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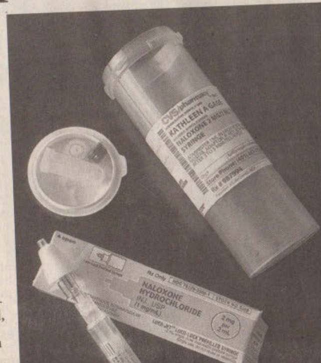
SCHOOLS

Amid heroin scourge, schools stock up on overdose antidote

By Michelle R. Smith
Associated Press



PROVIDENCE, R.I. — In addition to pencils, books and computers, count a new tool this year at many schools around the country: the heroin-overdose antidote naloxone.

Many schools now keep naloxone on hand, and some states allow or encourage schools to stock it. Rhode Island now requires it for all middle, junior high and high schools.

Naloxone, also known by the brand name Narcan, might never be needed in an individual school, say nurses, officials and health workers, but it can save a life if a child, par-

During that time, naloxone was administered once at a school, although it was later determined the person had not overdosed.

One of the children given Narcan was just 4 years old. The details of that case aren't clear, but some nurses said they worried about an overdose by a curious child with access to a relative's drugs.

Rebecca King said she has seen incidents of substance use as a nurse in a K-8 school in Delaware. Seeing a child collapsed on the floor is the "worst nightmare" of every school nurse, she said.

"Naloxone saves lives," King said. "It can really be the first step toward

ENTRY POINT

Overdose antidote: Alicia Gibbons holds an empty bottle of naloxone that she used to save the life of her daughter Ashley at their home in Mays Landing, New Jersey.

doi: [illegible]

An Overdose Antidote Goes Mainstream

Expanded access to the opioid overdose rescue drug naloxone has raised complex questions for policy makers.

BY KEITH HUMPHREYS

This past July the Food and Drug Administration (FDA) convened a public meeting in the Washington, D.C., area at which invited experts discussed the blossoming array of programs and policies designed to expand access to the opioid overdose rescue drug naloxone. That the well-attended meeting was held in a city where national policy makers not long ago condemned expanding access to naloxone[1] was one of many recent signs that an idea once restricted to crusading activists and boundary-pushing public health departments has gone mainstream.

Twenty years ago it was hard to find a medical professional who knew much about naloxone (which is shorthand for naloxone hydrochloride). Naloxone was approved by the FDA in 1971 as an injectable medication, under the trade name Narcan. Emergency departments in cities hard hit by the heroin epidemic of the period used it extensively to reverse overdoses.

The drug's mechanism of action during opioid overdose is straightforward. Heroin and other opioids (for example, morphine or hydrocodone) suppress breathing. When the suppression is severe, the resulting shortage of oxygen begins to damage the brain and other vital organs, potentially to the point of causing death. Naloxone is an opioid "antagonist," meaning it forces opioids out of the brain receptor to which they bind, rapidly reversing their effect on the body for a short period (for example, 30–60 minutes). If the individual goes back into overdose after this point, additional doses of naloxone may be required.

Naloxone does not reduce the impact of other drugs (such as alcohol or cocaine) that may be in the body. Neither does it affect addiction per se. A heroin-dependent person whose life is saved by naloxone is still heroin dependent. But the benefits of naloxone are easily grasped if one imagines some classic overdose situations: A father discovers that his teenage daughter has overdosed on Vicodin and frantically telephones for an ambulance, which will take twenty minutes to arrive; a highway patrolman encounters an overdosed driver slumped behind the wheel of a car that has skidded off of a rural road, and the nearest hospital is an hour away; a shelter volunteer finds a homeless man passed out on a cot with a needle in his arm, and there are no medical professionals on staff. It is no exaggeration to say that naloxone can be the difference between life and death (or lifelong brain damage) in such emergencies.

After the heroin epidemic of the 1970s waned, so did interest in naloxone. It continued to be manufactured, but the expiration of its patent meant that there was no longer much incentive to market it extensively.

