Welcome to the Poster Session on Opioid Overdose

https://injurycenter.umich.edu/research-symposium-2020/
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Associations with Opioid-Related Mortality: Buprenorphine Treatment Uptake and Critical Encounters Following a Non-Fatal Overdose Grant Victor, PhD, Center for Behavioral Health and Justice, School of Social Work, Wayne State University

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Opioid Policy and Chronic Pain Treatment Access Experiences: A Multi-Stakeholder Qualitative Analysis and Conceptual Model Stephanie Slat, BS, Department of Internal Medicine, University of Michigan

Effect of Gist Risk Messages on Parents’ Decisions to Retain Left-Over Prescription Opioids Terri Voepel-Lewis, PhD, RN, University of Michigan School of Nursing; Department of Anesthesiology, University of Michigan Medical School

The Impact of an Online Naloxone Training Curriculum for Community Laypersons Miranda Gali, BA, University of Michigan School of Public Health
Willingsness to Use Syringe Service Programs and Safe Consumption Sites in a Small Midwest Community

Emily Pasman1, Elizabeth Agius1, Michael Bromann1, Grant Victor1,2, Brad Ray1,2, & Stella Resko1,3

Wayne State University, 1 School of Social Work, 2 Center for Behavioral Health and Justice, 3 Merrill Palmer Skillman Institute

Background

Despite efforts to curb the opioid crisis, accidental overdose deaths and related harms persist. In 2017, more than 67,000 Americans died by opioid overdose. Many of these deaths involved injection drug use.1 White to recent years the US has seen decreased rates of heroin-involved overdose deaths, rates have stagnated or increased in rural and small metropolitan communities.2 Rural areas have also been identified as high-risk for rapid dissemination of HIV/HCY among people who inject drugs.3

Syringe service programs (SSPs) allow people who inject drugs (PWID) to exchange used needles and syringes for new, sterile needles and syringes. Many SSPs also offer other health and social services (e.g., HIV/HCY testing, linkage to care).

Safe consumption sites (SCSs) provide a hygienic setting where people can use pre-obtained needle/syringe kits and injectable drugs. SCSs have also been shown to increase detoxification service use, and in turn treatment initiation.4,5 SSPs and SCSs have grown in popularity internationally and in select urban communities in the US, while access is limited in rural and small metropolitan areas.6,7

Research Aims

Aims will be to use SSPs and SCSs among people receiving methadone treatment and with history of injection drug use in small metropolitan community and surrounding rural areas: 2. Identify factors associated with likelihood of use per program

Methods

Data Collection

Patients at an opioid treatment program (n=267) in a small metropolitan community completed a computerized survey (December 2019). Analyses were limited to participants who reported a history of Injection drug use (n=137, 61.1%) with complete data for all key variables (n=115, 92.6%).

Measures

Demographics: Gender, age, race, ethnicity, level of education. Community: Substance use history (AUDIT-C). Treatment: Follow-up of known health care providers. Treatment attended: Followed 1-year treatment was for other for a year. Overdose consequences: 17 items adapted from the Heroin Use Consequence Scale.8 Self-efficacy: 3 items adapted from the Experience of Shame Scale.9

Willingsness to use SSP/SPPS: Participants were asked a description of SPPS10 and asked “How likely would you be to use SPPS if you were available?”. Responses dichotomized: likely vs. unlikely for analysis.

Data Analysis

- Descriptive statistics were calculated for all key variables, CI-square and bivariate logistic regression were used to examine differences between likely and unlikely users of each program.
- Multivariate logistic regression was used to identify factors associated with willingness to use each program.

