



Naloxone and Emergency Medical Services: One State's Perspective and a National Legal Review

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On behalf of many others...



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Disclosure

- ✱ No academic conflict of interest
- ✱ No financial conflict of interest
- ✱ FDA Off-label use of a medication may be discussed
 - Intranasal naloxone administration

Outline

- ✱ The New York experience
 - Where we were
 - What we did
 - Where we are
- ✱ A legal review of EMS naloxone access across the US

Background

- ✱ Fatal opioid overdose in the United States is at epidemic levels
- ✱ In many areas the Emergency Medical Services (EMS) system remains the only source for pre-hospital naloxone access
- ✱ EMS personnel are generally divided into three tiers:
 - Basic Life Support—BLS (EMR and EMT)
 - Advanced / Mid-level (AEMT or EMT-I / EMT-Intermediate)
 - Paramedics

Background cont.

- ✱ The NHTSA National Scope of Practice Model includes naloxone administration at the Paramedic and Advanced level only.
- ✱ In many areas of the country Paramedic and Advanced EMS providers may not be accessible.
- ✱ Increased access to naloxone in the pre-hospital setting is likely to reduce fatal opioid overdose.

Intranasal Naloxone for EMT-B

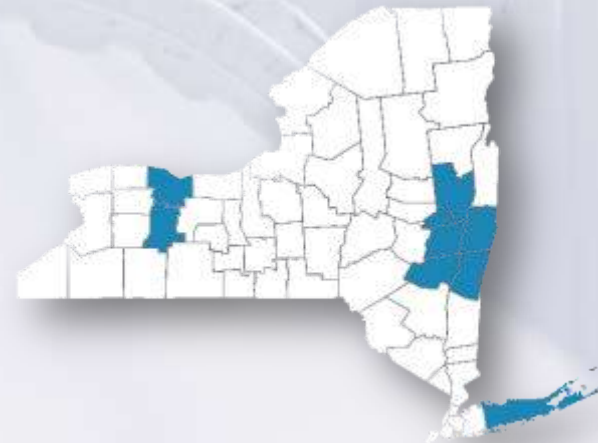
- ✱ EMT-B are frequently the first to arrive at the scene
- ✱ Intranasal atomizer reduces the potential for occupational exposure via needlestick
- ✱ Well-established off-label administration route
- ✱ No evidence suggesting negative health outcomes after experience in other programs
- ✱ No evidence of risk to personnel
- ✱ Success of previous programs, including Boston EMS

NYS EMS Programs

- ✱ Not eligible for participation in the Community Naloxone Program
- ✱ Local control
- ✱ County involvement
- ✱ Regional medical oversight
- ✱ State certification and systems

New York's EMS Response

- ✱ Disaster opioid overdoses in areas of New York with little coverage by advanced EMS providers
- ✱ NYS Department of Health authorized a pilot project to allow BLS providers to administer naloxone
- ✱ Three regions participated in the pilot – REMO, Rochester, Suffolk County



Training

- * < 90 minute standardized training includes lecture, 25 minute video, skills practice and Q&A
- * Trainer guide prepares trainers to conduct the training
- * Participant manual for all participants includes:
 - Slides
 - EMS protocol
- * Pre and post-testing of all personnel who underwent training was conducted

Some Pre and Post-test Questions

	Pretest Mean	Post-test Mean	Change
I can recognize opioid overdose	6.7	8.6	+1.9
I am comfortable treating opioid overdose	7.2	8.7	+1.5
I am confident administering IN	7.3	8.9	+1.6
Confident in knowledge of naloxone	6.2	8.7	+2.5
Should be in scope of practice for EMT-B	8.1	9.0	+0.9

