RESPONDING TO AN OVERDOSE SPIKE

A Guide for State Health Departments

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INTRODUCTION

This guide aims to help state health officials prepare for a rapid response to an opioid overdose spike event. Key components of an effective response include forming an overdose spike response team (OSRT) and overdose spike action plan (OSAP). This guide consists of potential action steps and factors for success, for each phase of the planning and response process. These tips are followed by sample job action sheets and other resources meant to support each phase of the process.

The information included in this guide is based on a review of the literature and resources available on current practices, including protocols provided by Maryland, Washington state, and Georgia; HIDTA's Overdose Detection Mapping Application (ODMAP) framework; and expert guidance provided by state representatives, federal partners, and organizations that attended ASTHO's Building State Opioid Preparedness meeting in January 2019. For the local perspective, NACCHO provided feedback on the guide and ASTHO staff attended local tabletop exercises in Chattanooga and Johnson City, Tennessee to inform the guide.

In May and July 2019, ASTHO conducted tabletop exercises with Utah and Georgia based on the phases of this guide. Information from the after-action reports from those exercises are incorporated in this guidebook.

This guide is not meant to replace existing emergency protocols your state might have in place. Rather, it is intended to serve as a model to consult for augmenting or informing your current overdose spike response process.

PRIMARY COMPONENTS

PHASE 1: Pre-Incident Planning

PHASE 2: Immediate Phase (mobilization through first 12 hours)

PHASE 3: Intermediate Phase (through 48 hours)

PHASE 4: Longer-Term Response (beyond 48 hours)

APPENDICES

APPENDIX A: Job Action Sheets for OSST Partners

APPENDIX B: References and Background Information

APPENDIX C: Calling for Help

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APPENDIX E: Decision Tree

APPENDIX F: Data for Opioid Surveillance

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PHASE 1:
PRE-INCIDENT PLANNING

The most effective response to an overdose spike will be achieved through planning for an event. Phase 1 consists of five main activities.

PHASE 1 OVERVIEW:

1. Identify surveillance team
2. Define a "spike"
3. Assemble an overdose spike response team
4. Develop an overdose response plan (map state resources and gaps)
5. Test the plan

OVERDOSE SURVEILLANCE TEAM

- Coordinate a state-level surveillance team to:
  - Identify existing data sources for surveillance activities at the local level and data the state captures directly; see Appendix F for examples of data to consider for the enhanced surveillance of opioid-related morbidity and mortality
  - Develop case definitions for overdoses
  - Develop data sharing agreements, with information about what data are being shared, who can access the data, and how it can be used
  - Analyze historical data to determine baseline averages for fatal and nonfatal overdoses
  - Identify a strategy for identifying spikes that occur across or along local jurisdictional boundaries
  - Provide ongoing surveillance of overdose data sources, such as syndromic surveillance data, PDMP data (if applicable), MAT providers, EMS/ED data, coroner investigatory reports, etc.

POTENTIAL OVERDOSE SPIKE RESPONSE STRIKE TEAM MEMBERS

- Attorney general
- Regional emergency coordinator
- Office of drug control policy director
- Drug intelligence officer (from DEA)
- State and local health department leads
- Chief epidemiological field officer (CEFO)
- HIDTA
- Communications directors (from public safety, DOh, mayor's office, governor's office)
- Medical director
- Public safety lead(s) – fire, EMS, law enforcement
- Behavioral health lead
- State social services officials (including those from mental health and child protective services)
- Chief medical officer
- Harm reduction lead
- Pain clinics
- Emergency department liaisons
- Community drug coalitions
- People with lived experiences
- Recovery communities
- Family and friends of people who use opioids
- Neighboring local health departments

DEFINE A SPIKE

This definition is critical to making a "go-no-go" decision for action. It will vary by state and by jurisdictions within states, and likely will be readjusted over time.

AFTER AN OPIOID INCIDENT, Utah Department of Health solicited input from stakeholders to update Utah's definition of an overdose spike cluster. They decided on five definitions:

1. An increase in the occurrence of fatal or non-fatal opioid overdoses above the current local rate for the target time period (weekly, quarterly, annually); or
2. An increase in the occurrence of fatal or non-fatal opioid overdoses as identified by aberration detection and substantiated through data verification; or
3. The identification of populations experiencing recurring fatal or non-fatal opioid overdose events; or
4. The occurrence of an opioid overdose event in circumstances deemed by the LHD to be of crisis trigger significance [i.e. based on younger age groups (less than 18 years of age), new opioid analogs, location (school]; or
5. The occurrence of two or more linked fatal or non-fatal opioid overdoses with a common exposure source and geographic-time location. (e.g., opioid analog as confirmed by laboratory testing, reported brand name, drug description, drug source, third party notification, circumstantial evidence).

ASSEMBLE AN OVERDOSE SPIKE RESPONSE TEAM (OSRT)

The size and composition of a response team can vary, and the deployment of the various team members will depend on the scope, location, and on-the-ground factors of the spike. The state health department should:

- Identify state-level OSRT co-leads. Co-leads will initiate and coordinate the planning. At least one lead should be engaged with public health and safety and have:
  1. visibility over health and law enforcement efforts and
  2. ability to elevate key issues to ultimate decision makers (directly report to cabinet-level officials). Co-leads will then identify and recruit OSRT members.
- Set up regular meetings with OSRT to:
  - Conduct mission briefings with all partners/ stakeholders so that everyone understands and accepts roles and responsibilities
  - Develop decision tree processes (see Appendix E)
  - Develop job action sheets for each member (see Appendix A)
- Ensure the team understands state capacity, as assessed by a readiness assessment that:
  - Identifies existing resources for the public (e.g., emergency hotlines)
  - Surveys existing partnerships focused on overdose prevention and response (e.g., between public safety and public health)
  - Assesses utility of treatment locators and of the frequency of updates
  - Assesses ability to locate open beds

DEVELOP AN OVERDOSE SPIKE ACTION PLAN (OSAP)

A written plan or protocol can ensure that the team understands how to operate during an event. The plan should:

- Identify threshold for when the incident command team and Emergency Operations Center (EOC) should be activated
- Identify threshold at which further assistance will need to be sought out, such as (see Appendix C):
  - Requesting support from the CDC Rapid Response Team
  - Requesting support through the EMAC (Emergency Management Assistance Compact)
- Include goals and activities for immediate, intermediate, and longer-term responses (including an exit plan and hotwash process)
- Incorporate an after-hours response plan for the local public
- Include a communications plan for notifying key agencies and partners:
  - Craft one-pagers for different OSRT partners (see Appendix B for an example)
  - Craft public service announcements for different target audiences
  - Engage with stakeholders, using language that does not stigmatize substance use disorder
  - Develop a "bad batch" community alert system and template message
  - Prepare template message(s) for alert system: to target audiences
  - Consider holding focus groups to determine
    1. what language is most acceptable for different geographical areas or populations;
    2. where to put messaging;
    3. what delivery mechanism(s) are most effective; and
    4. what info to include for different target audiences
  - Establish a means of contact or communication system with media groups and develop a plan to distribute PSAs in the event of a spike
    - For example, career epidemiology field officer can contact state health official, who can then notify the media, harm reduction staff, etc.