Results

Sample Characteristics (n=115)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>73</td>
<td>63.5</td>
</tr>
<tr>
<td>Male</td>
<td>42</td>
<td>35.2</td>
</tr>
<tr>
<td>Age</td>
<td>39-49</td>
<td>68</td>
</tr>
<tr>
<td>White</td>
<td>75</td>
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</tr>
<tr>
<td>Hispanic/SSRI</td>
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<td>31.9</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>0.9</td>
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<tr>
<td>Age</td>
<td>18-24</td>
<td>20</td>
</tr>
<tr>
<td>30-39</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>50-64</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Likely to use Syringe Service Program</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Likely to use Safe Consumption Site</td>
<td>81%</td>
<td></td>
</tr>
</tbody>
</table>

Bivariate Relationship between Predictors and Likelihood of Use of SSPs, SCSs

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Likely to use Syringe Service Program</th>
<th>Likely to use Safe Consumption Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>X or Y</td>
<td>X or Y</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>0.95</td>
<td>0.98</td>
</tr>
<tr>
<td>Age</td>
<td>0.94</td>
<td>0.94</td>
</tr>
<tr>
<td>Race</td>
<td>0.94</td>
<td>0.94</td>
</tr>
<tr>
<td>Likely to use Syringe Service Program</td>
<td>0.96</td>
<td></td>
</tr>
<tr>
<td>Likely to use Safe Consumption Site</td>
<td>0.96</td>
<td></td>
</tr>
</tbody>
</table>

Logistic Regression Predicting Likelihood of Use of SSPs, SCSs

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Likely to use Syringe Service Program</th>
<th>Likely to use Safe Consumption Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>X or Y</td>
<td>X or Y</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>0.96</td>
<td>0.96</td>
</tr>
<tr>
<td>Age</td>
<td>0.96</td>
<td>0.96</td>
</tr>
<tr>
<td>Race</td>
<td>0.96</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Conclusion

Willingsness to use SSPs and SCSs was high in this sample of people receiving methadone treatment with history of injection drug use. Previous research found 72% of those who indicated willingness to use an SCS when asked demonstrated the SCS when opened, suggesting high potential for SSP and SCS utilization in this small Midwest community.

Willingsness to use SSPs was consistent across socio-demographic measures. Likely use did not vary by gender, age, race, education, or community characteristics.

Those who reported more opioid-related consequences were more willing to use SSPs. Consistent with previous research in urban areas that shows SSPs may attract people who engage in high-risk/illegal drug use, who are often not reached by other service models.11,12

Lower levels of education were associated with greater willingness to use SCSs. Line with previous research, suggesting these programs successfully reach highly marginalized PWID, including those with lower levels of education.13

Greater self-efficacy were associated with greater willingness to use SCSs. PWID who experience greater feeling of ‘you can do it’/s are more likely to use SCSs. Opportunity to use substances in a safe, confidential setting, away from family, friends, or roommates.

Implementation of SSP and SCS outside larger urban areas may create opportunities to connect highly marginalized subgroups of PWID with other health care and social services. This is particularly salient in light of the ongoing HIV/HCY epidemics in rural communities.

Expansion of syringe service programs and safe consumption sites should be further explored as viable strategies to improve population health in rural and small metropolitan communities.

References

Naloxone Availability and Accessibility of Select Michigan Pharmacies that Participate in the Statewide Naloxone Standing Order

Gray, G.; Kaushal, S.; Rieck, H; MiOPEN/MEDIC Project Team; Dahlem, CH.

BACKGROUND

In the United States from 1999-2018, nearly 450,000 people have died from prescription and illicit opioid overdoses. An important strategy in preventing overdose deaths is to increase access and availability of the drug naloxone, an opioid antagonist that quickly and effectively reverses opioid overdose effects. Consequently, states began passing laws to increase access to naloxone. One legislation that has been widely implemented is a state-issued pharmacy naloxone standing order (SO) that allows pharmacists to dispense naloxone without a prescription from a medical provider. The State of Michigan passed their Pharmacy Naloxone Standing Order in 2016. However, little is known about the availability and accessibility of naloxone through pharmacies since this change was made. This is particularly important since similar studies have shown barriers to availability and access of naloxone in multiple states despite the implementation of a SO.

