DC | HEALTH

District of Columbia Department of Health **Naloxone Distribution**		**PROCEDURE 1550.000** Implementing Office: HIV/AIDS, Hepatitis, STD, TB Administration Training Required: Yes Originally Issued: JUN 06 2018 Revised/Reviewed:
Approved by: LaQuandra S. Nesbitt MD, MPH; Agency Director	**Review by Legal Counsel:** Phillip Husband, Esq.; General Counsel	**Effective Date:** JUN 06 2018 **Valid Through Date:** JUN 06 2021

I. Authority	Reorganization Plan No. 4 of 1996; Mayor's Order 1997-42; DC Law 21-186, Substance Abuse and Opioid Overdose Prevention Amendment Act of 2016; DC Code 7-403.
II. Reason for the Policy	In an effort to curb the number of deaths due to opioid overdoses, the DC Health established a Naloxone Pilot Program in 2016. Partner agencies distribute Naloxone to bystanders and other community members in particular "hotspots" or areas where overdoses have frequently occurred. Naloxone is an FDA-approved medication that temporarily reverses the effects of opioids such as heroin, methadone and morphine. Within DC Health, Naloxone distribution falls within the portfolio of the HIV/AIDS, Hepatitis, Sexually-Transmitted Disease and Tuberculosis Administration (HAHSTA).
III. Applicability	This standard operating procedure (SOP) shall apply to all HAHSTA employees, contract employees, and interns who have been assigned, whether temporarily or permanently, the responsibility of distributing Naloxone kits and Naloxone training (collectively referred to herein as "employees" or "HAHSTA employees").
IV. Policy Statement	The Naloxone Distribution Program is located within the Prevention and Intervention Services Bureau at HAHSTA. The HIV/HCV Testing Manager is the accountable manager, and the Naloxone Program Coordinator is tasked with the daily operation of the program.

	The Prevention and Intervention Services Bureau shall administer a network of community-based organizations (CBOs) that will perform Naloxone distribution services in the District of Columbia. HAHSTA shall create, solicit, and maintain agreements with CBOs to offer Naloxone distribution services. Prior to authorizing a CBO to begin offering Naloxone distribution services, HAHSTA staff will conduct a pre-decisional site visit (PDSV). At a minimum, HAHSTA staff shall use the PDSV to assess the following: 1. Capacity to reach out to focus populations, and engage them in services; 2. Capacity to link substance use services, including medication-assisted therapies; 3. Capacity to provide a comprehensive harm reduction program. HAHSTA shall maintain a standing order under which CBOs may distribute Naloxone. The Naloxone Distribution Program shall extend only to CBOs without the capacity to create their own standing order to distribute Naloxone. CBOs with the internal capacity to create a standing order are not eligible to participate in the Naloxone Distribution Program. However, HAHSTA will provide technical assistance to clinical providers seeking their own standing order or Naloxone supply upon request. Such provisions of technical assistance may include support with drafting documents and educating clinicians on the requirements of standing orders, including the District's Opioid Overdose Prevention Amendment Act. HAHSTA is responsible for developing an opioid overdose prevention/Naloxone training curriculum compliant with requirements in the Substance Abuse and Opioid Overdose Prevention Amendment Act of 2016. At a minimum, the training shall include: 1. The laws protecting individuals from civil liability associated with Naloxone administration and the safe reporting overdoses law; 2. The epidemiology of opioid overdoses in the District of Columbia; 3. The basic profile of opioids; 4. The pharmacology of Naloxone;

5. The importance of contacting emergency medical services and the proper administration of Naloxone;
6. The care of an individual after the administration of Naloxone.

Training sessions will be held regularly and announced on the DC Health website a minimum of one month in advance. No individual may dispense or administer Naloxone through HAHSTA's program without first completing the training. Training participants will receive a Certificate of Completion at the conclusion of the training. This certificate only entitles the recipient to participate in the HAHSTA Naloxone Distribution Program and shall not be interpreted as the recipient being "certified" in Naloxone distribution in any other context.

HAHSTA shall ensure that the written agreement with CBO partners require standard operating procedures (SOPs) governing Naloxone distribution programming. At a minimum, these documents shall include:

1. Program setting(s)/location(s) and hours of operation;
2. Phone, email, and website contact information;
3. Staff responsibilities;
4. Procedures for program participants to receive Naloxone kits;
5. Storage and handling procedures (for field and office);
6. Data collection, tracking, and submission procedures;
7. Overdose response policy including providing training to clients;
8. An outreach plan specifically detailing how the program will reach out to focus populations and engage them into services (See table below for detailed populations to target); where outreach events will take place; methods of outreach; any messaging or materials to be used during outreach events; key personnel/ staff persons/ volunteers who will be responsible for conducting outreach, and any other information relevant to overdose outreach efforts.

HAHSTA shall approve a CBO to begin offering only after conducting the PDSV, verifying the necessary SOPs are in place, and verifying that all staff that will be providing services have attended the HAHSTA training. HAHSTA reserves the right to

withhold authorization to begin Naloxone distribution services pending approved revisions of the SOP(s).