What brought naloxone back to prominence was the explosion of opioid prescribing and resulting overdose deaths that began in the late 1990s. The Centers

AMR

TECHNOLOGY

The Promise of mHealth

Mobile health efforts continue to push the healthcare delivery model beyond the walls of the hospital, but change must go beyond the technology itself. BY SCOTT MACE

>KEY VALUE PROPOSITIONS. Joseph Kvedar, MD, is founder and director of the Center for Connected Health at Boston's Partners HealthCare. He says two important—and reproducible—value propositions associated with mHealth are improvements in patient self-care and just-in-time care.

Ever since the first experiments with telemedicine, providers have been taking steps to move healthcare closer to where patients live and work. Now, mobile technology—epitomized by the millions of such apps already downloaded to smartphones, but also appearing in nearly unlimited form factors—is accelerating those steps.

At Boston's Partners HealthCare, a system with 2,700 licensed beds, 45 employees scrutinize these developments at the Center for Connected Health. One early effort to equip cardiac patients with remote monitoring technology resulted in a 50% drop in readmissions, says Joseph Kvedar, MD, founder and director of the center.

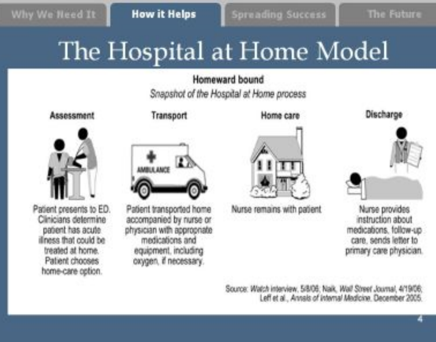
"We're all committed to a healthcare delivery model that moves care out of the hospital, out of the office, and directly and continuously into the lives of patients," Kvedar says. "We find that the best technologies to facilitate that vision are monitoring and communications technologies properly applied."

Kvedar says his team sees "two reproducible value propositions over and over again" regarding mHealth. One is improved patient self-care. "That to me is the most exciting one, that we can arm patients with data about themselves in context, and they manage it not dissimilar to the way a baseball manager manages a lineup of batting averages. They can see what they're hitting and if they need to improve something. They can do that and watch their numbers change. It's very, very powerful."

The second value proposition, Kvedar says, is just-in-time care. "We give providers a dashboard view of their population, informed by all of these sensor data, connected health data that are streaming in from those patients, and then enable those clinicians to reach into the lives of individuals who need the most at that moment in time," he says.

The sheer power of smaller, cheaper, and faster healthcare is evident in today's mHealth solutions; dermatology, Kvedar's specialty, has been an early beneficiary. "When I started doing this work, the camera we used was a $12,000 device that was about

TSAR FEDORSKY · GETTY IMAGES



How It Helps: The Hospital at Home Model

Homeward bound: snapshot of the Hospital at Home process

Assessment
Patient presents to ED. Clinicians determine patient has acute illness that could be treated at home. Patient chooses home-care option.