Purpose: To identify the availability and accessibility of naloxone through pharmacies that participate in the Statewide Naloxone SO for select counties in Michigan.

APPROACH/METHODS

Using the Michigan Department of Health & Human Services (MDHHS) Naloxone Standing Order Pharmacy List, we compiled a contact list of pharmacies participating in the standing order within select counties (Genesee, Grand Traverse, Ingham, Kalamazoo, Kent, Saginaw, Washtenaw, and Wayne). These specific counties were determined based on existing partnerships between the Michigan Emergency Department Improvement Collaborative (MEDIC) and emergency departments (ED) within those counties as part of a larger project aimed at developing and implementing naloxone distribution in the EDs.

Undergraduate research assistants were trained to conduct telephone interviews with every listed pharmacy within the select counties during their hours of operations. The interview collected from either the attending pharmacist or pharmacy staff was comprised of a standardized 12-question survey, administered with the aid of Qualtrics Survey Software where responses were recorded in real-time and automatically stored. Each survey lasted approximately 15 minutes and evaluated the pharmacy’s: 1) naloxone dispensing procedures, 2) out-of-pocket costs, and 3) education practices to inform both staff and naloxone recipients. The telephone interviews took six months to complete (from June to November 2019). All data were exported and analyzed using Microsoft Excel 2016.

RESULTS

Responses were obtained from 622 of 689 contacted pharmacies (90.3% response rate). Despite being listed as registered on State data, 53 (8.5%) pharmacies were not participating in the standing order. Of the identified standing order pharmacies (n=515), 125 (37.9%) had never had a customer pick up naloxone through the standing order, and 44 of the same sample population (8.5%) were uncertain. 491 (87%) had naloxone in-stock. Of the 74 (13.1%) pharmacies that did have naloxone stocked, 33 (5.9%) reported that naloxone could be obtained within one day of ordering.

Commonly carried naloxone formulations (left-to-right): Intramuscular naloxone, Narcan nasal spray, Evzio auto-injector. Out-of-pocket costs range from $35.11 to $5,000.

Patient education about naloxone use and overdose prevention was commonly implemented with the aid of brochures, or in-person instruction. 93.2% (n=525) provided such patient education. Staff and pharmacist training on how to use any of the overdose reversal options was reported among 92.3% (n=514) of the pharmacies.

REFERENCES


SAMPLE SURVEY RESPONSES

In response to being asked whether their particular pharmacy had naloxone currently in stock: “No, and we don’t normally carry it, unless someone comes in asking for it in which then we will put in an order.”

When asked if their pharmacy participates in the statewide standing order: “No, what is that?”

Also recorded: “No, and we never have.”

Even though they were registered on state data.

CONCLUSIONS

Despite the apparent availability and accessibility of naloxone, the results suggest that 46% of the pharmacies surveyed either had not dispensed naloxone or were uncertain if it was ever dispensed. Thus, similar to other states, barriers to utilization of the SO exist in Michigan. Pharmacy staff knowledge of SO dispensing procedures, variability of out-of-pocket costs, or lack of awareness of SO could contribute to barriers to SO utilization.
After controlling for participant differences, buprenorphine Rx reduced the risk of fatal OD. Critical encounters with the criminal justice system was the strongest predictor of experiencing a fatal drug-related OD.
Evaluation of Opioid Overdose Prevention Education for Medical Students
Jacquelyn B. Kercheval, BA,1 Rebecca Pilkerton, MD,2 Eve D. Losman, MD, MHSA,3 James Cranford, PhD,3 Chin Hwa (Gina) Dahlem, PhD, FNP-C, FAANP4

Background
- 128 daily US opioid OD deaths1
- Quarter-million annual ED visits due to opioid-related harm2
- New national push to train med students on naloxone,3,4 but major gap in co-rx of naloxone (1 / 69 opioid rxs) persists5