TIPS FOR RECRUITING AND COLLABORATING WITH OSRT MEMBERS:

- Sharing data is often a good way to get people to the table
- A mandate from the governor or executive leadership can bring people to the table
- Speaking a common language can facilitate good working relationships, so developing a one-pager of public health terms and definitions can facilitate communication

FACTORS FOR SUCCESS: RELATIONSHIP BUILDING

Encourage local departments of health (DOHs) to identify and connect with other stakeholders to be involved in or affected by response, for example:

- Emergency departments
- Medical examiner's, coroner's offices, and forensic laboratories
- Peer recovery specialists
- Community groups/coalitions/ advocacy groups
- Drug treatment facilities
- Correctional facilities and probation programs
- Schools and faith-based settings
- Social service agencies and Homeless shelters
- Syringe service programs
- Naloxone distribution programs
- Media
- People with lived experiences and persons in the recovery community
- Families and friends of people who use opioids
- Neighboring local health departments

- Consider additional training and education needs, such as:
  - Cross-training individuals from different disciplines, such as the ED staff; include state attorney's office
  - Training stakeholders in incident command systems and language
  - Conducting communications training for key stakeholders at the state and local level
- Share your plan with local jurisdictions and encourage them to develop their own OSAP. Communicating with local partners about what will work locally can help them make an informed go-no-go decision
- Consider a plan for supporting first responders and volunteer individual responders (e.g., local medical reserve corps unit) against compassion fatigue

STAKEHOLDERS	• Prescribing professionals	• Law enforcement and first responders	• Local health districts	• Community members

SUGGESTED TRAINING	• Ensure capacity to provide training around tapering
	• Applying for a MAT wavier
	• Handling patients with co-morbid issues
	• Telehealth
	• Standing orders
		• Naloxone administration
		• Mental health crisis training
		• Good Samaritan laws
		• Compassion fatigue and available resources
		• Safety training, including:
		  ◆ Investigation and evidence handling
		  ◆ Searching subjects
		  ◆ Special operations and decontamination
		  ◆ Personal protective equipment
			• Naloxone administration
			• Public communication strategies
				• Naloxone administration
				• Awareness of resources, including the hotline, safe stations, and where to look for information during an incidence

TEST THE PLAN

Exercises are critical for effective emergency preparedness. Conduct tabletop exercises so the response team can pilot test OSAP and modify as needed. The exercise will help assess your state's level of preparedness and identify areas of weakness to address through training.

PHASE 2:
IMMEDIATE PHASE
(MOBILIZATION THROUGH FIRST 12 HOURS)

PHASE 2 OVERVIEW:

1. Assess the threat
2. Activate the team
3. Communicate the threat
4. Eliminate the source

ASSESS NEED FOR HELP

- Can we function within normal day-to-day operations?
- Are we running out of resources? Which ones?
- How soon will we reach our threshold/exhaust our resources?
- What training considerations do we need to make?
- Do we need to contact the CDC Emergency Operations Center (EOC) for rapid technical assistance (TA)? Decide whether virtual or in-person technical assistance is necessary.
- Do we need to request an Opioid Rapid Response Team from the CDC Emergency Response Operation Center?
- Do we need to declare a state of emergency and engage the Emergency Management Assistance Compact (EMAC)?
- Do we need to start implementing an exit strategy?

ASSESS THE THREAT

- Keep up-to-date number of overdoses occurring, using real-time data from multiple sources
- Identify source: work with drug intelligence officer, public safety, and law enforcement to gather preliminary information about the source of the drug causing overdose deaths
- Identify affected population(s):
  - **a.** Perform active case finding; call local EMS and emergency department and ask about who overdose victims are and where they are overdosing;
  - **b.** Establish a case definition and create a list of confirmed, probable, or possible cases and
  - **c.** Conduct descriptive epidemiology

ACTIVATE THE TEAM

- Alert and gather the response team partners
- Notify stakeholders in the affected jurisdictions
- Decide if the ICS needs to be implemented; if yes, designate an Incident Commander
- Delegate tasks to complete in first 12 hours or activate job action plans
- Make sure there is a clear line of command and channels of communication
- Develop or implement plan to keep public health office open on weekend and holiday and to have public health officials available to respond to calls 24/7

COMMUNICATE THE THREAT

- Get the word out to affected communities and stakeholders. Implement the communications plan (see Appendix B for communication templates)

ELIMINATE THE SOURCE

- Coordinate with your drug lab, fusion center, bureau of investigation, HIDTA, and state poison control to help identify and eliminate the source

PHASE 3:
INTERMEDIATE PHASE
(THROUGH 48 HOURS)

Four main activities generally need to be implemented in the first 12 to 48 hours of an overdose spike. This time period will help determine whether the spike has subsided or is ongoing. However, it is often difficult to know if a spike has subsided within 48 hours. If it has definitely subsided or moved to a different state, see Phase 4 – Step 1a.

PHASE 3 OVERVIEW:

1. Monitor the threat/enhanced surveillance
2. Communicate the threat
3. Monitor, assess, and engage key resources
4. Assess need for help

MONITOR THE THREAT/ ENHANCED SURVEILLANCE

- Look at data regularly
- Re-assess that you know what drug you are dealing with
- Consider data from regional EMS, local emergency departments, enhanced surveillance (active and syndromic); active surveillance is needed even in areas with Overdose Detection Mapping Application (ODMAP) (see Appendix F)
- Assess input from multiple data/intel sources to confirm a downward trend in overdoses
- Assess data from HIDTA to determine whether the spike is moving to another area within the state or to neighboring state. May need to conduct regional calls
- Assess DEA and law enforcement data to determine if this source is being eliminated

COMMUNICATE THE THREAT

- Information campaign is critical in first 24 hours
- Get messages out to key stakeholders and high-risk individuals, such as pain clinic patients. Pain clinics may want to notify their own patients and increase services as needed
- Reassess communication messages, delivery mechanisms, and target locations and tweak if necessary – are they still accurate/appropriate? (see Appendix B for resources about communication)
- Issue a public service announcement (if necessary)
- Form a joint information center (JIC), which involves regular and frequent meetings among all the public information officers (PIOs) to discuss the upcoming report and walk through the talking points for consistent messaging
- Notify up the chain, if necessary

MONITOR, ASSESS, AND ENGAGE KEY RESOURCES

- Ensure availability and distribution of naloxone to key areas
  - Work with stakeholders on the rapid distribution of naloxone to affected communities
  - Team going to sites should include a peer from the affected population
- Check pharmacists' knowledge of standing orders
- Check availability of protective gear for first responders
- Check availability of hospital beds for treatment and rehabilitation
- Check capacity of addiction treatment facilities and peer navigator programs to meet with clients following a nonfatal overdose
- Check capacity of morgues to house fatal overdose victims
- May need to conduct DEA drug recognition training for public health officials or for law enforcement (e.g., what does black tar look like?)
- Activate a 24-hour warmline if threat looks like it will continue past 24 hours

PHASE 4:
LONGER TERM RESPONSE
(BEYOND 48 HOURS)

During this phase, the overdose spike may have or be in the process of subsiding. The information below should help inform your response for both scenarios. There are three main activities during this stage, most of which overlap with Phase 3.

PHASE 4 OVERVIEW:

1. Monitor the threat
2. Conduct follow-up communication
3. Monitor continuity of care and resources

MONITOR THE THREAT

If the threat of a continued spike in overdoses has subsided:

- Conduct an evaluation/hotwash of the response
- Create an after-action review (AAR) to document the best practices, gaps, and lessons learned to improve the emergency response process
- Consider additional partners for the OSRT for future responses
- Incorporate the AAR into your state's response plan or draft a response plan if the state does not have an official plan in place
- Consider ongoing care coordination for patients who experienced a non-fatal overdose

If the threat is still present, return to Phase 3 and consider contacting CDC's for assistance (see Appendix C)

CONDUCT FOLLOW UP COMMUNICATION

- Re-assess communications activities (e.g., the need to continue the hotline) and restructure plan if needed
- Conduct additional follow-up with DOH as needed
- Conduct regional calls with neighboring states if necessary
- Consider increasing awareness for testing the affected population for blood borne pathogens (e.g., HIV, hepatitis)

MONITOR CONTINUITY OF CARE AND RESOURCES

- Monitor, assess, and utilize key resources, including monitoring of personnel and first responders for fatigue
- Ensure availability and distribution of naloxone to key areas
- Check availability of hospital beds for treatment and rehabilitation
- Check capacity of addiction treatment facilities
- Check capacity of morgues to house fatal overdose victims

APPENDIX A:

JOB-ACTION SHEETS FOR OSST PARTNERS

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RESPONSE TEAM MEMBER JOB-ACTION SHEET

