/prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proportion and # patients on both opioid &amp; benzodiazepines</td>
</tr>
<tr>
<td><strong>Aggregate Quarterly Measures for all guidelines</strong></td>
<td>• % of prescriptions with associated OARRS check</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• # patients receiving opioids per quarter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Total opioid pills prescribed per quarter;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average MED per prescription</td>
<td></td>
</tr>
<tr>
<td><strong>Sample Patient Vignette</strong></td>
<td>Patients who are narcotic-seeking, doctor shopping and/or diverting opioids</td>
<td>Patients with addiction or tolerance to medications; those at greater risk for harm</td>
</tr>
</tbody>
</table>

**Acronyms:** ED=Emergency Department; MED=Morphine Equivalent Daily Dose; OARRS=Ohio Automated Rx Reporting System (prescription drug monitoring program); SBIRT=Screening, Brief Intervention, and Referral to Treatment for substance abuse | Created December, 2015
Activities to Support Ohio Prescribing Guidelines

- Promote the adoption and implementation of opioid prescribing guidelines (ongoing)
- Develop Social Marketing Campaign for public and prescribers (8/2016)
- Assess the adoption of the ED guidelines by Ohio hospitals (7/2016)
- Prescriber resources
  - Screening tools
  - Patient education materials
  - Acute pain guidelines training module
There were 81 million fewer doses of opioids dispensed to Ohio patients in 2015 compared to 2011.

Source: State of Ohio board of Pharmacy, Ohio Automated Rx Reporting System
Number of “Doctor Shoppers”, Ohio 2011-2015

Source: State of Ohio board of Pharmacy, Ohio Automated Rx Reporting System
Prescriber OARRS Queries, Ohio 2011-2015

Source: State of Ohio board of Pharmacy, Ohio Automated Rx Reporting System
Ohio’s Opioid Epidemic

Ohio Department of Health Initiatives
Violence and Injury Prevention Program (VIPP)

• Funding local agencies for comprehensive community-based efforts to address prescription drug abuse and overdose
  • Build coalitions among health departments, providers, law enforcement, and the community
  • Form a poison death review committee
  • Develop policy, systems and environmental change strategies such as:
    • Expanding access to naloxone distribution programs such as Project DAWN and/or promotion of naloxone co-prescribing for high risk patients.
    • Facilitating health care system changes including the implementation of opioid prescribing guidelines and other standardized pain management strategies.
    • Increasing use of OARRS among prescribers to influence prescribing behavior.
Violence and Injury Prevention Program (VIPP)

- Local Prevention Programs
  - Cuyahoga County
  - Clermont County
  - Portsmouth City (Scioto County)
  - Stark County (July 2016)
  - Hamilton County (July 2016)
  - Summit County (July 2016)
  - Ross County (July 2016)
  - Trumbull County (July 2016)
Partnering with Ohio Board of Pharmacy

- Enhance and Maximize OARRS
  - Expand and Improve Proactive Unsolicited Reporting
    - Develop a proactive reporting system (i.e. red flags) for OARRS users
  - Make OARRS Easier to Use and Access
    - Develop a batch reporting feature
  - Conduct Public Health Surveillance with OARRS Data and Publicly Disseminate Reports
    - Link OARRS data to existing data sets

- Evaluate HB 341
Naloxone Distribution Programs

• Naloxone (also known as Narcan) can reverse an overdose caused by an opioid drug (heroin or prescription pain medications).

• When administered during an overdose, naloxone blocks the effects of opioids on the brain and quickly restores breathing.

• No effect if opioids are not present and has no pharmacological effect, potential for addiction, or potential for abuse.
Project DAWN is a community-based overdose education and naloxone distribution program.

Project DAWN participants receive training on:
- Recognizing the signs and symptoms of overdose
- Performing rescue breathing
- Calling emergency medical services
- Administering intranasal Naloxone
• Kit with 2 doses of 1 mg/1 mL naloxone hydrochloride in pre-filled needleless syringes, nasal adaptors, breathing mask, instructions, referrals to local substance abuse/dependence treatment/ owner card

• Must use 300 MAD adaptor for intranasal use

• Take-home DVD to share with family, friends, and significant others

Approximate cost of kit: $75

Approximate cost of treating overdose in the ED: $3,640

Approximate treatment cost for patients admitted: $29,497

2012
ODH provides funding for a pilot Project DAWN (Deaths Avoided with Naloxone) in Scioto County.

2013
ODH provides funding for Ross, Stark, Hamilton Counties

SB 57
Signed by Governor July 2013

2014
HB 170
Signed by Governor March 2014

HB 483
Signed by Governor June 2014

2015
HB 4
Signed by Governor July 2015

HB 64
Signed by Governor July 2015

2016
ODH provides funding for Hancock, Huron, Licking, Morrow, and Clark Counties

HB 110
Signed by Governor June 2016
Fentanyl Health Alert and EpiAid Investigation

Health Alert From the Ohio Department of Health
September 24, 2015

Summary

Preliminary Ohio Department of Health data show that there were 502 fentanyl-related drug overdose deaths in Ohio in 2014, and at least 98 fentanyl-related deaths in 2015. By comparison, just 84 drug overdose deaths involved fentanyl in 2013. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the effects of overdose occur quickly, and critical minutes may be lost in the emergency room because fentanyl is not detected in routine toxicology screenings.