Objective
To evaluate the impact of an in-person naloxone training on medical students’ knowledge, feelings of preparedness, and confidence to teach others

Methods
Training:
- Adapted from existing Take ACTION curriculum (first responders, laypeople)
- 30-45 minutes, in-person, monthly
- N=156 3rd- and 4th-year medical students trained from 01/2019 - 01/2020

Assessment:
- 3 time points: pre-training, immediately post-training, and 3 months later
- Knowledge (7 Qs) and preparedness/confidence (Likert 1-5) assessed

Results

<table>
<thead>
<tr>
<th>Response Rates: N (%)</th>
<th>Pre-training</th>
<th>Post-training</th>
<th>3-mos-post</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>119</td>
<td>81 (68%)</td>
<td>17 (14%)</td>
</tr>
</tbody>
</table>

Naloxone Knowledge, Over Time
- With caveat of small sample at 3-months-post-training, an in-person opioid prevention training for medical students produces persisting increases in naloxone knowledge and perceived preparedness and confidence
- Some decay of knowledge, preparedness, and confidence over time

Conclusions
- Expands upon current literature: not only do in-person trainings work, but effects may persist over time

Innovation/Significance
- *p<0.05 pre to 3 mos
- **p<0.01 pre to 3 mos

References:
Changes in Initial Opioid Prescribing Practices Following the Release of the CDC Guideline for Prescribing Opioids for Chronic Pain

Jason E. Goldstick1,2, Gery P. Guy3, Matthew G. Myers1,2, Jan L. Losby3, Grant Baldwin3, Amy Bohnert1,4,5
1University of Michigan Injury Prevention, 2University of Michigan, Department of Emergency Medicine, 3Centers for Disease Control and Prevention, 4University of Michigan Department of Anesthesiology, 5University of Michigan Department of Psychiatry

The primary outcomes are
1. Initial prescription duration: Average days supply among those prescribed
2. Initial dosage: Starting dosage among those prescribed during follow-up

The analytic goals are to
1. Estimate the difference between the post-guideline outcomes and those expected by extrapolating the trajectories that began before the guideline
2. Derive adjusted estimates of guideline effects using generalized linear models, controlling for the pre-existing temporal trend and state fixed

Results: Changes in Initial Prescription Duration
• Duration departed from the linear trend post-guideline
• New prescribing duration was lower than expected from pre-guideline trend
• Adjusted results are analogous

Methods: Data Source
OptumInsights (a.k.a. Clinformatics Data Mart) medical claims data base
• Age 18+ commercially insured (employer-based, Medicare Advantage)
• Contains all billed services
All pharmacy claims/med fills
Any medical services
• Also contains enrollment records for all covered members
Includes basic individual data: age, sex, residence zip code

Results: Changes in Initial Dosage
• In later years, rates of high dose (50+ MME) were lower
• Rates much lower than expected from pre-guideline trend (not shown)
• Adjusted results are analogous

Conclusions
• Results suggest some clinicians may have changed their prescribing behavior
• Consistent with thousands receiving safer doses after 2016 than expected
• Lower doses reduce future risk of long term use and overdose
• Non-mandatory guidelines may catalyze prescribing behavior change

Acknowledgments
• IPA1906094 from Centers for Disease Control and Prevention (PI: Goldstick)
• U01CE002780 from Centers for Disease Control and Prevention (PI: Bohnert)
Translating an opioid safety intervention through an iterative website development process.

STATEMENT OF PURPOSE
- Our pilot study found Motivational Interviewing-based intervention effective:

METHODS
- Implementation study
- Iterative semi-structured interviews

RESULTS
- Integrate OPT-IN into site workflow.
- Website layout feedback.
- Material suggestions to aid intervention.
- Intervention training helpful.
- Leadership buy-in needed.

CONCLUSION
- The guides on the website help clarify the process.
- External facilitation needed to support implementation.
- OPT-IN program toolkit makes the conversation easier by providing available resources, prompts, and training.