Population or Characteristic*	Documentable Risk Factor
1. Seeking emergency medical care for opioid poisoning	Increased risk for subsequent unintentional poisoning
2. Suspected illicit or nonmedical opioid use	Risk for multiple drug use; continued multiple drug use
3. High-dose opioid prescription (≥80 morphine equivalent dose [MED])	Patient incorrectly ingests opioid resulting in higher risk of toxic levels
4. Opioid-naïve patient with a methadone prescription	Low threshold for overdose; inexperience with long-acting opioids
5. Person with smoking/COPD/emphysema or other respiratory illness or obstruction who uses any opioid	Increased risk of respiratory depression due to comorbidities
6. Person with renal dysfunction or hepatic disease who uses any opioid	Prolonged and/or increased serum concentrations of opioid due to decreased metabolism and/or excretion
7. Any opioid use and HIV/AIDS	HIV seropositivity is associated with an increased risk of overdose mortality
8. Any opioid use and known or suspected concurrent prescription drug, illicit drug or alcohol use	Additive effect of multiple central nervous system depressants
9. Any opioid use and concurrent selective serotonin reuptake inhibitor (SSRI) or tricyclic anti-depressant (TCA) use	Increased toxicological risk for opioid poisoning; higher risk for substance use and self-harm
10. Release from correctional facility	Relapse to/initiation of nonmedical opioid use; reduced opioid tolerance; risk for multiple substance use
11. Release from opioid detoxification or mandatory abstinence program	Relapse to nonmedical opioid use; reduced opioid tolerance; risk for multiple substance use
12. Voluntary request	Perceived risk of opioid exposure or witness to an opioid overdose
13. Patients entering medication-assisted treatment (MAT) program	Increased risk of poisoning in first month; risk for multiple substance use; increased risk for nonmedical opioid use if MAT stops; reduced opioid tolerance
14. Heroin use	Changes in content and strength of street drugs, including fentanyl

*Adapted from *Project Lazarus: community-based overdose prevention in rural North Carolina. Pain Medicine 2011; 12: S77–S85*

The Naloxone Program Coordinator is responsible for responding to Naloxone replenishment requests from participating CBOs, and ensuring prompt replenishment of Naloxone supply.

HAHSTA shall ensure that all agreements with CBOs to participate in the Naloxone Distribution Program contain language requiring CBOs to submit the Monthly Reporting Form by the 10th of each calendar month. HAHSTA will review each monthly report within 10 business days and provide the necessary feedback to each agency in an effort to improve the quality of program implementation.

	HAHSTA is responsible for monitoring compliance of CBOs with all terms of the written agreement to participate in the Naloxone Distribution Program. In the event of non-compliance, the Naloxone Program Coordinator may coordinate with the Contract Administrator/Subgrant Monitor of the CBO's agreement (if they are different employees) to provide additional technical assistance and, if appropriate, sanction the CBO. Any employee in violation of any part of this SOP may be subject to commensurate disciplinary action.
IV. Definitions & Acronyms	**CBO-** Community-based organization **HAHSTA-** HIV/AIDS, Hepatitis, Sexually-Transmitted Disease, Tuberculosis Administration **Comprehensive Harm Reduction program-** A set of public health strategies intended to reduce the negative impact of drug use including HIV, Hepatitis C, other infections, overdose, and death among people who are unable or not ready to stop using drugs. Such programs include the distribution of sterile and disposal of used hypodermic needles and syringes, education, linkages to drug treatment, HIV and Hepatitis testing, and an array of other health services. **Naloxone-** An FDA-approved medication that reverses overdoses due to opioids (e.g. heroin, OxyContin, Percocet, Vicodin, methadone). Naloxone is known as Narcan when produced for intranasal administration. **PDSV-** Pre-decisional site visit **SOP-** Standard operating procedure **Standing Order-** a physician's or other healthcare provider's order that can be exercised by other health care workers when predetermined conditions have been met. Under this model, a doctor with prescriptive authority issues a written order that Naloxone can be distributed by designated people, such as trained employees of a harm reduction program.

VI. Procedures	**Procedure A: Authorization of CBO Participation** 1. The HIV/HCV Testing Manager, or designee, shall schedule a PDSV. 2. The HIV/HCV Testing Manager, or designee, shall complete the PDSV on the prescribed date. 3. Upon completion of the PDSV (and resolution of any findings noted), the HIV/HCV Testing Manager, or designee, shall facilitate the extension of the HAHSTA standing order to the CBO. 4. The HIV/HCV Testing Manager, or designee, shall assist the CBO in enrolling its personnel in the HAHSTA training. 5. The HIV/HCV Testing Manager, or designee, shall verify that all CBO program staff have completed the training. 6. The HIV/HCV Testing Manager, or designee, shall review the CBO's SOPs to ensure adequate program structures and internal controls. 7. Upon verification of adequate SOPs, the HIV/HCV Testing Manager, or designee, shall authorize the CBO to begin Naloxone distribution services.
VII. Contacts	Naloxone Program Coordinator- (202) 671-5060 HIV/HCV Testing Coordinator- (202) 671-4986
VIII. Related Documents, Forms and Tools	Monthly Reporting Form Inventory Log