Background

Fentanyl, a Schedule II synthetic painkiller that is 30 to 50 times more potent than heroin, is often mixed with heroin to produce a stronger high, according to the Centers for Disease Control and Prevention. Fentanyl-laced heroin has been blamed for dozens of deaths across the United States this year, including 58 confirmed deaths in Detroit and 39 deaths in Baltimore. This year, fentanyl-related overdoses have also been reported in Virginia, Vermont, and Wisconsin.

The Ohio deaths involved 76 men and 22 women, ranging in age from 18 to 62. Eighteen deaths occurred in Butler County, 13 deaths in Franklin County, 11 deaths in Hamilton County, and 11 deaths in Summit County. There were 2 deaths in Brown County, 8 deaths in Clark County, 3 deaths each in Clermont and Cuyahoga County, 2 deaths in Lawrence County, 6 deaths in Lorain County, 4 deaths in Montgomery County, 3 deaths in Stark County, 2 deaths in Trumbull County and 4 deaths in Warren County, Adams, Gallia, Lake, Lucas, Mahoning, Perry, Portage and Tuscarawas Counties all had 1 death each. The deaths occurred among Ohio residents.

These data are preliminary and may not include the most recent overdose deaths.

Recommendations
EpiAid Data Results: Geographic Distribution

- 60 of Ohio’s 88 counties experienced at least one fentanyl-related overdose death in 2014.
- Highest number occurred in large (246) and moderately-sized (200) metropolitan areas.
  - 2/3 of all fentanyl-related deaths from 8 counties
- Highest rate of fentanyl-related deaths, however, occurred in moderately-sized metropolitan areas (6.6 per 100,000 people) and rural counties adjacent to metro areas (4.7/100,000 people).
60 of Ohio’s 88 counties experienced at least one fentanyl-related overdose death in 2014.

Highest number occurred in large (246) and moderately-sized (200) metropolitan areas.
- 2/3 of all fentanyl-related deaths from 8 counties

Highest rate of fentanyl-related deaths, however, occurred in moderately-sized metropolitan areas (6.6 per 100,000 people) and rural counties adjacent to metro areas (4.7/100,000 people).
## EpiAid Data Results: Coroner/Medical Examiner Data

<table>
<thead>
<tr>
<th>Characteristic of Fentanyl decedents</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Died in a house or apartment</td>
<td>81.8%</td>
</tr>
<tr>
<td>At least 1 bystander present</td>
<td>72.3%</td>
</tr>
<tr>
<td>EMS present</td>
<td>82.2%</td>
</tr>
<tr>
<td>Naloxone administered</td>
<td>40.8%</td>
</tr>
<tr>
<td><strong>Route of Fentanyl Administration</strong></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>57.7%</td>
</tr>
<tr>
<td>Injection</td>
<td>39.5%</td>
</tr>
<tr>
<td>Drug paraphernalia at scene</td>
<td>48.5%</td>
</tr>
<tr>
<td>Drugs found at scene</td>
<td>14.3%</td>
</tr>
<tr>
<td>Track marks on body</td>
<td>26.1%</td>
</tr>
</tbody>
</table>
# EpiAid Data Results: Coroner/Medical Examiner Data

<table>
<thead>
<tr>
<th>Medical History from C/ME record</th>
<th>Fentanyl</th>
<th>Heroin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health problem indicated</td>
<td>22.8%</td>
<td>24.1%</td>
</tr>
<tr>
<td>Substance abuse problem indicated</td>
<td>82.6%</td>
<td>74.7%</td>
</tr>
<tr>
<td>Recent release from jail, rehabilitation or hospital</td>
<td>10.4%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Previous drug overdose reported</td>
<td>13.9%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>
EpiAid Data Results: OARRS Data

Majority of heroin and fentanyl decedents not prescribed opioids at the time of death (~75%)

However, over 60% of fentanyl and heroin decedents had a history of opioid prescription at some point in the 6-7 years preceding their death. Of those:

- 50% were prescribed a max opioid dose of >= 50 MME
- 35% were prescribed a max opioid dose of >= 90 MME
EpiAid Recommendations

- **Public Health Surveillance**
  - Refine syndromic surveillance of ED data
  - Continue to collect and analyze Coroner/Medical Examiner data

- **Targeted Public Health Response**
  - 8 high burden counties
  - High risk individuals