SIGNIFICANCE
- This project refined the OPT-IN Toolkit to increase dissemination of this intervention to the broader population.

Thanks to our community partners!

Supported by a grant to the University of Michigan Injury Prevention Center by the Centers for Disease Control & Prevention Award Number R49-CE-002099. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Centers for Disease Control & Prevention or the Department of Health and Human Services.
Opioid Policy and Chronic Pain Treatment Access Experiences: A Multi-Stakeholder Qualitative Analysis and Conceptual Model

Stephanie Siat, BS, Avani Yagnati, BS, Jennifer Thomas, BA, Danielle Helinski, MPH, Michele Heisler, MD, Amy Bohnert, PhD, Pooja Lagisetty, MD, MSce

BACKGROUND & OBJECTIVES

• About 10 million Americans are on long-term opioid therapy for chronic pain.
• Primary care is a common source of these prescriptions and serves as an engagement point in multimodal treatment and in preventing negative opioid-related outcomes.
• As new guidelines around opioid prescribing are released, 40% of primary care clinics won’t accept a new patient on long-term opioid therapy.
• We aimed to answer the question: Why are primary care clinics reluctant to provide high-quality care for this population?

METHODS and RESULTS

Semi-structured interviews were conducted with three stakeholder groups: patients, clinicians, and office staff.

Recruitment:
• Clinicians and office staff were recruited by calling Michigan primary care clinics.
• Patients were recruited through advertisements on a health research recruiting site and through flyers posted in an academic medical center.

Thematic Analysis:
• Research associates independently coded each transcript.
• RAs met regularly to review coding and amend definitions. Once consensus was reached, the RAs and PI worked to develop a set of emergent themes informed by the data and prior literature.

Results:
• 25 interviews conducted: 15 patients, 7 providers, and 3 office staff.

THEMES AND REPRESENTATIVE QUOTES

1. Reduced clinic willingness to manage prescribed opioids for new patients
   "If they have been established, then they expect to get their monthly usual prescription. If they are new, then I can insist that they go to a pain clinic or try other possibilities." - Clinician

2. Systemic barriers to delivery of quality and nuanced pain care
   "Chronic pain is a multi-system issue that requires a primary care physician, a pain specialist, and a [psychologist] for their mental health. We are talking about three things here." - Clinician

3. Fear of liability and use of new guidelines to justify not prescribing opioids
   I don’t think it’s the policies necessarily that have influenced these providers. Just their thought process that they don’t want to take these patients on because then, it is their license... I think it’s the [liability] that comes into play." - Office Staff

4. Delayed prescription receipt due to prior authorization and pharmacy issues
   "The doctor’s office... kept giving me different stories as to why it wasn’t being filled and I would keep going to the pharmacist and they would keep saying ‘we didn’t get the prescription yet.’" - Patient

5. Poor availability of effective non-opioid treatments
   "We have quite a few Medicaid patients and a lot of pain management providers don’t take that, so it’s a long time for them to get it." - Clinician

CONCEPTUAL MODEL OF PAIN CARE ACCESS

Major Themes Representing Breakpoints in Care
- Reduced clinic willingness to manage prescribed opioids for new patients
- Fear of liability and use of guidelines to justify not prescribing opioids
- Systemic barriers to delivery of high-quality pain care
- Delayed prescription receipt due to prior authorization and pharmacy issues
- Poor availability of effective non-opioid treatments

CONCLUSIONS

• Issues of policy, logistics and clinic-level resources converge to disrupt consistency of primary care access for this population, creating potential for patient harm.
• Inconsistent access to primary care can lead to other negative opioid-related outcomes, such as withdrawal and suicidal ideation.
• Potential solutions to explore include an improved model of care coordination and reimbursement that allows for nuanced, high-quality care for chronic pain.
Effect of Gist Risk Messages on Parents’ Decisions to Retain Left-Over Prescription Opioids