10 point Likert Scale

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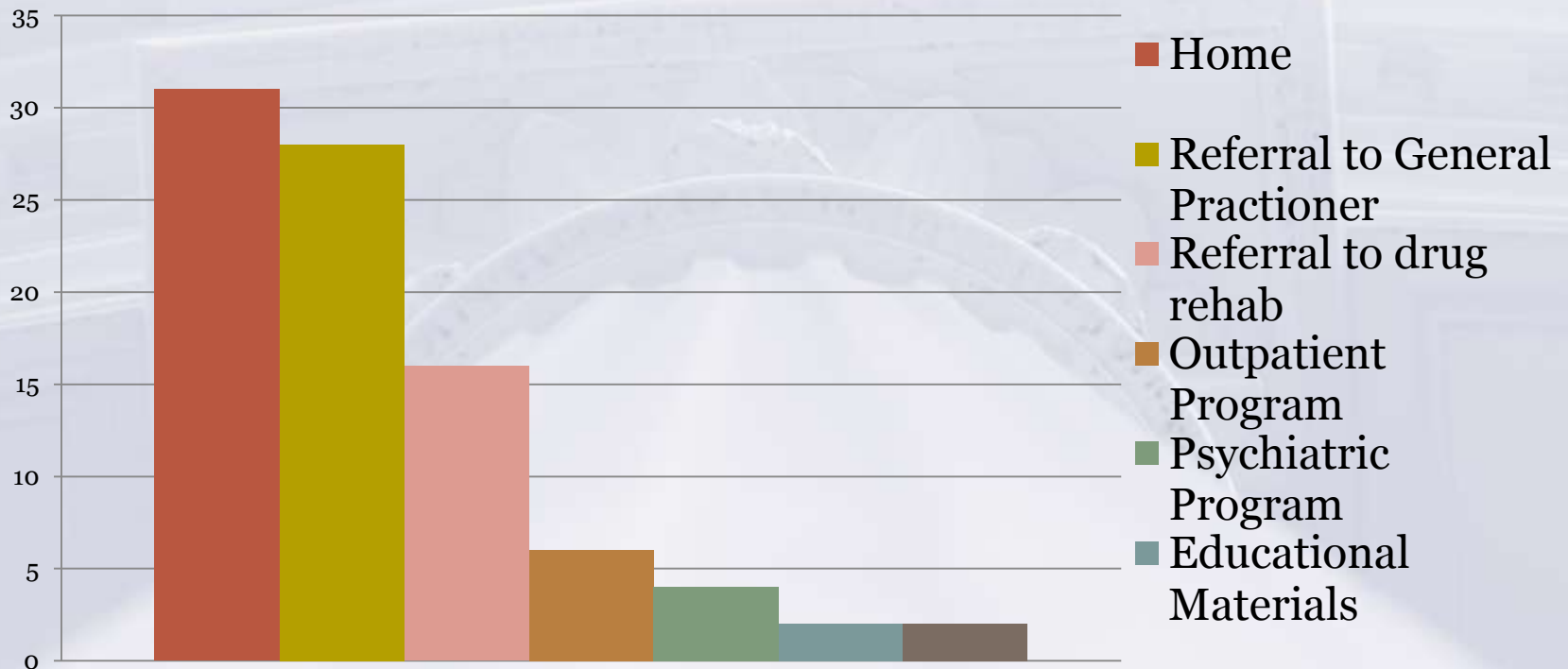
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What did we learn in NYS?

- * 2,035 EMTs trained
- * 223 opioid overdose reversals
- * Few protocol violations – none resulted in harm
- * No adverse events to patients
- * No significant hazards to EMS personnel
- * Case of reduced hazard for EMS personnel
- * Cases in Suffolk County reviewed
 - 6 of 9 hospitals contributed

Suffolk Discharge Data (N=81)

- * 80% Discharged from ED
- * 10% Left against medical advice
- * 10% Admitted (most received additional nrx in ED)



New York's Conclusion

- * Successful pilot program – 1 use per 10 trained EMT
- * Training for providers should be expanded **where useful** depending on structure of the system
 - Law enforcement
 - First response fire personnel if involved in EMS response
- * Ultimately a new addition for EMT-B scope of practice
- * Must maintain close oversight to assure new complications are quickly addressed
- * Must continue to assure safety of personnel

But What is Happening Across the US?

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SPECIAL CONTRIBUTION

Emergency Medical Services Naloxone Access: A National Systematic Legal Review

Corey S. Davis, JD, MSPH, Jessica K. Southwell, MPH, Virginia Radford Niehaus, JD, MPH,
Alexander Y. Walley, MD, MSc, and Michael W. Dailey, MD