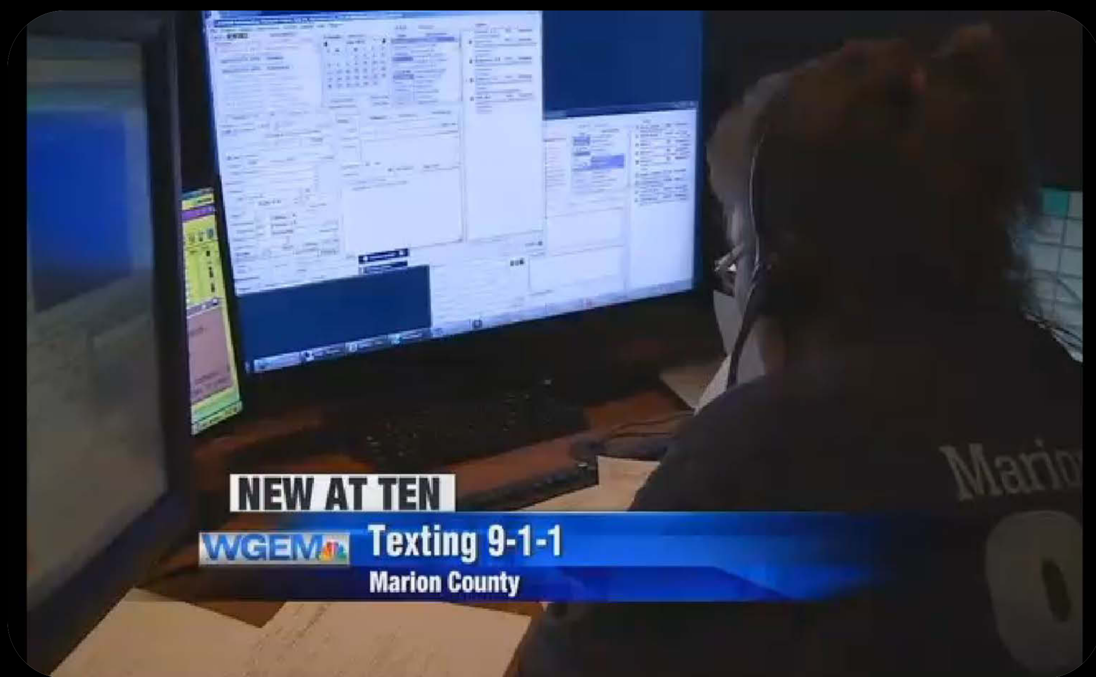
Transport
Patient transported home accompanied by nurse or physican with appropriate medications and equipment, including oxygen, if necessary

EMS Management of Patients with Potential Spinal Injury

Position Statement of the American College of Emergency Physicians
Approved by ACEP Board January 2015

The American College of Emergency Physicians believes that:

- Current prehospital management practices of patients with potential spinal injury lack evidentiary scientific support. Practices which attempt to produce spinal immobilization include the use of backboards, cervical collars, straps, tape, and similar devices (e.g., sand bags, head wedges). Evolving scientific evidence demonstrates that some of these current prehospital care practices cause harm including airway compromise, respiratory impairment, aspiration, tissue ischemia, increased intracranial pressure, pain, and can result in increased use of diagnostic imaging and mortality.
- Historically, the terms "spinal immobilization" and "spinal motion restriction" have been used synonymously. However, true "spinal immobilization" is impossible. "Spinal motion restriction" in this policy refers to the preferred practice, which attempts to maintain the spine in anatomic alignment and minimizes gross movement, and does not mandate the use of specific adjuncts.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by Amy McCarthy Jan 8, 2016, 12:30p | 8 COMMENTS

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The American Association for the Surgery of Trauma

Contemporary Update on Freeze Dried Plasma

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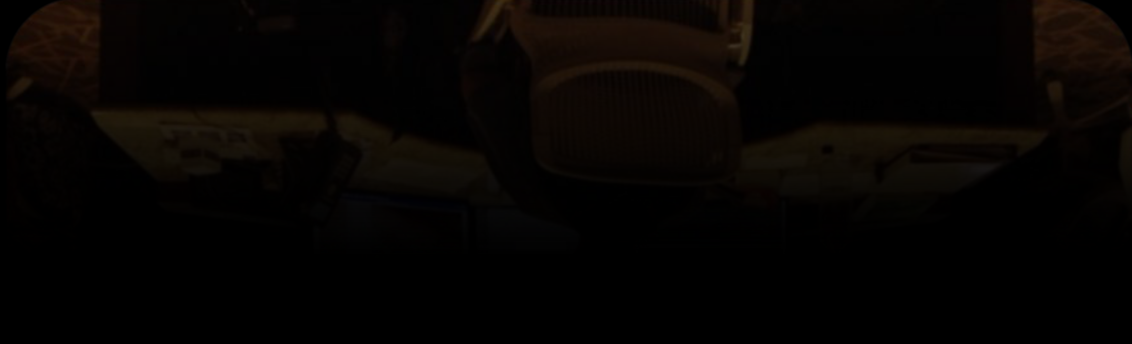