- **Facilitate Overdose Response**
  - EMS
    - Ensure availability of Naloxone
    - Raise awareness of fentanyl potency, importance of early administration of naloxone, and potential need for multiple Naloxone dosing
  - Layperson
    - Educate on importance of activating EMS early, even after administration of Naloxone
VIPP PDO Prevention

- Development/Implementation of **naloxone awareness campaign** in high-burden counties
  - [www.stopoverdoses.ohio.gov](http://www.stopoverdoses.ohio.gov)

- Provided naloxone to high-burden counties
Targeted Counties for Naloxone Awareness Campaign

[Map of Ohio with counties highlighted in red for targeted awareness campaign.]
VIPP PDO Prevention

STOP OVERDOSES.
CARRY NALOXONE.

Naloxone can reverse an opiate overdose.
Call 911 in an emergency.
stopoverdoses.ohio.gov
Public Awareness Campaign

STOP OVERDOSES.

Know these signs:
- Very pale
- Choking/ Vomiting
- Blue/ Gray Skin
- Snoring/ Hard to wake

Call 911 in an emergency. stopoverdoses.ohio.gov

Naloxone can reverse an opiate overdose.
http://www.odh.ohio.gov/odhprograms/naloxone/stopoverdoses.aspx
Public Health Surveillance

• Annual Drug Overdose Reports
• Factsheets
• New Activities (2016-2017)
  • Enhanced Overdose Surveillance
  • Leveraging use of state’s syndromic surveillance system
    • Epi Alerts based on ED chief complaint
    • Convening group to assist with development of community response plans
Epi Center Alerts

Montgomery County, OH - Drugs by Cusum EMA (Number of Records)

- All Ages + All Genders
- Cusum EMA
- Predicted
- Current Value

24-hour periods ending at 5:00am EST/EDT
Community Response Plan

Rapid Increase in Drug Overdoses Community Response Plan Outline

A. Introduction/Background:
The purpose of this plan is to offer guidance on mobilizing immediate local efforts to respond to Epicenter anomalies, when overdose visits to emergency departments and urgent care centers increase in their community. Epicenter is Ohio’s statewide syndromic surveillance system used by state and local public health agencies to detect, track, and characterize health events. The system has traditionally been used to monitor pandemic influenza, outbreaks, environmental exposures and potential bioterrorism in real-time. Epicenter gathers de-identified information on patient symptoms and automatically alerts public health when an unusual pattern or trend is occurring. This system was recently enhanced to include the ability to identify anomalies when drug related ED visits increase rapidly within a county in an effort to provide local health departments with more timely information to respond appropriately. The increase in ED visits may be indicative of an increase in suspected drug overdoses.

B. Goals/Objectives:
Immediately conduct epidemiologic investigations to confirm increases in drug overdose visits in a community and subsequently mobilize community partners and resources to mitigate the circumstances and prevent additional injuries and fatalities.

C. Surveillance/Public Health Investigation/Analysis:
LHD Epicenter alert response plan:
- LHD Epis is to ensure preventative staff should be aware of Epicenter.
- When LHD receives an Epicenter drug alert, the LHD should take the following steps to validate the alert and activate the Drug Overdose Community response plan:
  - Login to Epicenter and initiate investigation by reviewing the free-text reason for visit, chief complaint, and the electronic codes (if available), triage and/or nurses notes, as well as all electronic test results to the same emergency department or healthcare system to validate if the ED visit may be related to a drug overdose. This may include but not limited to references to “drug overdose” and “heroin.” Ideally, complete data on encounters should be reviewed and reviewed. This would include tierage and/or nurses notes, as well as longitudinal visits to the same emergency department or healthcare system. Currently, Epicenter has some initial diagnosis findings in anomalies and charts.
  - Review of the anomaly would include:
    - Identification of duplicate encounters of individuals
    - Identification of the number of overdose cases and type
    - Confirmation that the ED visit was related to a suspected drug overdose versus another drug-related condition such as alcohol or withdrawal.
  - If available, use other data sources to confirm the alert:
    - Contact county coroner’s office to verify if suspected drug overdose deaths correlate with an increase in ED visits or Epicenter alert
    - Patients with drugs with synthetic opioids (or pure heroin) can lead to a high mortality rate.
Prevent Drug Abuse Before it Starts

Start Talking!
Building a Drug-Free Future
starttalking.ohio.gov

Talking to Your Kids About Drugs

1. Talk frequently
2. Show interest
3. Be clear
4. Be consistent
5. Know the facts about drugs/alcohol/tobacco
6. Be respectful & genuine
7. They talk, you listen
8. Scare tactics don’t work
9. Control your emotions
10. Take advantage of teachable moments

Learn more about these 10 tips to help you Start Talking today at starttalking.ohio.gov
Contact Information

Mary DiOrio, MD, MPH
Medical Director, Ohio Department of Health

(614) 995-0775