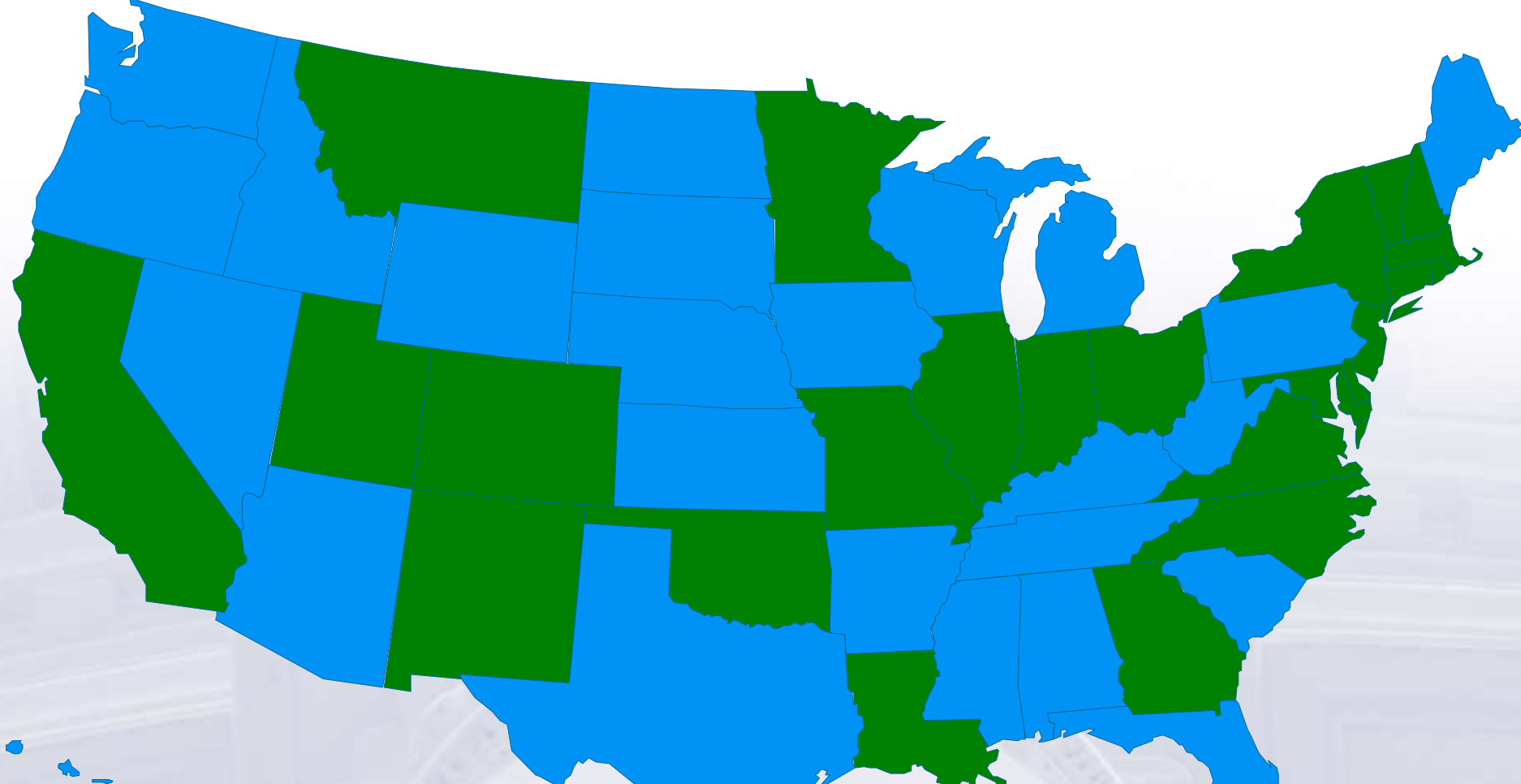
- ✿ Goal: To review the National scope of the authority of EMS personnel to administer naloxone for the reversal of opioid overdose

Methods

- ✱ Laws, regulations, and policies from 50 states, the District of Columbia, Guam and Puerto Rico were identified, reviewed and coded to determine which levels of EMS providers are permitted to administer naloxone
- ✱ Protocols governing route and dose of administration were also reviewed
- ✱ Study concluded in 11/30/2013

Results as of December, 2013

- ✱ All jurisdictions permit Paramedics to administer naloxone
- ✱ 47 of 48 jurisdictions with mid-level personnel (AEMT/EMT-I), all but one authorize administration of naloxone
- ✱ 12 jurisdictions may allow EMTs to administer naloxone
 - 12 explicitly permit EMTs to administer naloxone (CA, CO, DC, MA, MD, NM, NC, OH, OK, RI, VA, VT)
 - 4 additional states through pilot programs or agency medical director authority (DE, IL, NY, WI)



Naloxone for Basic EMT – 2014

From 12 States to 24 in 1 Year

■ Advanced or Paramedic Only ■ Basic

Results cont.

- ✱ Many states follow the NHTSA Scope of Practice Model as policy
- ✱ Additional states may allow BLS personnel or other first responders to administer naloxone as part of a separately regulated community access program
- ✱ Additional jurisdictions have expanded access since the completion of the study

Conclusions

- ✱ Naloxone administration is the standard of care for AEMT and Paramedic personnel, but in many areas advanced providers may not be available
- ✱ Changing State law, regulation, or protocol to permit all levels of EMS providers to administer naloxone when clinically indicated would likely save lives and resources
- ✱ Updating the NHTSA National Scope of Practice Model to include naloxone administration would be beneficial

Thank you to:

The thousands of EMS providers and instructors in NYS who demonstrated that treating opioid overdose was a BLS skill...and also:

- * Lee Burns, EMT-P, Director, Bureau of EMS, NYS DOH
- * Richard Cotroneo, AIDS Institute, NYS DOH
- * Jeremy Cushman, MD, University of Rochester
- * Corey Davis, JD, MSPH, Network for Public Health Law
- * Robert Delagi, Suffolk County Department of Public Health, NY
- * Sophia Dyer, MD, City of Boston EMS
- * Emma Furlano, MS3, SUNY Stony Brook
- * Mark Hammer, AIDS Institute, NYS DOH
- * Virginia Niehaus, JD, MPH, Network for Public Health Law
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- * Linda Sinclair, MD, Albany Medical Center
- * Jessica Southwell, MPH, North Carolina Institute for Public Health
- * Sharon Stancliff, MD, Harm Reduction Coalition
- * Alexander Walley, MD, MSc, Boston University
- * And the countless others whose work contributed to our success