The Opioid Crisis—How Can Coalitions Help?

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(Originally published in 2017)

Any disaster that killed 100 people today in the United States would be sustained front page news. And yet, this is an everyday occurrence: 3,000 people will die this month, the same number will die next month, and by the end of 2017 approximately 12,000 additional people will die from opioid overdoses. This fact is somehow overlooked in this sneaky epidemic.

The causes are many. Over-prescribing of narcotics for acute and chronic painful conditions resulted in countless patients habituated or addicted to narcotics. Cheap heroin flooding into U.S. markets and wide availability made it easier to access the drug and get hooked. Severe withdrawal symptoms make it difficult to give up. And synthetic derivatives that are easy and cheap to produce, but can be far more potent than the "original" product (and resistant to usual reversal agents like naloxone), have resulted in a dramatic increase in deaths.

While at press time, no formal declaration had been made, in August, President Trump claimed that the opioid crisis is a "public health emergency." The question for our disciplines is what does that mean, and to what degree can the tools we use to respond to infectious disease epidemics and conventional disasters be used to mitigate this emergency?

Multiple states and Native American communities have declared public health emergencies. The advantages and the power afforded under these declarations differ from state to state. Often, the declaration involves the ability to shift resources to the problem, change the legal landscape, and draw the attention of lawmakers to the issue.

Historically, use of naloxone was limited to advanced life support providers and hospitals. There has been a major effort to ensure that naloxone is available earlier—providing it to drug users, their loved ones, and first responders, and altering the legal requirements and liability. These interventions have certainly saved lives, although the doses of naloxone may be insufficient to reverse the newer agents and should not be seen as a "safety net." In addition, stocking, replacement, and other issues continue to challenge these programs.

Controversy surrounds potential dangers to first responders from the new synthetic opioid derivatives. Some law enforcement officers and emergency department nurses have experienced symptoms when handling articles contaminated with powdered narcotics. In many cases, symptoms experienced by these responders are not

Due to the increase in 911 calls in Regions 8 and 9, our first responders exhausted their supplies of PPE, especially their nitrile gloves. I had to make a request to our coalition partners for CPR face shields, adult ambu bags, and other equipment to handle this influx.

—Jackie Campbell, RN, Health Care Coalition Coordinator Region 8/9 (KY)

The opioid crisis has put such a demand on the county coroners in some of the rural communities of northern Kentucky that the Hospital Preparedness Program (HPP) Region 7 coalition acquired this past summer two additional body coolers to add capacity and help deal with the surge in remains until they could be processed. We bought two more for rural county coroners in HPP Region 15 within Central Kentucky for the same purpose. While we are dealing with an unusual surge problem, this enhances the overall capacity of the health care preparedness system, should the next round be associated with a highly contagious disease outbreak or a terrorist event. People assume that all hospitals and communities have a morgue that can store the deceased, but that isn't always the case—particularly in rural areas. Not every county has a hospital, and it may only have the ability to store one body for a short period of time. When the cause of death is undetermined, or needs to be confirmed, the deceased may have to be sent to a state facility for the Medical Examiner to review. The other fact many don't realize is that in some states, the County Coroner could be an elected official, not necessarily an undertaker or someone who is affiliated with a local facility that examines or processes remains.

—Dick Bartlett, Emergency Preparedness Program Coordinator, Kentucky Hospital Association

consistent with those typically associated with narcotic exposure, but intoxication is possible when the substance is inhaled or ingested. Transmission is not possible through intact skin, but the substance can enter a small cut or scrape. During patient care, providers should always be wearing appropriate examination gloves. Although the risk of inhaled powder during patient care activities is not defined, and is likely very low, first responders should be careful not to aggressively brush powders and should strongly consider use of a filtering face mask. Simple masks offer some protection and should be used if the recommended N95 or other respirators are not available.

Once the patient is medically stabilized at the hospital and observed to ensure that the opioid effects do not outlast the naloxone effects, the patients are often discharged without specific follow-up plans. Some hospitals do provide Narcan kits, and some share patient education and referral materials. In general, there are too few treatment programs for narcotic addiction and many users live too far from approved programs. Physicians need special licensure and training to provide addiction services and often do not have the resources or training to address the needs of those addicted. In addition to treatment, major social interventions and support are usually required to help the user avoid relapse, and to navigate the health insurance issues associated with treatment.

A comprehensive look at the threat, programs, information, policies, and stakeholders at the local level is needed if the community or region is to have a unified approach to this problem. Fortunately, HCCs can bring EMS, hospitals, public health, law enforcement, and emergency management together to do just that, as is evidenced by the quotes that accompany this article.

Heroin and Norco use are a major issue in Region 6 (MI). Fentanyl is also suspected in numerous deaths. HCCs are working with hospitals, EMS agencies, and medical control authorities to make Narcan available throughout the region and to give hospitals the education and resources needed to deal with this major issue. Region 6 has included nasal Narcan in all medical first responder vehicles and in the EMS bags carried throughout the region.

—Jerry Evans, MD, Region 6 Health Care Coalition Medical Director

Potential HCC actions may include:

- Sharing information and creating situation reports and incident action plans
- Providing a forum for discussion of the issue among the stakeholders and including legal counsel and political officials
- Collecting public health, hospital, law enforcement, and EMS data to determine the epidemiology of the problem in the area
- Collecting information about resources in the area in one place
- Determining current programs and policy for naloxone use and options to create consistency within the region
- Ensuring that consistent information is given to overdose survivors at the hospitals to facilitate follow-up
- Facilitating complementary interaction between social services and treatment programs in the area
- Developing concise, tailored provider and public messaging around the epidemic in the area
- Creating a strategic plan outlining the contributions and roles of the involved disciplines
- Weighing the advantages and disadvantages of emergency powers and declarations
- Evaluating potential liability and indemnification issues based on local and state laws and ordinances

Coalitions do not have a required role in the opioid crisis. But we do have the tremendous opportunity to showcase how our membership and our structure can be used to benefit the community in an emergency that is insidious and claims far more lives in many of our communities than any recent infectious disease outbreak or mass casualty event. It also affords the opportunity to increase HCC visibility with potential partners, including jurisdiction and political officials. Hopefully, engagement on issues such as these can lead to opportunities to involve the key coalition partners in other efforts to prevent injury and death in the community.

There are no short-term answers to the opioid problem. Control of the flow of drugs is difficult, reaching the victims in time to intervene is unpredictable, and getting the patients the treatment, follow-up, and resources that they need to quit is complicated, even when it's possible. This crisis will require a dramatic commitment of resources at the federal, state, tribal, and local levels for us to effectively reduce these deaths. We all have a role to play, both as responders and advocates. ■

As with much of Michigan and the nation, Region 5 has witnessed an explosion in nonfatal and fatal opioid overdoses. The coalition infrastructure is well poised to both gather data and push out information to partners, particularly hospitals, EMS, and law enforcement agencies. With the emerging use of synthetic opioids, the 5th District Medical Response Coalition also serves as a clearinghouse of information for responders concerned about safety and proper personal protective equipment for dealing with these incidents.

— William Fales, MD, FACEP, FAEMS
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— Medical Director, Kalamazoo County Medical Control Authority
State Medical Director, Michigan Bureau of EMS, Trauma, and Preparedness

Access the ASPR TRACIE fact sheet Opioids: Frequently Asked Questions for more information.