BEHAVIORAL HEALTH SPECIALIST

1. Member Title: Behavioral Health Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist in coordination of on-scene behavioral health responders, if requested by local incident management personnel
- Consult with staff, patients, clients, and family members on appropriate behavioral health services needed
- Assist patients, clients, and family members in location of and connection to available behavioral health services
- Observe Strike Team members for signs of stress or emotional difficulty; refer for support or substitution if needed
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Specific Behavioral Health Training, including Professional/Clinical Services Training
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

CLINICAL CARE SPECIALIST

1. Member Title: Clinical Care Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assess current clinical/health care resources for needs
- Provide consultation to clinic managers (Pain Center Closure), hospitals, health departments (OD Cluster) as needed
- Assure that appropriate client or patient referral practices are engaged
- Support Epidemiology Specialist team member in acquisition of needed medical records and other incident-specific information needed for field investigation or surveillance processes
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Health Care Management Training
- Clinical Care Training (RN, MD, etc. not required, but recommended)
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

EMERGENCY MEDICAL SERVICES (EMS) SPECIALIST

1. Member Title: EMS Specialist

2. Incident Type: OD Cluster

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist local incident management in assessing need for additional (external) jurisdiction EMS assets
- Assist responding EMS agencies with replacement of depleted Naloxone and other prehospital care supplies, if needed
- Assist responding EMS agencies with pertinent information for reporting, after action review, etc.
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- EMS Technical Training (EMT/Paramedic) optional but recommended
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

EPIDEMIOLOGY SPECIALIST

1. Member Title: Epidemiology Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Initiate field investigation and surveillance processes, including case definition, incident rate, population health assessment, clinical picture, etc.
- Assist Clinical Care Specialist team member with consultation and key epidemiology information to support client/patient care
- Develop appropriate public health interventions
- Provide consultation services to health care services and public health leadership
- Document and report findings
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Epidemiology and Surveillance-Specific Training
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

FATALITY MANAGEMENT SPECIALIST

1. Member Title: Fatality Management Specialist

2. Incident Type: OD Cluster

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist local jurisdictions in identification, appropriate movement, and storage of remains
- Assist with additional storage solutions (e.g., state medical examiner facility) for fatality surge
- Develop report with fatality numbers, information, location, etc. as needed and allowed by law
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Coroner, Medical Examiner, Pathology Training not required, but recommended
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

HUMAN SERVICES SPECIALIST

1. Member Title: Human Services Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist clients, patients, and families with Medicare, Medicaid, and other related state or community social services
- Engage Children's or Adult Protective Services as needed (OD cluster)
- Assist clients in transitioning to other clinical centers (pain center closure)
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Specific, job-related training for human services type employment
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

INCIDENT MANAGEMENT SPECIALIST

1. Member Title: Incident Management Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assure communication/liaison with Strike Team's jurisdiction Public Health incident management system
- Assure communication/liaison with Emergency Management or on-scene command post
- Assist Team Leader in ensuring that all Strike Team activity remains within the mission assignment provided by the jurisdictional incident management system
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Monitor for safety issues related to Strike Team members and report accordingly
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Monitor team members for fatigue, family concerns, etc.
- Consider team member replacements and ensure smooth transition of members
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- ICS 300 Course
- Cultural Competency Training (specific to the incident location)
- Training for competency of communication/technology resources to be used

RESPONSE TEAM MEMBER JOB-ACTION SHEET

INFORMATION MANAGEMENT SPECIALIST

1. Member Title: Information Management Specialist

2. Incident Type: Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Investigate/develop access routes for sharing of critical information among team members, incident management personnel, and other responders as needed
- Determine key information on client population (e.g., patients who will require immediate access to medical treatment, prescriptions)
- Work with Epidemiology and Clinical Care Specialists to identify and alert other healthcare organizations of potential surge of patients needing continued care
- Provide consultation services to health care services and public health leadership
- Focus on protection of sensitive medical data of center patients
- Document and report findings
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Continue to provide patient information to external health care facilities to ensure continuity of care for former pain center patients
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

LABORATORY SERVICES SPECIALIST

1. Member Title: Laboratory Services Specialist

2. Incident Type: OD Cluster

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Assist jurisdictional response agencies with specimen sample collection, as needed
- Communicate with clinical, commercial, and state-level labs to coordinate analysis and identification of specimen samples
- Assist with additional support coverage by various labs in a surge incident
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Position-specific training–microbiology, toxicology, lab procedures, etc. (not required but recommended)
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

LAW ENFORCEMENT SPECIALIST

1. Member Title: Law Enforcement Specialist

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Connect and provide information to local law enforcement personnel to aid in their investigation
- Manage scene safety for team members
- Aid in scene control in support of local law enforcement, if necessary
- Assist scene responders and Laboratory Services Specialist with sample acquisition, as needed (chain of evidence protocol, etc.)
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Law Enforcement-Specific Training, with accompanying certification
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

PHARMACY SPECIALIST

1. Member Title: Pharmacy Specialist

2. Incident Type: Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Operational Briefing
- Receive tactical assignment
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Support local clinic staff with RX management/transfer, including documentation
- Provide consultation to clients/family members on impacted dispensing/administration process, locating other pharmacies, etc., as needed
- Communicate as needed with State Board of Pharmacy regarding pharmacy service closure, referrals, records, etc.
- Support Team Leader's efforts to provide key information to jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Assist with position-specific team member replacements as needed
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Begin demobilization procedures as directed
- Begin after action process as directed

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term "in house" management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- Pharmacist-Level Training and Education
- Pharmacy Management Training
- Cultural Competency Training (specific to the incident location)

RESPONSE TEAM MEMBER JOB-ACTION SHEET

TEAM LEADER

1. Member Title: Team Leader

2. Incident Type: OD Cluster or Pain Center Closure

3. Member Roles—Immediate (Mobilization through first 24 hours)

- Attend Incident Command Operational Briefing
- Receive actical assignment for Strike Team
- Confirm internal and external communication systems between team and Incident Command
- Muster team and prepare for deployment if indicated
- Review assignments with team members and assign tasks
- Monitor work processes and adjust as necessary
- Monitor use of existing resources and report needs
- Maintain situational awareness
- Document actions in Unit Log
- Establish communication channel with jurisdictional incident management system
- Brief relief member at end of shift

4. Member Roles—Intermediate (Through Week One)

- All items above
- Monitor team members for fatigue, family concerns, etc.
- Consider team member replacements and ensure smooth transition of members
- Begin planning early for team demobilization
- Begin planning for incident after action review
- Direct demobilization procedures as directed
- Direct team hotwash and prepared for after action review

5. Member Roles—Extended (Beyond Week One)

- All items above
- Begin planning for transition to longer term “in house” management of the incident

6. Team Member Training Needs

- Appropriate FEMA National Incident Management Courses (ICS 100,200,700)
- ICS 300 Course
- Cultural Competency Training (specific to the incident location)
- Training for competency of communication/technology resources

APPENDIX B:

REFERENCES AND BACKGROUND INFORMATION

astho.org
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

OPIOID RAPID-RESPONSE TEAMS TRAINING PLAN:

ADDITIONAL RESOURCES

Opioid Overdose Epidemic Data

Opioid Overdose on CDC.gov

Drug Overdose Deaths in the United States, 1999–2017

Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017

2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States

Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016

Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015

National Vital Statistics System: Provisional Drug Overdose Death Counts

Heroin

Vital Signs: Today's Heroin Epidemic

Relationship between Nonmedical Prescription-Opioid Use and Heroin Use

Drug-poisoning Deaths Involving Heroin: United States, 2000–2013

Trends in Deaths Involving Heroin and Synthetic Opioids Excluding Methadone, and Law Enforcement Drug Product Reports, by Census Region — United States, 2006–2015

Fentanyl

CDC Health Advisory: Increases in Fentanyl Drug Confiscations and Fentanyl-related Overdose Fatalities

