The Opioid Epidemic: Do or Die

We *DO* something or they will keep *DYING*!

The Problem:

Nationwide -

- During 2013 – 2014 the number of drug products obtained by law enforcement that tested positive for fentanyl increased by 426% and synthetic opioid-involved overdose deaths (excluding methadone) increase by 79%.
- In March and October 2015, the DEA and the CDC, respectively, issued nationwide alerts identifying illicitly manufactured fentanyl (IMF) as a threat to public health and safety. IMF's are being mixed in unknown concentrations with heroin.
- The fourth quarter of 2016 the DEA laboratory system noted a decrease in fentanyl seized from approximately 65% to 50% due to a 300% increase in furanyl fentanyl.
- Aside from fentanyl, there have been 9 other IMF'S identified aside from fentanyl (50- 100 times more potent than morphine) and carfentanil (greater than 10,000 times more potent than morphine).
- This generation's AIDS crisis? In 2015 52,000 people died of drug overdoses; the peak year for AIDS related deaths was 51,000 in 1995. With our present crisis, there is no end in sight!

Local –

- In 2015, Florida Heroin Deaths escalated to 779, a 74% increase from 2014; and a 2400% increase from 2010. Fentanyl deaths increased over 69% (538 to 911) from 2014-15.
- In 2015, North Florida Heroin deaths rose to 45, a 181% increase from 2014; and a 10,000% increase from 2010. Fentanyl deaths increased nearly 70% (33 to 56) from 2014-15.
- Overdose victims – 2015 - JFRD responded to 2,114
  2016 – JFRD responded to 3,114
- 911 calls have tripled.
- In 2015 – cost of transporting OD victims was $1,895,388.00; 2016 cost $3,143,376.00 with current trend projections reaching $4,451,124.00 in 2017. JFRD is transporting one OD every 2 hours.
- Naloxone use by Paramedics has increased fivefold with one-tenth of medical supply budget spent on naloxone.
- In 2016 Duval County had 106 murders and 464 overdose deaths (up from 201 in 2015).
- Age distribution of drug related deaths in Duval County is 20 to 60 years old with 86.9% being Caucasian.
- The morgue is continually over capacity!
- A sampling of urines from a lab servicing the nation analyzing positive heroin samples in Florida from 2013 to 2016 found a 56.41% increase in associated fentanyl positivity (not testing for the other IMF's).

This is an epidemic that is growing faster than we ever imagined. The cost in lives and money is pushing the envelope of everything the system has to offer. We need a solution now!!!!

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Phase I of a Solution: A Pilot Project.....Project Save Lives

GOAL: 1) Create a seamless, collaborative, stabilization and treatment solution between three key entities: UF Health Jax (ED and Dept. of Psychiatry), Gateway Community Services (GCS) and River Region Human Services (RRHS); 2) Reduction in opioid-related overdoses, recidivism and death. 3) Identify all supporting partners: Already identified – UF Health, GCS, RRHS, LSF Health Systems, Drug Free Duval, Florida Alcohol and Drug Abuse Association, Jacksonville City Council, JFRD. More to be identified.....

Pilot Model (Phase I):

- ED staff triage and stabilize the patient. Urine drug screen obtained.
- Recovery Peer Specialist (RPS) to speak with family/identified significant other(s) – offer support and educate regarding the next steps and resources.
- Once stable, RPS to speak with patient regarding his/her role and the next steps of the process.
- SBIRT (Screening, Brief Intervention, and Referral to Treatment evidence-based practice tool) administered by Mental Health staff in ED. Drug Free Duval will donate a web-based version of SBIRT to the ED.
- Assessment performed by Mental Health staff in ED.
- UF Psychiatric Residents consulted to ED for medical/psychiatric evaluation.
    - If ED/hospital Suboxone induction is indicated; performed by UF Faculty/Resident/ARNP/PA. Refer to GCS or RRHS residential or outpatient services. If referral to residential service, RPS to transport to RRHS or GCS residential services. If outpatient treatment is indicated, RPS to meet with patient next day for transport and/or accompany to GCS, or RRHS outpatient referral appointment.
    - If ED/hospital Suboxone induction not indicated; RPS to transport to GCS detox/stabilization. GCS to determine need: Suboxone, Vivitrol or Methadone; Residential or outpatient treatment. Referral, when ready, to be made to GCS or RRHS services indicated.
    - If ED/hospital Suboxone induction and detox/stabilization not indicated; refer to GCS/RRHS for Vivitrol/Suboxone outpatient treatment or RRHS methadone treatment. RPS to transport and/or accompany the next day. Narcan with education given to family/SO.
    - Patient refuses treatment; RPS/Mental Health staff/Resident to educate family regarding resources and the Marchman Act process. Narcan with education given to family/SO.

Phase II: Expand model to all area ED's and other treatment providers.....**A citywide seamless support network.**

Phase III: Include mental health and other substance use disorders entering area ED's via an expanded stabilization and treatment model.

The Recovery Peer Specialist is a critical position in this model!

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The Needs for Phase I:

- Education of JFRD
- Training of ED staff.
- SBIRT training (8 hours) of staff assigned.
- Training and hiring of Recovery Peer Specialists (initial training already offered by LSF). First group is graduating April 28th. Further specialized training for the pilot is to be developed and offered by Dr. Pomm.
- Expand capacity of residential beds by 30-40 between GCS and RRHS (10-20 each).
- Create a flexible residential model that can be utilized for stays from days to weeks, not just weeks to months. Discussion of this residential model change is already in process.
- Expand capacity of outpatient staff at RRHS and GCS as needed.
- Data collection and analysis for Pilot will be managed by UF Health Jax Department of Psychiatry.
- Tweaking and perfection of model before Phase II.
- Develop research needed to access funding sources. Local, state and federal.

Partial Budget for Phase I:

- SBIRT training - $1,000 per staff plus $50 annual fee for all users (one per shift).
- Salaries for RPS at approximately $25,000 per RPS – one model is 24/7 coverage based out of RRHS/GCS residential facilities with priority given to ED calls. Fully functioning model requires 5 per agency (total of ten).....$315,000 incl. fringe.
- Full expansion of bed capacity to 40 – $2,400,000 per year. Pilot might begin with bridge money for 2-3 months worth of expansion.
- Research budget needs....?
- Urine drug screening in ED.....?
- Suboxone for ED.....? If use buprenorphine.....$4.00 per 8mg pill. Average stabilization dose is 16mg per day.