Rachel Breidster (Moderator): Hello and welcome to Public Health Live, the Third Thursday Breakfast Broadcast. I am Rachel Breidster and I’ll be your moderator today. Before we get started, I would like to ask that you please fill out your online evaluation at the end of the webcast. Continuing education credits are available after you take our short posttest and your feedback is helpful in planning future programs. I also want to let you know that the planners and presenters of Public Health Live do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity and no commercial funding has been accepted for this activity. As for today’s program, we will be taking your questions throughout the hour by phone at 1-518-880-3516 or by email at phlive.ny@gmail.com. Today’s program is Preventing Harm: Addressing and Preventing Opioid Addiction and Overdoses and our guests are Val White, the Deputy Director for Surveillance, Prevention, Drug User Health and Administration at the New York State Department of Health AIDS Institute. Steve Hanson, the Associate Commissioner of the Division of Treatment and Practice Innovation in the Office of Alcoholism and Substance Abuse Services (OASAS). And Sharon Stancliff, the Medical Director for the Harm Reduction Coalition. Thank you for joining us.

So good morning everyone, we have so much to cover today. But I would first thank you all for joining us today.

All: Thank you

Val White: Good morning.

Sharon Stancliff: Yup, very good.

Steve Hanson: Glad to be here.

Moderator: Right, so Val let’s get started if you would talk to us about what are main objectives that we hope to accomplish in the hour that we have today.
Val: Sure, thank you. By the end of today’s presentation everyone would be able to: Describe the scope of the public health problem of overdose from heroin/prescription opioids; Restate at least three actions that have been used in local community-based responses to opioid dependence in New York State; and Name at least two actions that response personnel can take to link individuals into care and treatment.

Moderator: Great, thank you. Now Sharon, with that in mind and given the high profile nature of our topic today, can you share with us who is being impacted by heroin and opioid overdoses and let’s start by looking at US as a whole.

Sharon: Sure. Opioid overdoses are really affecting many populations. It’s urban, but primarily rural and suburban across the country. It affects all age groups, so it’s a very pervasive problem. And in the slide you are looking at, you can see opioid analgesic overdose stats in blue and you can see the dramatic rise from 2000 up through 2014. You notice in a couple years ago, we thought we were really plateauing out maybe some of our interventions are beginning to work. They probably are, but there’s an increase there. And very disturbing is the increase in heroin-related deaths, which while there is less people taking heroin across the country than prescription opioids. We’re seeing a really dramatic rise in those deaths at this point.

Moderator: Now keeping that information in mind Val, how does the problem with opioid compare with heroin here in New York State?

Val: Thank you, this slide shows a 5-year trend of heroin and opioid analgesic and you can see that the blue bar, which is the heroin, increasing dramatically in each of the 5 years. There’s increasing in general, but the heroin increases is the most dramatic. It is also important to note that, it’s not all mutually exclusive data as well.

Moderator: Now keeping that information in mind Val, how does the problem with opioid compare with heroin here in New York State?

Steve: Well there are a couple things Rachel, one of the biggest things is that along with the heroin use you seen a huge problem with prescription opioid use. We hear stories everyday of young people being prescribed prescription opioids due to a sports injury or surgery becoming dependent on that and the switching to heroin if they have difficulty obtaining their prescription drug. The availability of heroin is much greater today than it was a few years back. And part of with Dr. Stancliff was saying, we are seeing a tremendous increase in the number of
overdose deaths that are occurring in a younger age demographic and also not just in city centers but moving out into rural and suburban areas. That are some of the biggest issues that are out there today.

**Moderator:** Now Sharon, what does this look like where the Harm Reduction Coalition is located, does the epidemic look any different in New York City than the rest of the state?

**Sharon:** Well New York City has lagged behind in per capita deaths, but we are experiencing an increase in overall deaths from drugs primarily opioids, both including the prescription opioids and heroin. We are seeing, up until recently, New York City wasn’t seeing very much fentanyl mixed in, but like Erie County and like much of the State at this point, we’re beginning to see fentanyl creeping into the heroin. Up until recently, was about 4%, this year it’s left up to about 15% of the opioid overdoses. And this is very disturbing because fentanyl is really hard to control because it’s so potent.

**Steve:** And another aspect of that is when people are buying it on the street, they don’t know if it is heroin or heroin fentanyl mix. And when somebody thinks they’re getting heroin, but is getting something that is 10, 20, 50 times more potent, there is where you have your big risk of having an overdose.

**Moderator:** I see. Now Steve let’s talk about heroin as compared to other opioids. Are there differences in the impact between them?

**Steve:** Um, what we see are a number of different changes in what’s going on. As the chart with overdosed deaths shows, prescription opioids can count for many more overdose deaths currently than due to heroin. But we’re also seeing like that other substances are coming into play with that and we’ve seen over the past 10 years changes in our admissions into OASAS treatment programs. Some areas increasing dramatically over the number of heroin admissions than what they had historically.

**Moderator:** And now, you mentioned earlier there are some differences, one of the things we are seeing is the changes moving from city centric to kind of affecting suburbs and rural areas. Can you talk about some of those differences that exists between the rural and urban?

**Steve:** Well traditionally, New York City has had a fairly steady heroin problem. It decreased in terms of the number of admissions we seen from OASAS. But what we seen in the rest of the state is that now it increase 3-fold, both from Long Island and Upstate New York, in terms of where Upstate admissions for heroin are the same as they are for New York City. And that’s a big change, in terms of the location, the portion of the population that’s using that.
**Moderator:** And does this hold true for other opioid admissions as well?