CDC Health Advisory: Influx of Fentanyl-laced Counterfeit Pills and Toxic Fentanyl-related Compounds Further Increases Risk of Fentanyl-related Overdose and Fatalities

CDC Health Advisory: Rising Numbers of Deaths Involving Fentanyl and Fentanyl Analogs, Including Carfentanil, and Increased Usage and Mixing with Non-opioids

Notes from the Field: Overdose Deaths with Carfentanil and Other Fentanyl Analogs Detected — 10 States, July 2016–June 2017

Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July–December 2016

Fentanyl Law Enforcement Submissions and Increases in Synthetic Opioid–Involved Overdose Deaths — 27 States, 2013–2014

Trends in Deaths Involving Heroin and Synthetic Opioids Excluding Methadone, and Law Enforcement Drug Product Reports, by Census Region — United States, 2006–2015

OPIOID RAPID-RESPONSE TEAMS TRAINING PLAN:

ADDITIONAL RESOURCES

State Reports on Fentanyl Overdoses

Characteristics of Fentanyl Overdose — Massachusetts, 2014–2016

Increases in Fentanyl-Related Overdose Deaths — Florida and Ohio, 2013–2015

Overdose Deaths Related to Fentanyl and Its Analogs — Ohio, January–February 2017

Counterfeit Norco Poisoning Outbreak — San Francisco Bay Area, California, March 25–April 5, 2016

Multiple Fentanyl Overdoses — New Haven, Connecticut, June 23, 2016

Notes from the Field: Counterfeit Percocet–Related Overdose Cluster — Georgia, June 2017

HotSpot Report - New Hampshire 2016

New York City Health Advisory: Increase in Drug Overdoses Deaths Linked to Increased Presence of Fentanyl in New York City

New York City Health Advisory: Presence of Fentanyl in Cocaine Contributing to Increase in Drug Overdose Deaths

Opioid Overdose Outbreak — West Virginia, August 2016

Illicit and Prescription Opioids Supply

2017 National Drug Threat Assessment

Reported Law Enforcement Encounters Testing Positive for Fentanyl Increase Across US

Counterfeit Prescription Pills Containing Fentanyls: A Global Threat

National Forensic Laboratory Information System (NFLIS) Reports

NFLIS Brief: Fentanyl, 2001–2015

NFLIS Brief: Fentanyl and Fentanyl-Related Substances Reported in NFLIS, 2015–2016

NFLIS 2016 Annual Report

National Drug Early Warning System DEA Emerging Threat Reports

Drug Overdose Investigation Guidance

Laboratory Testing for Prescription Opioids

Using Literal Text From the Death Certificate to Enhance Mortality Statistics: Characterizing Drug Involvement in Deaths

Prescription Drug Overdose Data & Statistics Guide: CDC WONDER Multiple Causes of Death Dataset

OPIOID RAPID-RESPONSE TEAMS TRAINING PLAN:

ADDITIONAL RESOURCES

HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014–2015

Public Health Approaches to the Epidemic

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain

Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States

Federal Response to the Opioid Crisis

What We Know, and Don't Know, about the Impact of State Policy and Systems-Level Interventions on Prescription Drug Overdose

Opioid Overdose Epidemic Background

Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths

New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

The Role of Opioid Prescription in Incident Opioid Abuse and Dependence Among Individuals with Chronic Non-Cancer Pain: The Role of Opioid Prescription

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain: The SPACE Randomized Clinical Trial

Heroin Use and Heroin Use Risk Behaviors among Nonmedical Users of Prescription Opioid Pain Relievers - United States, 2002-2004 and 2008-2010

Relationship between Nonmedical Prescription-Opioid Use and Heroin Use

Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates

Prescription Drug Monitoring Programs and Opioid Death Rates—Reply

Increased Use of Heroin as an Initiating Opioid of Abuse

Underlying Factors in Drug Overdose Deaths

National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment

Additional Opioid-Related Publications

Other key CDC publications **can be found on CDC.gov**

MARYLAND PRESCRIBER-ENFORCEMENT ACTION PROTOCOL

I. Purpose

Law enforcement actions focused on reduction of inappropriate prescription practices are an essential component of Maryland's opioid response strategy. When enforcement actions take place, effective communication between law enforcement and public health is necessary to address urgent medical concerns and reduce the impact on Maryland's health systems.

II. Scope

The PRESCRIBER-ENFORCEMENT ACTION Protocol identifies communication and coordination procedures in the event of a law enforcement action against a prescriber or medical facility stemming from the alleged inappropriate prescribing of controlled medications. The Protocol identifies information needs, information sharing channels, and public health response priorities.

III. Information Sharing

DESIGNATED HEALTH POINT OF CONTACT

(TO BE CONFIDENTIALLY NOTIFIED PRIOR TO OR IMMEDIATELY FOLLOWING A PRESCRIBER-ENFORCEMENT ACTION)

Fran Phillips RN, MHA
Deputy Secretary of Public Health Services
Maryland Department of Health

(410) 999-7400 cell
fran.phillips@maryland.gov

IMPORTANT INFORMATION ELEMENTS

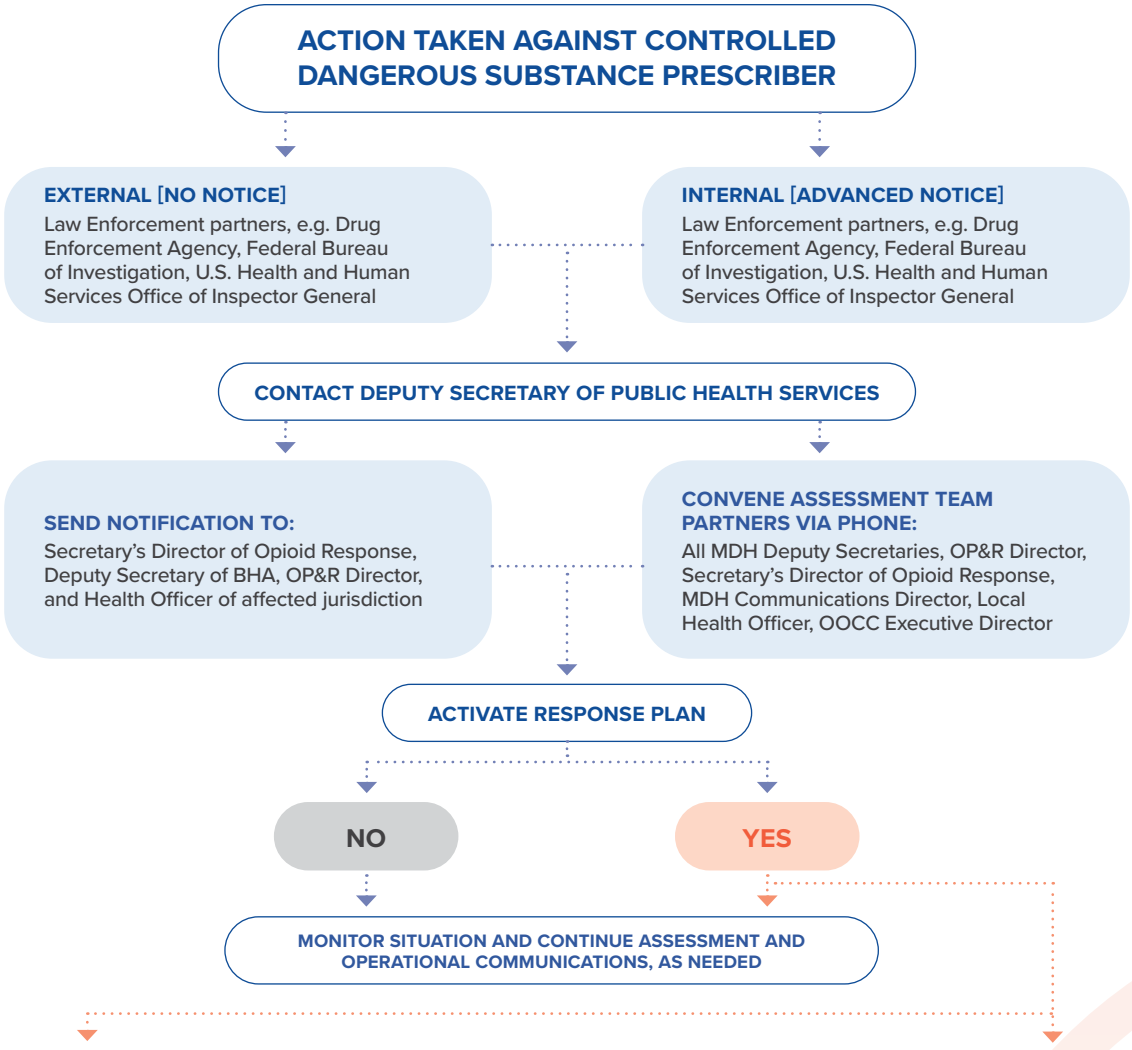
When possible, a notification from law enforcement to Dept. of Health should include:

- Type of law enforcement action
  - Record seizure
  - Removal or surrender of DEA registration or controlled substance license
  - Facility closure
  - Arrest of prescribers
- Timing, location, and duration of the action
- Ability to share clinical information
- Law enforcement point of contact for any follow-up communication about the enforcement action

INFORMATION SHARING PARAMETERS

When possible, a notification should specify the parameters for re-sharing any information that is shared between law enforcement and Dept. of Health:

- **Sensitive**
  Approved for re-sharing with directly-impacted health authorities only
- **For Official Use Only**
  Approved for re-sharing with official partners only (gov't response partners, medical providers, pharmacists, etc.). Should not be shared with the public
- **Approved for Public Release**



PHS / BHA / MEDICAID RESPONSE ACTIVITIES

- Mobilize resources [pre-scripted messaging, county emergency hotline, collate / map provider resources by specialty area]
- Develop list of resources for continuity of care [BHA]
- Distribute partner notifications / situational awareness / guidance documents and situation reports to key points of contact for further distribution, as approved [OP&R]
- Distribute initial list of PDMP data and locations of patients byinsurance type to assessment team [OP&R and BHA]
- MCOs / Beacon / Mobile support coordination [Medicaid and commercial insurers]
- Implement legal authorities, as needed
- Update MDH Office of Communications

LOCAL HEALTH DEPARTMENT RESPONSE ACTIVITIES

- Collect PDMP provider consent
- Post LHD contact number for patients
- Establish call center as needed
- Notify pharmacies, EMS, and care providers
- Provide coordination for continuity care
- Utilize health data to support local response, as available
- Provide situation reports to assessment team for distribution
- Coordinate public information in county

KEY ELEMENTS FOR CONTINUITY OF CARE

- Determine level of urgency [CDS license status, facility status, patient population]
- Obtain list of patients and current medications from provider, PDMP, or OCSA
- Establish communications with patients [by phone, call-in number, or direct patient contact]
- Provide patients with resource guidance and lists [primary care, pain management clinics, MAT programs]
- Alert pharmacies to incident and urgency toprovide prescription continuity

OPIOID-OVERDOSE SURVEILLANCE AND RESPONSE INFORMATION FOR FIRST RESPONDERS

Opioid Overdoses in Georgia

Opioid-involved overdose deaths have been rapidly increasing in Georgia since 2010, driven initially by increased use and misuse of prescription opioids (e.g., oxycodone and hydrocodone). However, in recent years there have been substantial increases in the number of heroin- and fentanyl-involved overdose deaths. From 2010 to 2017, the number of opioid-involved overdose deaths increased by 245% in Georgia.

DPH Surveillance and Response Efforts

DPH uses a variety of data sources to track drug overdose trends across Georgia. Our most timely data source is Syndromic Surveillance, which is a near-real time method of categorizing visits from emergency departments (ED) across Georgia into disease or illness syndromes, based on the patient chief complaint upon admission. These data can be used as an early detection method for drug overdose outbreaks. DPH also relies on external partners to report overdose clusters/increases or unusual situations. Notifications from first responders are particularly important because they may be aware of overdose events which are not captured in our Syndromic Surveillance data.

Once DPH is notified of an overdose cluster/increase, we alert relevant partners (including healthcare personnel, coroners/medical examiners, first responders, and community partners). Timely detection of overdose clusters/spikes may prevent overdoses, protect first responders, and lead to a better understanding of patient outcomes.

How to Report

To report an increase in overdoses, a potential overdose cluster, or any other unusual drug-related event, **call the Georgia Poison Center at 1-800-222-1222.**

Resources

Personal Protective Equipment

Opioids may come in several forms, including powder. Some opioids can be absorbed through the skin, or through accidental inhalation of airborne powder. First responders should take precautions when responding to a call where unknown substances may be present. For more information, see https://www.cdc.gov/niosh/topics/fentanyl/workerrisk.html.

Naloxone Standing Order

Georgia has a standing order which allows anyone to purchase naloxone at a pharmacy without a prescription. For more information on the standing order, please see https://dph.georgia.gov/naloxone.

Naloxone Administration

For information on how to administer naloxone to someone who may be overdosing, please see https://dph.georgia.gov/approved-training.

Georgia 911 Medical Amnesty Law

The GA 911 Medical Amnesty law provides immunity to those seeking medical attention for themselves or someone else due to an overdose. This immunity includes possession of certain drugs or drug paraphernalia, and civil and criminal immunity for administration of naloxone. For more information, see http://www.georgiaoverdoseprevention.org/about.

Georgia Prescription Drug Monitoring Program (PDMP)

The PDMP is an electronic database used to monitor the prescribing and dispensing of controlled substances. Law Enforcement may access PDMP data through a search warrant or subpoena. For more information, https://gdna.georgia.gov/georgia-prescription-drug-monitoring-program-ga-pdmp.

Georgia Overdose Statistics

For more information about drug overdose surveillance and statistics in Georgia, please see https://dph.georgia.gov/drug-overdose-surveillance-unit.

LETTER TEMPLATES FROM NORTH CAROLINA DEPARTMENT OF HEALTH: INFORMING EMS OF A POTENTIAL OVERDOSE CLUSTER

Dear [First Responder Agency],

This email is to inform you that we have recently seen an increase in opioid overdose emergency department visits among residents of *[County name]* County. *[Include any relevant specifics, such as if patients are mostly from a certain geographic area of the county.]*

We are informing you for your situational awareness. An increase in overdoses such as we are now seeing can result from several factors, including circulation of more potent products in our community. *[If there is* ***reliable*** *information about a potent product circulating in the area, specifics of this should be included.]* Your agency might want to increase the doses of naloxone being carried by your first responders in case they encounter multiple victims or victims who require higher than usual doses of naloxone.

Please let us know how you decide to proceed with this information. Meanwhile, we'll continue to monitor the situation and will share any relevant updates with you. If you have any questions, please contact *[name, position]* at *[phone number; email].*

Sincerely,
[Your Name]

Dear [Local Hospital Contact],

This email is to inform you that we have recently seen an increase in syndromic surveillance overdose counts in NC DETECT for *[Name]* County. As you know, syndromic surveillance is not very specific, and these numbers are subject to change as more data are received. We are therefore reaching out to you to ask if you have noticed an increased number of overdose patients in your emergency department.

Increases in overdose cases can be a signal of a more potent product circulating in the community that could present a higher threat of fatal overdose. When this occurs *[Name of Health Dept]* works with partners in law enforcement and EMS to make them aware and prepared to experience a higher demand on resources such as naloxone supplies.