Study: One-third of N.J. emergency room visitors aren't sick enough to be there

57 comments

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By Susan K. Livio/The Star-Ledger
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on May 09, 2012 at 3:05 PM, updated May 09, 2012 at 6:50 PM

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Star-Ledger file photo

Newark Beth Israel hospital is shown in this file photo.

TRENTON — One out of three people who went to emergency rooms at two hospitals in Newark and Long Branch didn't actually have medical emergencies and could have been treated at less-costly doctor's offices or clinics, according to a study released today.

And a comprehensive effort to educate and follow up on these patients reduced emergency room visits at Newark Beth Israel Medical Center and Monmouth Medical Center in Long Branch by more than 20 percent by the end of the study.

"This project is all about patients — making sure they get the right care in the right setting," said Betsy Ryan, president of the New Jersey Hospital Association, one of three groups that conducted the study. "But this is one of those scenarios in which

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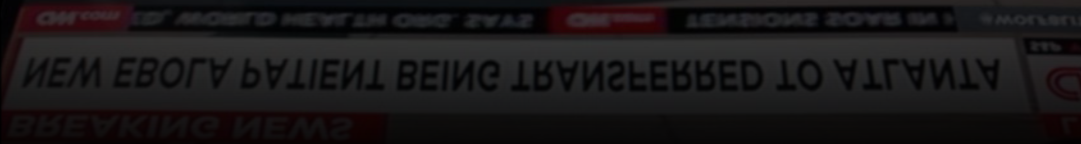

Care Priorities	U.S. Incidence	# of Deaths	Mortality Rate
AMI [1]	900,000	225,000	25%
Stroke [2]	700,000	163,500	23%
Trauma [3] (Motor Vehicle)	2.9 million (injuries)	42,643	1.5%
Severe Sepsis [4]	751,000	215,000	29%

Source: (1) Ryan TJ, et al. ACC/AHA Guidelines for management of patients with AMI. *JACC*. 1996; 28: 1328-1428. (2) American Heart Association. Heart Disease and Stroke Statistics – 2005 Update. Available at: www.americanheart.org. (3) National Highway Traffic Safety Administration. Traffic Safety Facts 2003: A Compilation of Motor Vehicle Crash Data from the Fatality Analysis Reporting System and the General Estimates System. Available at http://www.nhtsa.dot.gov/. (4) Angus DC et al. *Crit Care Med* 2001;29(7): 1303-1310.

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Education.

Education reform…

- What's changing in our profession?
- What's changing in the art & science of education & professional development?
- The important details of the journey to EMS 3.0

Education is the most powerful weapon which you can use to change the world.

Nelson Mandela

Are you an ambulance that moves
sick & injured people
or a
healthcare system that moves?

Our changing profession

(whether we know it or not…)

- *We will always be the time-sensitive guardians of life…*
- Value based care
- Evidence based approaches
- Systems of care
- Navigation
- MIH / CP
- Hospital @ home
- Public safety emphasis
- Rapidly emerging illness / injury
- ALS v BLS (eerie music)

What's changing in the art & science of education & professional development?

- "Professional development"
- Competency
- Delivery methods
- Lifelong learning
- Interprofessional approaches
- Targeted programs
- Just in time education
- Consultative care models

Details of the journey…

- Who's driving the bus and who's on board?
- Is this EMS or "other" healthcare?
- Collaborative Consensus & Command
- Credentialing & Privileging
- Accreditation
- Re-aligning the ALS / BLS umbrella

Thanks for this privilege…

"How well do you know this doctor? This is a warranty for a vacuum cleaner."