**Steve:** Um, traditionally, the prescription opioids were more of an Upstate problem than a New York and Long Island were significantly less. They’ve been trending down a little recently, primarily we think from the positive impact from the ISTOP program has had on cutting down on overuse of prescriptions.

**Moderator:** Now Val, now that we have a sense of the scope of the problem, let’s discuss how New York State has responded. And each of you have led a role in your organization as to how the state is trying to address this. So how has the response been organized, why has it been organized that way?

**Val:** Thanks Rachel. Due to the scope of the problem, multiple partners are needed to each do their own expertise and their own perspectives to helping to combat the epidemic we are having right now. The New York State Department of Health AIDS Institute began the Opioid Overdose Prevention Program back in 2006. And it was a very small program at that time. It really is the foundation from what all the programs we do today is built off of. But in 2014, the commitment from the Governor really spurred a lot more interest and a lot more collaboration amongst many state agencies. So that’s when we began working more closely with OASAS and Division of Criminal Justice Services. We worked with the Harm Reduction Coalition back in over a decade or a couple of decades on many issues related to drug user health, from syringe exchange to overdose prevention to any drug user issue that the AIDS Institute is involved in. But they’ve done a very active role in overdose prevention in the last couple of years, they’ve stepped up a lot. We also are working with the Department of Correctional Services, State Education Department, New York City Department of Mental Health and Hygiene, we try to make sure that we’re all on sync and we all are doing things that are consistent across the state, so collaboration has really been a key. Albany Medical Center has worked with us on many things related to law enforcement as well as all the registered programs that I am going to talk about in a couple of minutes that all play a part as well.

**Moderator:** So it all sounds certainly very comprehensive, which I would imagine is necessary given like you said, the scope of the problem. Did either of you want to add anything to that? Or do you feel like Val

**Sharon:** I think she covered most of it. We are sort of the capacity building folks. They pull us in, both OASAS and the state Department of Health to go out and help all of these different sorts of agencies actually implemented the programs so it’s been very exciting.
**Moderator:** Great, now Val can you give us a brief overview of the different populations that you’re working with?

**Val:** Sure. As I mentioned it started really with the community programs back in 2006. And we have registered programs across the state that can provide opioid overdose prevention trainings. Right now, we have over 300 programs that are registered around the state. It’s also permissible under the scope of practice for EMS to include intranasal naloxone as well. That started a few years ago as well. And we’re gonna talk a little be later in the program, but law enforcement has been one of the key populations that we’ve been working with in the last couple of years because they’re often the first ones on the scene, so they encounter the overdose victim and you don’t wanna have to wait for other help to come.

**Moderator:** Absolutely.

**Val:** So we had to have them trained so they are equipped with intranasal naloxone and they could respond immediately and save many lives, we’re gonna talk about more. We’re also as I mentioned, gonna be working with Department of Correctional and Community Supervision, we’re now doing overdose prevention training in 9 correctional facilities around the state, which is a great need because there’s such a huge number of overdoses that occur the first couple of weeks after somebody is actually released from prison. We worked with SED over the last year, so that school personnel could be trained as well and to have naloxone available in the schools in case an overdose should occur. Our latest one we are working on really extensively and we’re gonna talk quite a bit about is pharmacy. So that pharmacy, pharmacists will be able to dispense naloxone around the state.

**Moderator:** So a really multi-faceted approach here to try to reach a variety of different populations. Now can you talk to me about the overdose program, how it started and what it involves?

**Val:** Sure. It started as I mentioned back in April of 2006 under Public Health Law section 3309. We have more than 300 programs around the state. All 12 of the addiction treatment centers that are run by OASAS are registered programs. Also 23 syringe exchange programs that are located around the state are also registered programs. And again, it’s just different points of access. Some people go to the syringe exchange programs, other people would go to an ATC. So it’s about meeting, about having something available for everyone depending on their needs and where they would go to access services. We have a website that’s listed on the slide and if you go to the website, we actually have a map that you can click on different regions of the state and it shows where the programs are around the state with contact information and addresses. There’s also a calendar
of trainings on the website, so that if someone is looking for a training in their area they can one that’s close by.

**Moderator:** Excellent

**Val:** We’ll put those out about 3 months ahead, so people can have an idea of where they can be trained if they need to be trained. To date, we have trained over 112,000 individuals around the state, which is a huge number and about 3,500 naloxone reports have been received. We think that’s definitely undercounted. Not everybody that does administer naloxone does send the reports in.

**Moderator:** Sure.

**Val:** But 3,500 reports and over 1,800 of them are from members of the community. So we are definitely saving a lot of lives with the program.

**Moderator:** Excellent. Now let’s talk a little bit about who are the responders you are trying to reach through the program?

**Val:** So responders can be opioid users, who themselves can be at risk for an opioid overdose. It could be family and friends, a lot of times its family members that actually call because they have loved ones that they know are using drugs and want to make sure they have naloxone available should they need it. It could be staff at agencies that could encounter people that are at risk and having it on-site at their facilities is really important. It sometimes is just interested members of the public that think it would to have it just in case they encounter it. The more we do of this, the more stories we hear about people who happen to just run into it in their neighborhood when they’re at an event. It just seems to be happening in more and more places. And the guidelines indicate that people that are trained and can get the naloxone need to be 16 years of age or older.

**Moderator:** Now Sharon, what types of agencies or organizations can become registered overdose prevention providers?

**Sharon:** Well it might be a question of which one can’t at this point, it’s really widespread. Any community-based organization, most of any health care facility that’s governed under the state, the departments of health can, law enforcement, pharmacies, schools, universities, it’s really widespread. And our role it to help them do everything from initial registration, which is actually pretty simple but sometimes help is needed, do some outreach to find the right programs, and once they are signed up, we assist them in figuring out how to fit it into their program. So we got a lot of experience with different programs, so we can train the trainers,
help them develop how they can best reach their participants, patients, clients at risk.