If you are seeing patients presenting to your emergency department with opioid overdose, please keep the following recommendations in mind:

- Prescribe/dispense naloxone to patients discharged home after an opioid overdose to prevent death from future overdose.
- Inform patients that naloxone can be dispensed at participating pharmacies under NC's standing order for naloxone. Information on participating pharmacies and use of naloxone can be found at www.naloxonesaves.org.
- For those using injection drugs, provide information on syringe exchange programs: https://www.ncdhhs.gov/divisions/public-health/north-carolina-safer-syringe-initiative/syringe-exchange-programs-north. Syringe exchange programs are effective in decreasing the transmission rates of HIV and hepatitis C, as well as connecting users to treatment.
- Connect patients to substance use treatment services. Contact information for 24/7 crisis lines can be found at www.ncdhhs.gov/providers/lme-mco-directory.

We appreciate your partnership in working to save lives in our community. If you have any questions, please contact *[name, position]* at *[phone number; email].*

Sincerely,
[Your Name]

PROPOSED ACTIONS AFTER LICENSE SUSPENSION OR RESTRICTION OF A PAIN SPECIALIST

The purpose of this document is to provide guidance on potential actions to take after the license of a pain specialist is suspended or restricted. These proposed action steps can be adapted based on the situation.

Actions Prior to Serving Suspension/ Restriction

- ☐ Prior to the suspension/restriction, board or commission reports pending action to the Assistant Secretary of Health Systems Quality Assurance.
- ☐ The Assistant Secretary for Health Systems and Quality Assurance discusses the case with the executive director of the board or commission and decides on timelines for activities.
- ☐ Board or commission pulls PMP data on all opioid and benzodiazepine prescriptions written by the provider in the past six months.
- ☐ Using this data, board or commission determines the following:
  - Number of unique patients who received an opioid and/or benzodiazepines prescription.
  - Proportion of patients by county of residence.
  - Proportion of patients on high dose opioids (> 90 mg MED daily).
  - Proportion of patients on opioids and benzodiazepines.
  - Proportion of patients paying for prescriptions using cash.

Actions at the Time of the Suspension is Served

- ☐ State health officer contacts Office of the Insurance Commissioner to determine which private insurers are contracted with the provider.
- ☐ State Health Officer informs health care authority and Department of Labor and Industry of action.
- ☐ Board or commission includes letter to provider and sample letter to patients in suspension packet that encourages provider to notify patients as soon as possible about license suspension/ restriction and reminds provider of his/her requirement to provide medical records.

Actions after Suspension/ Restriction Served

- ☐ Local health department* contacts the provider and/or clinic manager and does the following:
  - Asks questions to better understand the provider's patient population, including the proportion of patients on different types of insurance.
  - Determines if any patients have intrathecal pain pumps. If there are patients on intrathecal pain pumps, the local health department will ask the provider to report these patients to their insurer so the insurer can contact these patients and connect them to pain specialty care.
  - Encourages the provider to send a letter to all his/her patients to let them know about the temporary suspension and need to find a new provider as soon as possible. DOH has a sample letter.
  - Establishes a plan for how the provider will continue to provide medical records.

*Department of Health will contact provider or clinic manager if clinics in multiple counties close.

- ☐ Health care authority contacts medical directors of Managed Care Plans and asks them to identify affected patients using their claims data, risk stratify these patients based on opioid dosages and co-morbid conditions, and provide case management services as needed.
- ☐ State health officer contacts medical directors of private insurance plans contracted with the provider and encourages them to identify affected patients using their claims data, risk stratify these patients based on opioid dosages and co-morbid conditions, and provide case management services as needed.
- ☐ Local health department, working in collaboration with local healthcare leaders, compiles a list of all the pain specialty clinics in the area and surveys them regarding their capacity. DOH can assist as needed if resources exist.

- ☐ Local health department alerts ER and primary care providers about the action and encourages them to assist with managing displaced patients. (DOH has sample alert.)
  - Informs them of CDC and AMDG Guidelines for Prescribing Opioids.
  - Informs them of the UW Pain Hot Line staffed by UW pharmacists to assist providers with medication management.
  - Informs them of UW Telepain which is a telemedicine service for managing patients with chronic pain.
- ☐ Local health department considers asking Collective Medical Technologies to add an alert to the Emergency Department Information Exchange to indicate when a displaced patient enters an ER. (This can be arranged through HCA.)
- ☐ Local health department convenes pain specialists and healthcare leaders in the community. They collaboratively do the following:
  - Determine the capacity in the area to manage patients on chronic opioid therapy.
  - Develop a plan to "divide up" displaced patients.
  - Develop a standard approach to managing patients on high dose opioid.
- ☐ Department of Health and local health department post information on their web sites with resources for displaced patients: http://www.doh.wa.gov/Emergencies/PainClinicClosures.

GUIDELINES FOR PUBLIC HEALTH OFFICIALS RESPONDING TO CLUSTERS OF DRUG OVERDOSES

The purpose of this document is to provide guidance to local health jurisdictions on responding to clusters of overdoses or unusual reactions to illicit drugs.

Advance Preparations:

1. Identify stakeholders and partners who may be needed in and/or affected by the response (see Box 1) and obtain their contact information. These partners can help with event confirmation, case finding, and communication with high risk persons.

2. Meet with partners to discuss communication channels and procedures and possible actions in the event of a multiple person overdose event.

Goals of the meeting:

- Develop relationships and expectations; confirm contact information
- Discuss partners' roles in response plan
- Discuss capacity and capabilities for emergency action, if any
- Assess options for event coordination (incident management): LHJ? County emergency preparedness staff? Poison Control? Other gov. entity?
- Discuss triggers for involving county emergency management and how public health fits into the ICS structure
- Discuss information sharing (see below)
- Determine which resources and systems will most likely be stressed or overwhelmed in a multiple person overdose event (e.g., supplies of naloxone, buprenorphine treatment slots, drug testing budget, crisis clinic phone lines, health department staff to conduct case investigations, EMS, healthcare system, mortuaries, etc.)
- Identify options for personnel/volunteer surge capacity
- Determine which agencies have contact with high risk persons for the purpose of communicating with this population during an overdose event (often persons using illicit drugs)

Box 1

SUGGESTED CONTACTS TO INCLUDE IN PLANNING

- Local emergency medical responders
- Local emergency departments/ hospitals
- Local law enforcement: www.waspc.org
- Local medical examiner/coroner
- Local HAZMAT team
- Local homeless provider
- Adjacent tribal nations (State Tribal Directory)
- Syringe service program staff (Syringe Exchange Directory)
- Other naloxone distributors
- Local DEA and HIDTA agents
- Washington State Poison Control Center (1-800-222-1222)
- Washington State Toxicology Lab
- Washington State Crime Lab

- Determine which entity could be the point of contact for the press and calls from worried well
- Discuss need for and process development of public messaging
- Review confidentiality considerations for protected health information and relevant authorities

3. Information Sharing: Discuss the local health officer's authority with partners (see box 2). Local health officers can request patient level information on persons impacted by public health hazards. Discuss partners' privacy concerns. Advance discussions may help speed information sharing in an emergency.

- Health organizations may want a written or formal request, or need language disclosures in the medical record or disclosure log
- Discuss typical scenarios and provide examples of what information may be requested during an event

Box 2

DUTIES & AUTHORITY OF LOCAL HEALTH OFFICERS

Power and Duties: http://app.leg.wa.gov/RCW/default.aspx?cite=70.05.070

Authority to investigate any condition deemed necessary and to require notification of any condition of public health importance: http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-505

Authority to look up patients who overdosed in the Prescription Drug Monitoring Program and notify providers: ESHB 1427

4. Discuss information sharing and communication between the health department, healthcare staff, law enforcement and the public.

- Law enforcement and DEA may be best sources of information about illicit drugs in the community. They are the appropriate investigators for sources of illicit drugs. However, their legal role may preclude release of case specific information that may jeopardize prosecution
- Law enforcement may arrange for toxicology testing related to criminal charges, but not for public health purposes
- Persons who sought or offered help for an overdose should not be charged with drug possession or drug use unless they have outstanding warrants or commit other crimes per RCW 69.50.315
- Law enforcement and EMS may be able to expand emergency outreach with naloxone in an emergency
- Public health should be the lead in determining health messages for the public

5. Discuss plans to evaluate the physical environment, seized drugs found at the scene, and biological specimens from suspected cases.