Terri Voepel-Lewis PhD, Carol J. Boyd PhD Alan R. Tait PhD, Sean E. McCabe PhD, Brian J. Zikmund-Fisher PhD
School of Nursing, Department of Anesthesiology and School of Public Health, University of Michigan, Ann Arbor, MI 48109
This research was fully supported by the National Institute on Drug Addiction (NIDA) (Grant #R01DA044245)

The presence of left-over prescription opioids in the home has contributed to widespread misuse, diversion, and poisonings among children, adolescents, and young adults in the U.S.\textsuperscript{1-3} The majority of teens who have reported prescription opioid misuse obtained the drug from their own past prescription or from that of a family member or friend.

The purpose of this study was to determine whether our interactive Scenario-Tailored Opioid Messaging Program (STOMP) would increase parents’ risk perceptions and disposal intentions, thereby decreasing their retention of left-over opioids.

Methods

- IRB approval and informed consent was obtained.
- Sample: 648 parents whose children were prescribed an opioid for acute pain management were included.
- Parents were randomized to receive routine prescription information with or without our STOMP intervention: \textit{an interactive, decisional intervention that provides simple gist-risk messages plus an advice component}.
  - At baseline, 3 days post-STOMP, and 14 days post-STOMP, we assessed parents’ perceived risk of keeping/sharing opioids; perceived risk of child misuse (eg, sharing between children); and disposal intentions.
  - After the child stopped opioid use, we assessed parents’ retention decisions (eg, kept their child’s left-over opioid).
- Mixed effect models tested our hypotheses controlling for other parent and child factors.

Results

- Perceived riskiness of keeping/sharing opioids and of child misuse increased over time for STOMP parents (p<.001) but not for control parents (p=.59).
- STOMP was associated with a 36% increased likelihood of parents’ disposal intentions overall (aOR 1.36 [95\% CI 1.05, 1.75], p=.020) when estimated for both low and high parental risk perceptions.
- STOMP parents were 53\% less likely than control parents to retain left-over opioids (aOR 0.47 [95\% CI 0.33, 0.68], p<.001).
- Higher perceived riskiness of keeping/sharing opioids and of child misuse significantly lowered the odds of retention, while past parental misuse increased the odds of prescription opioid retention (see Table).

Table. Effect of STOMP on Parents’ Opioid Retention

<table>
<thead>
<tr>
<th>Factor</th>
<th>Adjusted OR</th>
<th>95% CI</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>STOMP</td>
<td>0.54</td>
<td>0.35, 0.82</td>
<td>.004</td>
</tr>
<tr>
<td>Risk Perceptions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keep/Share Opioid</td>
<td>0.84</td>
<td>0.75, 0.94</td>
<td>.003</td>
</tr>
<tr>
<td>Child Misuse</td>
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<td>0.65, 0.82</td>
<td>&lt;.001</td>
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<tr>
<td>Access Concern</td>
<td>1.06</td>
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<td>.307</td>
</tr>
<tr>
<td>Parent Female</td>
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<td>0.99, 2.77</td>
<td>.057</td>
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<tr>
<td>Parent White</td>
<td>1.28</td>
<td>0.70, 2.33</td>
<td>.419</td>
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<tr>
<td>Education (ordinal)</td>
<td>0.93</td>
<td>0.81, 1.08</td>
<td>.358</td>
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<td>Health Literacy</td>
<td>1.23</td>
<td>1.04, 1.46</td>
<td>.017</td>
</tr>
<tr>
<td>Past Opioid Use</td>
<td>0.89</td>
<td>0.55, 1.44</td>
<td>.631</td>
</tr>
<tr>
<td>Opioid in Home</td>
<td>0.95</td>
<td>0.60, 1.51</td>
<td>.822</td>
</tr>
<tr>
<td>Past Opioid Misuse</td>
<td>2.59</td>
<td>1.46, 4.61</td>
<td>.001</td>
</tr>
<tr>
<td>Child Female</td>
<td>0.68</td>
<td>0.44, 1.03</td>
<td>.069</td>
</tr>
<tr>
<td>Child Age</td>
<td>1.04</td>
<td>0.98, 1.10</td>
<td>.195</td>
</tr>
<tr>
<td>Child Pain Interference</td>
<td>0.97</td>
<td>0.86, 1.09</td>
<td>.598</td>
</tr>
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</table>