**Moderator:** Now it seems like law enforcement personnel are a critical partner in these efforts and you all have spoken about that a little bit, can you tell us all about who is involved in the effort to train and the training of law enforcement personnel receives because they’re not usually thought of in terms of having a public health role. Can you talk about that?

**Sharon:** Sure. I like to think of them in a public safety role. That is part of law enforcement for certain. So it’s been really great to partner with many many folks, OASAS, Department of Health, Albany Med has been really critical in working on this, and then the registered programs. So we been able to build some bridges a little bit between law enforcement and syringe access programs. We’ve tailored the training programs for law enforcement to really fit their needs of how to recognize an overdose and respond to it, but also a little bit how to understand a little bit better some of the problems facing people that use drugs. And we do have some other public health laws that relate to for example, syringe access and we have the Good Samaritan law. It’s a very compact training that we’ve taught to the trainers and trainers in law enforcement and now they’re on their own.

**Moderator:** Excellent. Now Val you mentioned that schools play an important partner in this role. And given that young people are so impacted by the epidemic, it makes sense that we are reaching out to the schools. Have you found that that’s controversial at all and how have you been able to partner with schools successfully?

**Val:** We really haven’t found it controversial. I think everybody just understand you know how serious the epidemic is. There’s also a lot of education that we’re doing along with the training, so that counselors or teachers or people that work with kids all the time can actually recognize maybe if somebody is actually drugs. So that hopefully, long before we get to an overdose situation, you know you can be a little bit more aware. But we work closely with the State Education Department and OASAS and the Harm Reduction Coalition, we all really partnered to develop guidance for schools. It’s a web-based training, you know we worked a lot and there’s a lot of resources out there. I mean SED has a website that’s really extensive and that schools can actually go on and get sample policies and procedures. And we, it started just last year, so it’s relatively new. We had to do some regulations and some guidance, but we’ve got 29 registrations in and that’s over 113 different schools around the state. And the last few months, there’s been a real increase in the number of schools you know that are signing on. Cause I think as I mentioned earlier, everyone has been realizing that there’s so many
deaths that are occurring and I mean just having naloxone available at the school and on-site just in case it’s needed and having people in the school trained, so they could administer if they had to has been really beneficial.

**Moderator:** Excellent. Now Val, I think our audience would like to hear more about the number of responders that you’ve trained. So can you talk a bit about that?

**Val:** Sure, back in October of 2014, we made it a requirement that all our registered programs send us reports on a quarterly basis of the number of people being trained. So for the 12-month period from October ’14 to October ’15, over 43,000 responders were trained by registered programs. And it’s a combination, it is community members, there’s still a lot of community members being trained. Law Enforcement, which again the numbers are huge. We actually trained over 8,400 Law Enforcement officers around the state and firefighters as well. Some firefighters were trained around if they are EMS, so they have the training. But we’ve been focusing a little more on the non-EMS firefighters and training them as well. So you know, this a 12-month shot of October to October with 43,000, but I mentioned it is over 112,000 that has been trained around the state.

**Moderator:** That’s really excellent to hear. Now Sharon, can you talk a bit about naloxone, how it’s been administered, who’s administered it, can you share some of that information?

**Sharon:** Sure I can tell you a little bit of what we actually know. There’s both intramuscular and intranasal naloxone being used around the state. It seems to be switching more to intranasal, but there’s still especially needle exchanges, using intramuscular. And the chart shows the numbers of reports we’ve gotten and some of it is, it’s really, it’s all valuable information, but some of it might be a little bit misleading. As you can see, let’s look at the 2015, we’ve got 504 responses from the community reporting they got it in needle exchange or drug treatment, 963 from law enforcement, which is really exciting and then the new firefighters are coming on. Now this is all great information, law enforcement are mandated to report, so that’s extremely useful. The community, it’s been really hard to get the community to send in their reports. But briefly I want to mention that studies done by the city, the Department of Health in the city on people that were trained at syringe exchange programs and a couple of methadone programs and they talked to them for 3-6-12-months over the course of a year, those community members used about 22% of the naloxone that was distributed to about 400 people. So that’s a dramatically higher rate that what was seen by voluntary reports.
**Moderator:** Interesting. So now can you talk to us about an example of what would be a very high risk population and what is New York State doing to try and target the help that those populations are receiving?

**Sharon:** Rachel this is a really exciting program. As Val mentioned people that are released from prison are extremely at high risk of overdose particularly after the first two weeks of incarceration, but continuing to be much higher rates than the general population. You can see it on the bar graph there, where the dark purple, I mean the dark green is the first week after incarceration overdosed deaths. So we’re talking about a very high risk population and we’re also talking about a population that’s maybe they’re going out into communities that are high risk communities. So we want to address both that they might relapse and die over an overdose, but we’re also telling a population that’s really stigmatized that we’re giving you a tool that can really save a life. So that’s really exciting. At this point, there’s 22,000 releases a year and the Department of Corrections and Community Supervisions in concert with the Department of Health has committed to training all soon-to-be-released inmates and parolees on the use of naloxone and offering them a kit at the door when they walk out the door. In addition, they also have a standing order within corrections saying that ‘should there be an overdose, a suspected overdose, nurses may without a direct order from a physician deploy naloxone immediately’, which I think is a big step.

**Moderator:** Absolutely. Now can we delve a little bit deeper into the training and how it works, can you tell us more about who is being trained and how do you actually do the training?