- Environmental Assessment: discuss triggers for requesting HAZMAT assistance and recommending evacuations. Prepare informational materials regarding secondary exposures
- Testing of drugs found on scene: Discuss protocols with law enforcement agencies on how to submit confiscated drugs from scene to the WSP Crime Lab for expedited testing
  - Assess other resources within the LHJ for expedited drug testing (e.g. through coroner/medical examiner, private laboratory)
- Testing of biological specimens from suspected cases: Discuss protocols for submitting urine or blood specimens obtained from suspected overdoses cases to the State Toxicology Lab (206-262-6100). The Washington State Toxicology Lab performs drug and alcohol testing for coroners, medical examiners, law enforcement, prosecuting attorneys, and the State Liquor Cannabis Board for all 39 counties. They reserve the right to decide which methods to use. It is possible to establish an advance contract for public health testing of specimens. The contract may specify consultation of the State Toxicologist and state or local health officer. The contract will designates which budget is billed
  - Assess other resources within the LHJ for expedited toxicological testing (e.g. hospital laboratory medicine departments, private laboratories)
- Build capacity within the LHJ to interpret toxicological test results (false negative results, implications of positive results vis a vis determining cause of death, presence of multiple drugs, etc.)

Response:

Step One: Collect preliminary information
Gather information about the event(s), number and demographics of people impacted, suspected drugs, form(s) of drug, route(s) of administration, if drugs were combined by user or not, time and location of ingestion, symptom onset, symptoms, toxicology results, and health outcomes (deaths, hospitalizations, discharged from ED, treated on scene). Inquire which drug types are included on the panel used for toxicological testing.

If fentanyl is combined with heroin or other drugs by the dealer, more events are likely. If fentanyl is combined with other drugs by the user, the event may more likely be limited to the user group.

Step Two: Perform active case finding
Contact your local EMS, emergency departments, and the Poison Control Center to see if other people are experiencing similar symptoms in the area. Check RHINO to see if patients with similar symptoms are presenting to emergency departments in the area. Consult with key informants from the community of affected persons (persons who inject drugs). Consider the potential for enhanced surveillance.

Report the event to the DOH duty officer and determine if other similar events have been reported from other local health jurisdictions.

Step Three: Establish a case definition
An example case definition might be:

"Any person with central nervous system and/or respiratory depression with evidence of recent illicit drug use and no other more likely diagnosis identified."

Step Four: Make a line list of confirmed, probable, or possible cases
Include information such as age, sex, location, time of symptom onset, symptoms, PMP prescribed controlled substances, suspected drugs, route of exposure, outcome (ED visit, hospitalization, death), etc.

Step Five: Descriptive epidemiology
Summarize the event and develop hypotheses, modify case definition, and seek additional information as needed. Incorporate toxicology results and information as available. Create maps indicating location & timing of events.

Step Six: Consider the need for immediate public health actions
Decide if immediate public health actions are necessary such as communication with the public, health care providers/EMS, or persons who use drugs; or rapid dissemination of naloxone. Coordinate communication with other agencies. Identify potential future resource challenges/shortages and take steps to ensure availability of needed resources or mitigate shortages. Monitor to determine the extent of the problem and identify when the number of overdoses has returned to baseline.

After the investigation and response, write up an after action report with partner input. Share lessons learned. Thank partners.

Box 3

DRUG EVENT RESOURCES

Power and Duties: http://app.leg.wa.gov/RCW/default.aspx?cite=70.05.070

Authority to investigate any condition deemed necessary and to require notification of any condition of public health importance: http://apps.leg.wa.gov/wac/default.aspx?cite=246-101-505

Authority to look up patients who overdosed in the Prescription Drug Monitoring Program and notify providers: ESHB 1427

Resources:

Kieran Moore, MD, CCFP (EM), FCFP, MPH, DTM&H, FRCPC, Maximilien Boulet, BSc, Julia Lew, BSc, Nicholas Papadomanolakis-Pakis, BSocSc, MPA. A public health outbreak management framework applied to surges in opioid overdoses http://www.wmpllc.org/ojs-2.4.2/index.php/jom/article/view/732

Fentanyl outbreak in Georgia http://www.georgiapoisoncenter.org/wp-content/uploads/2017/06/June-2017-Deadly-Novel-Synthetic-Opioid-Exposure-Outbreak-in-Georgia_FIN....pdf

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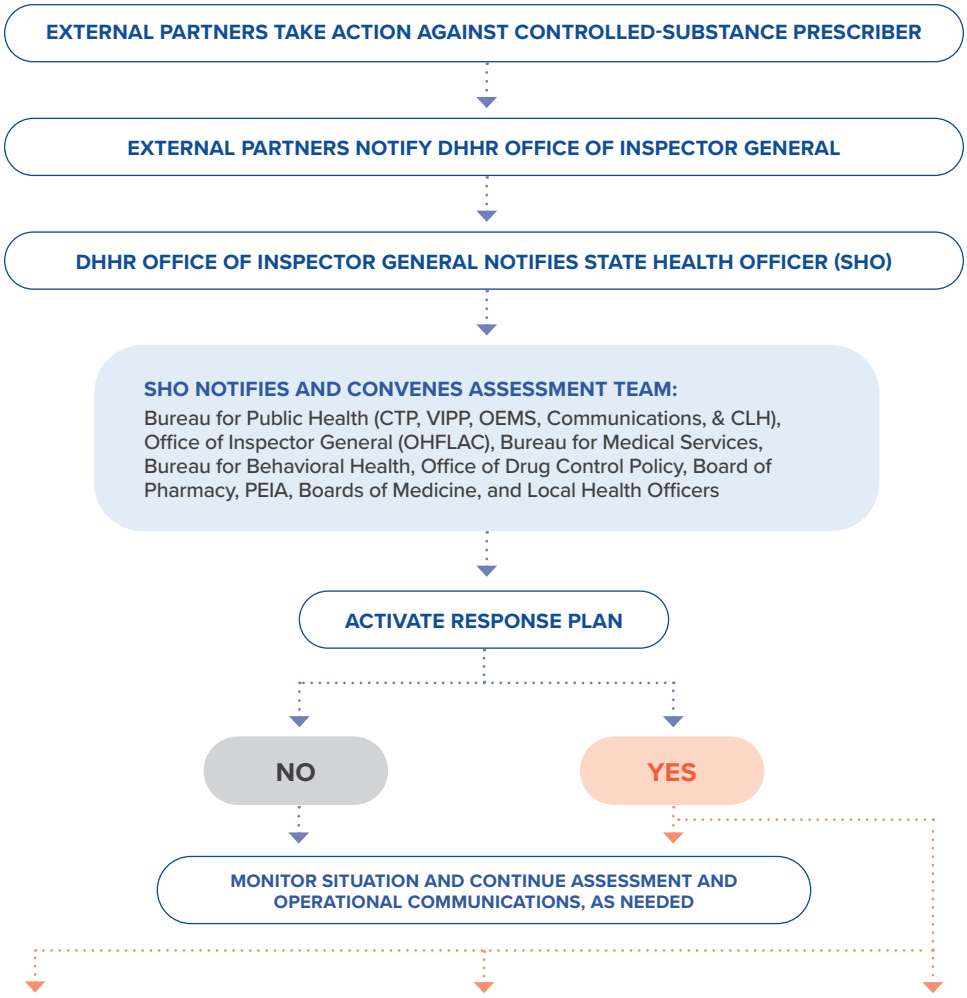

DHHR ACTIVITIES

- Mobilize resources (pre-scripted messaging, emergency hotline, map provider resources by specialty area)
- Notify pharmacies and hospitals, develop list of resources for continuity of care
- Distribute partner notification, guidance documents, and situation reports to key points of contact for further distribution
- Establish communications with patients
- Mobilize care management resources
- Implement legal authorities, as needed
- Update DHHR Office of Communications
- Alert Bureau for Children and Families