Conclusion/Innovation

- Our innovative STOMP intervention not only enhanced risk perceptions, but also affected parents’ opioid retention decisions.
- Adaptation of this intervention to address the risks of other controlled substances (e.g., stimulants, anxiolytics) has the potential to reduce diversion and misuse among children who are prescribed these medications.

References

The Impact of an Online Naloxone Training Curriculum for Community Laypersons

Miranda Gali, BA,1 Bidisha Ghosh, MS,2 Gina Dahlem PhD, FNP-C, FAANP2
1University of Michigan School of Public Health, 1University of Michigan School of Social Work, 2University of Michigan School of Nursing

Background
Opioid overdose has been on the rise across the nation. Increasing access to naloxone is an effective public health intervention to reduce opioid overdoses. Community laypersons (CLPs) are often first to identify when an overdose is taking place. Equipping CLPs with naloxone as well as teaching them proper intervention strategies can help work to reverse opioid overdoses across communities.

To work to address this gap in knowledge in a more accessible format for CLPs our goals were:
1) create a web-based training for CLPs on naloxone, targeting knowledge, attitudes, and feelings of preparedness
2) Evaluate effectiveness of the web-based training format

Approach
A web-based training was created with community partners via a Wordpress site for CLPs across Washtenaw county to utilize. Our community partners for this project were the Home of New Vision and Washtenaw County Sheriff’s office. The online training was designed so that each participant took a pre-test, followed by online modules, and a post-test after the training. Survey questions assessed knowledge, beliefs, and attitudes towards naloxone, and feelings of preparedness to use naloxone.

Results
136 participants completed the full training, including both the pre and post-test surveys. This training consisted of 25 content areas which educated CLPs on how naloxone works in the body, how to appropriately respond to an opioid overdose situation, and how to train others to use naloxone in an instance of opioid overdose.

We found statistically significant differences between pre—post measures for all domains of knowledge, attitudes, and feelings or preparedness (p<0.05).

Conclusion
Through our program, we were able to see that an online naloxone training is effective for preparing and educating CLPs who may encounter individuals experiencing overdose in their communities. CLPs knowledge, attitudes, and preparedness surrounding naloxone improved.

You can access our website to learn more about how you can help in the event of an opioid overdose here: www.overdoseaction.org

Significance
Online trainings can be an effective and efficient way of disseminating naloxone trainings. This is especially salient given the currently Coronavirus pandemic, as online trainings are more often utilized.

Harm Attitude Pre versus Post

The above graph represents attitudes between pre-post measures on whether the participant believed by intervening during an overdose they would cause harm. In post-survey most strongly disagreed that they would cause harm to an individual by intervening.

Pre (%) Post (%)

Strongly disagree 20 0
Disagree 40 20
Neutral 60 40
Agree 0 20
Strongly agree

Percentage

Pre (%) Post (%)
Q&A

Please type your questions in the Q&A box and the moderator will ask the panelists select questions.
- Evaluation survey to follow by email

- Register now for our upcoming summit - The Science of Suicide Prevention: New Strategies for Understanding and Intervening on March 16, 2021 from 12PM – 5PM. Information on how to register and submit abstracts can be found on the event page on our website injurycenter.umich.edu

- Become a member! Sign up at injurycenter.umich.edu/about-us/membership/becoming-a-member/

- All recordings from today will be available on our website in the coming weeks

Thank You!