**Sharon:** Okay, it’s still evolving. We’ve been doing it for about a year, 9 facilities so far. But we trained the trainers at the facilities that train the inmates. We just recently completed a video that will be very useful on that can be found on our website very soon. And we’ve also been training the staff, who’ve much of the staff comes from communities where they’re having overdoses. So while the correctional officers don’t carry it within the facilities, they can carry it at home where they found it useful. And we’re training parolees as well, and finally we are working on getting family members trained as they come to visit. At this point, we’ve trained over 2,400 inmates and about a third of them have accepted kits to go into the community, not all have been released yet. There’s been extremely high uptake among the staff members, it’s not 100%, but maybe 80% and we’ve been trained about 500 parolees and about two thirds of them have taken kits. So these folks are going out there and hopefully saving lives and I hope that we’ll track some of them.
**Moderator:** Great. One of the more recent initiatives is to try and expand access of Narcan or naloxone through pharmacies, how does that work?

**Sharon:** Well under the law that was passed in 2014, pharmacies can be now be issued standing orders whether through their own pharmacy prescriber or through a variety of us in the rest of New York State, the Department of Health or the Harm Reduction Coalition. They can have a standing order, so if you walk into a pharmacy looking for naloxone you will be able to get it perhaps with your insurance perhaps without. But it would look to you as if it is over-the-counter, actually behind that there is a prescriber. We’ve designed a training that is very brief for the pharmacist, so that you actually know how to recognize an overdose and how to use your naloxone, referrals to places for more extensive training or when the pharmacist has more time a little more from the pharmacist.

**Moderator:** Now you talked a little bit earlier about the intra-, intra-venous, or intramuscular versus the intranasal, can you talk about the forms that Narcan or naloxone takes?

**Sharon:** Sure. We’ve got 4 formulations that are available right now. The one that’s most common you can see on the upper left hand side that is a, we need to do a little preassembly for that. That is a intranasal product, that is totally generic, therefore never presented to FDA, not approved by FDA but widely distributed by many departments of health. On the right is the most inexpensive one, it is intramuscular and on the bottom two there is a device that talks you through it that’s intramuscular that kind of fun and then the newest product is on the lower right, which is a intranasal device. So all of these four may been seen on various parts of New York State and the rest of the country.

**Moderator:** Excellent. Now part of what we’ve been hearing about is the over prescription of opioid pain killers and the efforts to reduce those efforts and working with physicians to try and curtail that and establishing take back bins, take back programs. Can you talk a little bit about what support is out there for those education efforts for prescriptions opioid abuse and what resources exists for physicians?

**Sharon:** Sure, I mean a lot of that is being scaled up at this point, but resources for the physicians include the new CDC guidelines, the New York City Department of Health created guidelines for more judicious opioid prescribing some time ago. There’s a lot of education beginning to happen in physicians’ offices about this. There are take back programs whether in law enforcement or in pharmacies where we can encourage consumers to return unused medications to get those out of circulation.
Moderator: Alright. To learn more about how these programs come together at the local level we spoke with Katie Cusano and Sean Britton from the Broome County Departments of Mental Health and Public Health

Sean Britton: BOAC, the Broome Opioid Abuse Council is a multidisciplinary panel, which is led by our county executive with support for numerous county department heads, representatives of the opioid treatment based community and the non-governmental sector. So we have a few projects we are currently working on, one is we are trying to expand the access of medication take back within the community. We’ve reached out to local pharmacies to see about doing medication take back and we’re looking to do that further with additional law enforcement agencies. Another project we’ve worked on and we’re very proud of is O.P.R.A.D., which is the Opioid Prescription Reduction by Academic Detailing project and what we’re trying to do is reduce the overall availability of opioids within the community through supporting evidence-based guidelines among clinicians whom prescribe opioids. And our hope is by reducing the total number of opioids available in the community, there will be less available for diversion or to become abused and we also hope that less individuals will be habituated on opioids through prescription medications they receive from their clinical providers.

Katherine Cusano: Because social media is so prevalent, we want to be able to get information out. We know that so many people are on Facebook, so we actually went on Facebook, we created a group called “Living in the Light of Recovery in Broome County”. And we invited a lot of people that we already knew were in recovery and asked them to invite people, so and what we do is we put out inspirational messages, we put out information about upcoming trainings within the community, information about services that are available, new programs. The YWCA has a new program that’s called “The Bridge” and this is a wonderful program, we are really excited about this. It’s actually paid for by the County Department of Social Services and they are paying for 8 apartments at the YWCA that can house women who are addicted to opioids and who have recently had a baby and the infant has been affected by the opioids. And New York State OASAS has generously given us about $250,000, $100,000 of which is going to support a family navigator. Sometimes families aren’t sure who to call or how to make it through the system, so this person will be of contact and help guide them through the treatment process. And the peer advocates, they will be people who are in recovery themselves, who can actually go to points of entry. So it’s really important for people to be able to talk with others, it just as it is for people in recovery to be able to go to a meeting and be with others who have experienced the same thing. I think critical piece for any community is to bring together as
many people as you can get to the table. And look at all the sectors, don’t just look at county employees, don’t just look and department heads. You need to look at agency staff. You need to look at parents. You need to look at the youth. You need to look at the schools. You need to look at people from every sector of the community.

**Sean:** Through this multifaceted approach, we’ve been able to do a lot of interventions, which over the long run we hope are going to decrease the prevalence of opioid addiction within our community, as well as provide supportive treatment and recovery for individuals currently infected by the disease.

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**Moderator:** So Sharon, a critical piece of this equation is payment. So how is this being covered by insurance providers or other payers?