LOCAL HEALTH DEPARTMENT RESPONSE ACTIVITIES

- Post clinic shutdown notice on website and social media
- Provide coordination for continuity of care
- Provide situation reports to assessment team for distribution
- Coordinate public information in county

BOARD OF PHARMACY

- Provide initial list of CSMP data and locations of patients to the Office of Health Facilities Licensure and Certification (OHFLAC)

KEY ELEMENTS FOR CONTINUITY OF CARE

- Determine level of urgency (license status, facility status, patient population)
- Obtain list of patients and current medications from provider or CSMP
- Establish communications with patients by phone, call-in number, or direct patient contact
- Provide patients with resource guidance and lists (primary care, pain management clinics, MAT programs)
- Alert pharmacies and hospitals to incident and urgency to provide prescription continuity

APPENDIX C:

CALLING FOR HELP

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CALLING FOR HELP

FEDERAL RESOURCES	
1. CDC EOC	Emergency Operations Center: https://www.cdc.gov/cpr/eoc.htm
2. EMAC	The Emergency Management Assistance Compact State Offices and Agencies of Emergency Management Contact information listed at: https://www.emacweb.org/index.php/mutualaidresources/contact-state-emergency-management-agencies
3. REQUEST AN OPIOID-RAPID RESPONSE TEAM (ORRT)	To request ORRT assistance, please contact the CDC Emergency Response Operations Center at 770-488-7100 and ask for the Opioid Rapid Response Team point of contact. The ORRT program will set up a brief call to discuss the state/jurisdiction needs. For questions, contact the Opioid Rapid Response Team at ORRT@cdc.gov. https://www.cdc.gov/opioids/opioid-rapid-response-teams.html
4. ONLINE TECHNICAL RESOURCE AND ASSISTANCE CENTER (ON-TRAC)	CDC created this online system to provide health departments a platform for requesting technical assistance from CDC SMEs on public health preparedness: https://www.cdc.gov/cpr/readiness/on-trac.htm

APPENDIX D:
GLOSSARY

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GLOSSARY

1. AFTER ACTION REVIEW

An After Action Review (AAR) is a standardized means to debrief after an emergency event. The purpose of an AAR is to identify best practices, gaps, and lessons learned to improve the emergency response process. This review results from conducting a hotwash.

2. CAREER EPIDEMIOLOGY FIELD OFFICER (CEFO)

Career Epidemiology Field Officers (CEFOs) are assigned to each state to strengthen nationwide epidemiologic capacity and public health preparedness. They serve to increase the level of effective public health surveillance, epidemiology, and response efforts. CEFOs support state health departments' day-to-day operations and emergency response activities.

3. CASE DEFINITION

A case definition includes criteria for person, place, time, and clinical features that are specific to the outbreak under investigation.

4. CDC EMERGENCY OPERATIONS CENTER (EOC)

CDC's Emergency Operations Center (EOC) is staffed 24 hours a day, seven days a week, 365 days a year by experts to monitor information and coordinate risk communication strategies for known and unknown public health emergencies. Their email form can be completed by clicking on the email icon at https://www.cdc.gov/cpr/eoc.htm.

5. CLUSTER

An overdose cluster is an event that occurs when a series of overdoses occur in the same geographic area.

6. DESCRIPTIVE EPIDEMIOLOGY

Descriptive epidemiology is the process of reviewing case definitions to compile the who, where, and when of the situation occurring on the ground (e.g., which population/locale affected).

7. EMERGENCY MANAGEMNET ASSISTANCE COMPACT (EMAC)

The Emergency Management Assistance Compact (EMAC) is a mutual aid organization that is activated when states declare an emergency.

8. INCIDENT COMMAND SYSTEM (ICS)

The Incident Command System (ICS) is a management system designed to integrate facilities, equipment, personnel, procedures, and communications under a common organizational structure.

9. HOTWASH

A hotwash is the immediate "after-action" discussion and evaluation of an agency's (or multiple agencies') performance following an exercise, training session, or major event. The main purpose of a hotwash is to identify strengths and weaknesses of the response to a given event and to inform the AAR. Hotwashes should be conducted by the evaluator immediately following the exercise. It also provides an opportunity for the players to gain clarification on their functional area.

10. JOINT INFORMATION CENTER (JIC)

The Joint Information Center (JIC) is a location where personnel with public information responsibilities perform critical emergency information functions, crisis communications, and public affairs functions.

11. LOCAL HEALTH JURISDICTION (LHJ)

A local health jurisdiction (LHJ) refers to a county board of health. NACCHO has a directory of local health departments: https://www.naccho.org/membership/lhd-directory?searchType=standard&lhd-state=VA#card-filter

12. OVERDOSE DETECTION MAPPING APPLICATION PROGRAM (ODMAP)

Overdose Detection Mapping Application Program (ODMAP) is a surveillance system that provides near real-time data for suspected overdoses across jurisdictions to support public safety and public health efforts to respond to overdose spikes.

13. PUBLIC INFORMATION OFFICER (PIO)

Public Information Officers (PIOs) are the communications coordinators or spokespersons during an emergency response. They are responsible for communicating internally with incident personnel and externally with the public and media with incident related information.

14. SPIKE

A spike is when the total number of suspected overdoses for a jurisdiction exceeds a pre-determined threshold for a specified time.

12. TABLETOP EXERCISES

Tabletop exercises are table-based activities in an informal setting with the goal of generating discussion around a hypothetical emergency preparedness scenario. Tabletops can be used to increase awareness around the considerations of a specific emergency scenario, rehearse concepts, and guide in the prevention of and/or the response to the scenario.

Overdose Spike Response

DECISION TREE

PHASE 1

PRE-PLANNING

1. **Identify Surveillance Team** member to determine the members, roles, and responsibilities of the Overdose Spike Response Team (OSRT)
2. **Define a "spike"** and threshold for action
3. **Assemble the OSRT** with an incident command structure to centralize the response
4. **Develop an Overdose Response plan**
5. **Test the response plan**

PHASE 2

FIRST 24 HOURS

1. **Assess the threat** by monitoring overdose data
2. **Activate the OSRT team** to decide if incident command structure needs to be stood up
3. **Communicate the threat** to stakeholders
4. **Eliminate the source** of the overdose

ACTIVATE THE OSRT?

YES

Regular, short, and frequent A-Team meetings

NO

Monitor and assess the situation and provide communications as needed

SPIKE CONFIRMED

PHASE 3

THROUGH WEEK ONE

1. **Monitor the threat** and enhance surveillance as needed
2. **Communicate the threat:** a public information campaign is critical in the first 24 hours
3. **Monitor, assess, and engage key resources**
4. **Assess need for help**

PHASE 4

BEYOND WEEK ONE

1. **Monitor the threat:** if threat has subsided proceed to conducting a hotwash and after-action review to inform pre-planning; if threat is present, revert back to Phase 3
2. **Reassess communications activities** and restructure as needed
3. **Coordinate continuity of care** for patients and resources

APPENDIX F:

DATA SOURCES FOR OPIOID SURVEILLANCE

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DATA SOURCES FOR OPIOID SURVEILLANCE

Public Health

- Coroner investigatory reports
- PDMP (if applicable) or other similar state system
- Medical examiner autopy reports
- Vital statistics death certificates
- Substance use disorder treatment records
- New HIV diagnoses
- Estimated acute Hepititis C cases
- Post-mortem toxicology report
- Harm reduction data: naloxone distribution, syringe exchange, and or fentanyl test strip services
- ESSENCE syndromic surveillance
- Poison control center reports

Public Safety

- Corrections
- HIDTA ODMAP (if available)
- Drug seizure data

First Responders

- Emergency medical services

Human Services

- Housing
- Social services
- CPS data to monitor children of parents with SUD

Medical Claims & Hospitals

- Pharmacy claims
- Healthcare facility records
- Medicaid
- Hospital discharge data