**Sharon:** Well like many things in naloxone, this is evolving rapidly as many states sign on, but Medicaid across the nation must pay for one formulation of naloxone for anyone at risk of overdose. They don’t define who’s at risk for overdose, so that’s pretty broad. Prior authorization is allowed. Here in New York State, Medicaid fee-for-service has stepped up to the plate and said they’ll pay for it with the standing orders at the pharmacies and that’s the first step for seeing what the Managed Care companies in New York State do. Private insurance I don’t track as well, we know that they’re covering at some is and some isn’t. But here in New York, if someone can’t afford naloxone, we can go to the website that Val mentioned and find free naloxone anywhere.

**Moderator:** Excellent, now Val what have learned so far about the use of naloxone? Are there mandated reports or data that you’re collecting?

**Val:** We are collecting data on the usage reports that I mentioned earlier that we do have over 3,500 usage reports and we’re collecting on the number of people trained. We also just recently completed a report that we are gonna, that we’re mandated to do under Public Health Law 3309 on an annual basis. This is issued by the Department of Health, but it’s a multi-agency effort. Many state agencies contribute to pieces of it. It was released in March 2016 and then it will be released on an annual basis. And it does have overdose death information, it has emergency room data, it has information the opioid overdose prevention program, the uses of naloxone. It’s a very comprehensive report, it’s also available on the website as well that people could read it in more detail.

**Moderator:** Great. Now Sharon are there other ways that we can tell this is an effective approach?
**Sharon:** Yes, there’s ongoing research at this point I already mention the New York City Department of Health study that has yet to be published. But over the years, there’s been studies that define yes people that are around drug users or are drug users do wanna carry naloxone. We do know that they can actually learn a lot from the brief trainings. We’ve got data that says it’s not used as a parachute, we don’t see any increases in drug use among people carrying naloxone. I’ll tell you about the reduction in overdosing communities in a moment, but it also in the world of public health comes in as cost-effective. I think our strongest study on the impact of it is in Massachusetts, where they sort of did a snapshot after about 3,000 people have been trained and they had some 380 uses of naloxone, all by people who use drugs and in the towns where naloxone was deployed, they had somewhere between a 24 and 46 percent reduction in naloxone, I mean reduction in fatal overdoses. The more naloxone in the community, the more the impact. So we really think we got data that says that this works, which is intuitive anyways.

**Moderator:** Absolutely. Now availability of naloxone can prevent an overdose from becoming fatal, can we prevent overdoses from happening in at risk populations?

**Sharon:** I think so and I think it’s so vitally important that we work towards that. There’s a lot of data on opioid use and opioid agonist therapy whether methadone or buprenorphine, but here we’re looking at the impact of increasing access to buprenorphine through primary care and through drug treatment in one city, which is Baltimore. And there’s a very strong correlation with seeing the red line, which is overdosed deaths go down over the years is up to 2009 as long as I have the data. With the increase in buprenorphine dispensing that started in 2002, so that’s a flat line and then suddenly rises up. And then also increased access to methadone in the city. So I think this is something that we’ll be looking at through the OASAS program, but it’s something that we really need to work hard on quickly.

**Moderator:** Thank you. So Steve now that we talked about preventing the harm from overdoses, let’s turn to talk about treatment and prevention of opioid abuse and treatment access. Can you tell me what OASAS has done to address the problem?

**Steve:** Sure Rachel. Like as I mentioned, saving lives or reversing the overdoses is a critical component, but that’s only a start in terms of what needs to happen. OASAS oversees over 900 treatment providers, we have about 240,000 people that are in treatment on any given year, so OASAS is an active part of this. The Narcan programs, we’ve provided funding, we operate 12 facilities that are state
operated that have been doing trainings. We have over 15,000 people who are trained and 71 documented reversals. We’ve been focusing on patients and family members as part of our goal. We also working on how to improve our prevention efforts, our treatment efforts, and our recovery efforts. We’re redesigning our residential systems to better address stabilization and early recovery particularly from opioids and to also enhance community re-integration when people are ready to come back in the community and needs supports. We’re developing a new level of care tool that really focuses on ascertaining what types of treatment that somebody needs and reflecting that the risks of heroin use versus some other substances is much higher and needs to be reflected in the types of care that they get. We’ve been working with the Governor’s office and all our partner agencies on Medicaid Redesign to help improve the health of the state and provide services and reduce costs that will really be more helpful to people than what our past system has. We’ve been trying to expand our opioid treatment providers particularly with methadone and buprenorphine, working with VIVITROL, and then I’ll talk a little bit later about trying to make our webpage much more user-friendly for folks.

**Moderator:** Now how has healthcare reform impacted what you’re doing in terms of substance abuse and services across the state?

**Steve:** Well one of the problems that our old Medicaid system has is it sort of pushes people into hospitals and they would go to inpatient programs, they would go to detox programs, over and over again, but not being really helped in the community. So what we’re trying to do is add community based support, so people aren’t going into the hospitals, aren’t going into detox, but have those supports that can help them stay clean and sober in their community, in their homes with their families, etc. We have new systems in terms of new services called Home and Community Based Services that are available that provide addition supports that are kind of nontraditional vocational training, et cetera, et cetera that can help people. And working with health homes to help coordinate care. Make sure people are going to those appointments and they’re connecting if they have a co-occurring disorder, they’re going to their mental health appointments and their substance abuse appointment.

**Moderator:** Now how have the programs expanded in other ways to respond to the crisis across the state?

**Steve:** Well one of the things we were lacking was access to opioid treatment programs, methadone and buprenorphine programs, particularly upstate. They were huge swaths of the state where you had to drive 2 and a half hours every day to get your medication. So we’ve been expanding, we have new programs in
Watertown, Utica, and Troy being planned. We opened up Peekskill and Albany and have more in the works. We’re trying to give people access to this very very effective treatment for heroin and other opioids.

**Moderator:** Excellent. Now for a glimpse into how another local county is approaching this epidemic. We spoke with Onondaga County Health Commissioner Dr. Indu Gupta about their county’s efforts the critical components of treatment access.

>>> Clip Roll-in<<<

**Dr. Indu Gupta:** Heroin and opioid epidemic has touched everyone in our community. It is a rising trend, it has become a problem throughout our community whether it’s suburb, whether it’s city, whether it’s younger or older and all races all social classes. So whenever there is a crisis, we take the approach how do we address this crisis first? People are dying because of that, so how do we prevent that death first? The second part the equation here multipronged approach is to have availability of treatment for those who are addicted. There is a big support in our community to raise awareness through our taskforce and through our community partners to make sure that all the community members are aware where all the resources are. So the way we can handle this treatment part is one is the Medication Assisted treatment, which is very specifically geared towards either methadone or suboxone, however the third portion of that is VIVITROL, which is a prescription medication, which can be provided by a primary care provider. That has started to catch up in our community. There is a significant entrust in our provided community. The other thing is very important in March of 2016, CDC has come up with guidelines for opioid and pain killer prescribing guidelines for chronic pain and that should be very widely used and their significant acceptance by the provided community in the prevention efforts, ACR Health has been very important partner because they are very engaged in Narcan training. One thing, which I would like to say that there is sometimes people feel like having Narcan has made more drug addicts, I would disagree completely with that because one of the notions in the crisis is that you need to save lives. How can you put someone in the treatment of rehabilitation if you cannot save them? But there are so much support in from the Behavioral Health community that if they take the prescription part and have work collaboratively with the behavioral health providers then we can actually achieve that goal. And that hopefully can reduce the problem in which we are seeing in the community, lack of beds, lack of treatment availability that will be a significant support in that, but again that is a work in progress and certainly there is a more and more interest.
Moderator: So Steve, Dr. Gupta from Onondaga spoke about a new type of treatment that’s becoming available and you mentioned it earlier actually, the VIVITROL. Can you tell us more about that?

Steve: Sure. VIVITROL is a really exciting thing that we’re taking a look at and it shows great promise. It is different in that it works by blocking opioids in the brain so that they won’t work and its form is an injectable, it will last for 30 days. So giving somebody an injection of this gives you a significant safety margin of 30 days to engage them in other programs, treatment prevention, et cetera, et cetera to help them along. One of the barriers is the cost, it’s about $900 per dose, it’s covered by many insurances, but not all, and we’re hoping to change that. And we’ve been working particularly in the criminal justice system with Alkermes the manufacturer to work on giving access to people who are coming out of jails and prisons. Dr. Stancliff mentioned high overdose rate in the first week. By injecting someone prior to being released, you have that safety window that we can get people engaged and they don’t think ‘well I’m gonna party the first week and then get back into it’ and unfortunately may experience an overdose. So it’s still early, it’s a relatively new medication, and its form is an injectable, and we don’t think it’s for everybody, but we’re trying to figure out who the people that this would be most effective for.

Moderator: Excellent. Now can you tell us more about how you make sure that consumers and providers know what services are available?

Steve: Well one of the things we’ve been trying to do is make the OASAS website more consumer friendly. That people come to us and say ‘oh I don’t know where to go for help’ so we wanted to set up our webpage to really provide a good place for people to start. So our treatment webpage on our website off with a convenient emergency care caller HOPEline 24/7 to talk to somebody right away. Many people are ‘I don’t know if there’s a bed, um I heard this program is filled and there’s a waiting list, what can we do?’ We have a program on it that they can take a look at and find out where beds are. There’s other information in terms of explaining, giving people information about what’s involved in treatment, how to work with your insurance company to get it covered, what the different levels of care do, and how to respond if there’s an issue.

Moderator: Now you brought up the issue of availability of beds and that’s something I’ve heard before, the concern of there’s not enough beds available in substance abuse facilities, so I wonder has OASAS done anything or what has OASAS done to track that concern about availability? 43:22
Steve: Well we looked at our data in terms of utilization and we believe that there are beds that are available at any given moment. The problem is finding them, knowing where they are. So created the bed availability report and all of our residential and inpatient programs submit on a daily basis how many openings they have or when they can next admit somebody, what kind, male bed or female bed, under 18, etc. And so people can go in and look, both consumers, family members, and other providers and say ‘well I need a bed in Albany County’ they can go into the website, enter in Albany County and hit search and they’ll see all of the Albany county services where the beds are available. So we’re hoping that really improves access, so people can find it right there rather than make endless phone calls looking up things in the phone book, etc.

Moderator: Sure. That sounds like an excellent program. Now do you have public awareness campaigns that’s targeted to specific audiences?

Steve: Yes, we’ve as part of the Governor’s initiative dating back a couple of years to address this. We’ve had an aggressive campaign to try and address these issues. We’ve had our combat heroin website. We’ve have had a variety of media pieces, both on television, radio, posters, on the thruway rest stops to address these issues. We are looking to help families recognize the importance of knowing what’s in your medicine cabinet. Unfortunately, one of the places that many people get prescription opioids access is from somebody else’s medicine cabinets, so trying to pay attention to those. How to navigate our system, it’s a little bit complex and if you don’t know it can be a little scary, so we’re trying to make that easy. And while there’s a lot of attention to opioids, there are other drugs out there that are causing problems also. And we’re particularly focused on making people aware of synthetics like K2 and spice and bath salts. So we’ve had some campaigns devoted to that.

Moderator: Now given that this program or this problem is impacting young people at such an alarmingly high rate, what efforts have you made to educate and inform parents about the problem, about resources that are available?

Steve: Well one of the things parents frequently tell us is ‘well I don’t know what to talk about, I know that using drugs are bad, but what do I say to my children?’ So we’ve prepared some resources, we have the Talk 2 Prevent, which is a series of videotapes and it’s other materials that help people talk about prevention and something that we’re very excited about Kitchen Table Toolkit, which helps families know what to do in terms of ‘how do I talk to my kids, what are the things that I can bring up, what sort of information?’ and there are videos that are available and other things to it.

Moderator: How has the Kitchen Table Toolkit, how has that been received?
Steve: It has been received very very well. People have been coming up to us and saying ‘this is a great resource! We’ve used it. It gives me a way to talk to my kids, it gives me information that I didn’t know, so when my kids ask me questions, I have good answers for them.’ So we’re very very excited about that and all that information is available on our website.

Moderator: Excellent, well it certainly sounds like a lot of work has been done from all of these difference agencies to address what we know is a really complex problem. So before we take questions from our audience, I wanna ask each of you if you wanna share with our viewers what do you think is the most important things for folks to know about this issue? So, Steve if you wanna start.

Steve: Well I think the biggest thing that we know now is that this is an everybody issues, it is not a those people who live there. If you ask anybody, ‘Do you know of somebody who’s been impacted by opioid abuse?’ These days at least half the people put up their hands, they know somebody. It’s become such an epidemic and being able recognize that everybody needs to worry about this and that’s a big piece of it.

Moderator: And Sharon?

Sharon: Well I want to acknowledge, we’ve got a lot of partners in this and we are using another set of partners that we haven’t talked about today, which is the people that are using the drugs. They are getting naloxone and saving lives with it, which is kind of reflective of the fact that when we gave injectors needles, they rehearsed an HIV epidemic among injectors. So they are and need to continue to be partners in developing the services.

Moderator: I think that’s an excellent point.

Val: I really think a lot of it is just the collaboration that’s needed. You know if others are figuring out how to do it in their community then it really is that everybody has a role. I mean the commitment from the Governor in New York is huge. Um really gave us kind of it kind of spurred, you know a lot of things to happen more quickly. But you know, state agencies have a role, a Harm Reduction Coalition, you know have a role, people in the community. You know, the local health departments around the state have also really stepped up. You know they’ve done a lot of work and you know they have a lot of, everyone has a different reach. So a lot of it is really being able to reach individuals where they’re at at that particular point. You know whether it’s harm reduction, whether it’s drug treatment. You know it’s that, you know there’s there needs to be many accesses access points for individuals.
**Moderator:** Absolutely. Well thank you all very much, I think we covered a lot of information in the time we’ve had so far. So let’s take a look and see what questions we’ve gotten from the audience. Um, so the first one “why is the AIDS Institute involved in this work around preventing heroin and opioid overdoses?”

**Val:** Well, the AIDS Institute has really been involved in working with people who use drugs for a long time. I mean back in the 80s, we had a substance abuse program that worked with HIV and you know it started there. And then syringe exchange became legal in 1992 and now we have 23 programs in the AIDS Institute that we regulate. So I mean, we’ve had a lot of, we’ve been working with them for a long time. You know we did start the Overdose Prevention program back in 2006 and it’s just kind of evolved, you know it’s just kind of been a progression, you know there’s been a huge impact in reducing the number of HIV cases among people who use drugs. You know we’re doing work with HCV. You know many things just fall under the umbrella.

**Moderator:** Okay. Now we have another question “where are the drugs, in particular heroin, coming from in this current epidemic?”

**Sharon:** Well much of the drugs come into this part of the country, well to much of the country, from Mexico, not so much from the the further away places. But what we’re seeing is networks that reach smaller towns different places than where we standardly see drugs like you know Chicago and New York, Baltimore. We’re seeing drugs, I never thought I’d say heroin and Kentucky in the same sentence, but it does come up from south of the border. I think a deeper concern, well this is already deep concern, but is the fact that we’re seeing fentanyl come in. Fentanyl is a completely synthetic drug that can be manufactured in clandestine laboratories with varying degrees of purity, varying analogs of it so they can actually have different effects and apparently those labs are found Mexico, China. But we are seeing some labs here in the United States, so this is is sort of an emerging issue among the synthetics that are out there.

**Steve:** It’s also important to remember that the prescription opioids are a huge part if this problem and they’re here. They’re not coming in from some place else, they’re in everybody’s medicine cabinet, they’re on the streets, et cetera.

**Moderator:** Yeah absolutely. Now I have another question “could you please share what’s the data, what’s the data source for the data that you’ve been presenting?” And that’s specifically referencing the heroin and opioid admission data.

**Steve:** That comes from, um OASAS keeps track of admission data from all of our programs, so we can track trends and look at program performance. So that
data comes from a set that we looked at primary heroin admissions for all our programs, it’s over a 10-year period that we track that for that particular slide.

**Moderator:** Yeah okay, also a note about resources and references that we have tools and programs that are mentioned on today’s program are available on not only are there, not only is there on the websites that you guys mentioned, but also that there’s also information that I believe will be provided on our program webpage as well. So are there specific resources that you feel like we might want to make sure that we highlight?

**Steve:** Well I think we mentioned from OASAS that we put a lot the prevention material on there, we have links from the Department of Health on where to get the Overdose Prevention training, links to other sources such as the National Institute of Drug Abuse, which has a ton of information about what substances are, what treatment’s effective, et cetera.

**Val:** And on the Department of Health website, we do have a lot of information on pharmacy dispensing. So we have a directory of all the pharmacies that are currently able to dispense naloxone around the state as well as links to the New York City Department of Health and Mental Hygiene site you know for a list of the ones just in New York City. You know we have a number of different links just on our website that goes to many other websites as well.

**Moderator:** Okay.

**Sharon:** And HarmReduction.org for the people who might outside the state-area have links to resources around the country. We’ve got links to many videos on how to train on overdose, we like to PrescribeToPrevent, which is a great resource for pharmacy, we like to a site that people can put in their zip code and find out where to get a naloxone kit, and we have resources on how to develop overdose programs.

**Moderator:** And I believe there’s also resources available on our shows website: [www.phlive.com](http://www.phlive.com) so when this program is over at the end of the hour, it’s great to know that people have a wide variety of other resources they can turn to. Let’s see we have another question “what was done to get policy changes accomplished that have affected this? Who is at the table from State government?” And this is coming from another state, so maybe looking to see how did, how did we kind of get the wheels turning in State government?

**Steve:** I think that one of the things that really has driven this has been some of the grassroots support from the community, families that have been affected by this have been very active in moving the legislature and the executive office to take action. We’ve had some significant actions over the past couple of years.
OASAS has been working on developing recovery community support groups that families can use and you can’t do any better than having those folks knocking on legislators door and saying “here’s what how this impacted my child, we need your help.” So that was a big piece of it.

**Moderator:** Okay.

**Sharon:** I would agree. I would also, I mean I think the grassroots certainly comes first. It’s also important to get the various professional organizations on board for changes like your Medical Societies, Pharmacy Societies, talking to Law Enforcement. I mean we’ve been talking about collaborations straight through and it’s the collaborations that can make the policy level changes.

**Val:** And you know talking amongst state agencies to figure out which policy changes can happen in which agency and which one needs you know a federal level you know change to make it occur. I mean conversations happen between the state agencies really on a weekly basis. So I mean I think some of that just figuring out who actually does have the the authority to try to start making the changes whether it’s through regulations or through you know laws or you know whether it needs to have things done in a couple state agencies to make things happen.

**Sharon:** Folks can find a little information on how to move that process along on HarmReduction.org. We have some policy guidance.

**Moderator:** Great. Now another question “what would you say to people who are using drugs illegally and are concerned about being arrested if they seek treatment, are there any legal consequences for this population?”

**Steve:** People don’t get arrested for seeking treatment, in fact the criminal justice system has moved tremendous strides in the past 20 years to encourage people to get into to treatment. They’re much more interested in getting folks help then saying “oh you’re using heroin, we’re going to arrest you”, so when people come in they’re also protected by some of the strongest confidentiality laws that exists in our country and in terms of somebody seeking that kind of help, we cannot release that information without their permission except for some very narrowly defined exceptions that have more to do with the health and safety issue than trying to get the Criminal Justice System involved.

**Sharon:** In New York State we are in great shape that way. I would say that one population that has really having a hard time though is pregnant woman. We do see arrest of pregnant woman for being found to be using drugs under their, not in New York state that I am aware of, but for using drugs under various
circumstances, unfortunately sometimes when they knock on the door of
treatment. So it is a big fear for a really at-risk population.

Moderator: Okay now let’s see next question that has come in and they are
coming in rapidly, “many prevention programs were implemented almost 10
years ago, however the charts show a dramatic increase in opioids and heroins,
why is that?”

Sharon: We don’t know where we’d be if we didn’t have these prevention
programs. I think it’s important you know not only to look at the changes in
prevention programs and the changes in deaths, but we need to look at the DEA
figures on how much heroin is flowing into this country at this point. I mean
we’ve reduced some of the prescription opioids with the prescription drug
monitoring programs, but we really need to have treatment options for people
that are already dependent on drugs and the seizure rates that are reported by the
DEA and other agencies are very high up. I’d like to think that’s because they are
more efficient at it, but usually seizure rates indicate how much is flowing in.

Steve: The other thing is that because the cycle things change. We’re in a very
big down cycle for cocaine and stimulants right now. We’ve seen a tremendous
decrease on the number of admissions for cocaine and crack over the past ten
years. I think one the things that is impacted has been the availability of
prescription opioids, how easy it is prescribed, who it’s prescribed for, and there
are a lot of concerns on how easily people have been given access to that and what
can problems it can create downstream.

Moderator: Alright and just a quick question before we have to close “Do any of
you have resources available in Spanish?”

Sharon: I think all of us have some on our websites, yeah.

Moderator: Okay. Excellent.

Steve: We have, we have, we’re mandated to have it in six different languages, so
we have a variety of languages that people can go to their websites for the New
York State agencies and be able to get information translated.

Moderator: Alright, well thank you all very much for being with us today. I
think we’ve covered a tremendous amount of information.

All: Thank you.

Val: Great to be here.

Moderator: Thank you for joining us today. Please remember to fill out your
evaluations online. Your feedback is always helpful to the development of our
programs and Continuing Education credits are available. To obtain Nurse Continuing Education hours, CNE, MCHES credits, learning must visit www.phlive.org and complete an evaluation and post-test for today’s offering. Additional information on upcoming webcasts and relevant public health topics can be found on our Facebook page. Don’t forget to like us on Facebook to stay up to date. This webcast will be available on demand on our website within two weeks of today’s show. Please join us on July 21st for our next Public Health Live program focusing on immunization programs for pregnant woman. I’m Rachel Breidster, thanks for joining us on Public Health Live.