Naloxone Saturation Policy Academy: Wisconsin

Remedy Alliance // For The People
RemedyAllianceFTP.org

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About me

- Naloxone access since 2004
  - First nasal
  - First statewide standing order
  - First municipal police & fire dept
  - First effectiveness study
  - First naloxone saturation quantification study
- Chicago in 2008
- OSNN nlx buyers club 2012

About Remedy Alliance / For The People

- Cheap generic injectable naloxone & nonprofit nasal
- Established in 2012
  - 16 years after first OEND
  - 6 states w/ naloxone access laws
  - 5 years before any federal funds for naloxone
  - 0 branded naloxone products
- Currently >430 orgs in 45 states, DC & PR
- 2M doses/year
- 501(c)(3) nonprofit organization

Disclosures

- Remedy Alliance is a non-profit wholesale distributor of naloxone that provides low and no-cost naloxone specifically to harm reduction programs distributing for free to people who use drugs.

- We operate in accordance with the FDA's "Exemption and Exclusion From Certain Requirements of the Drug Supply Chain Security Act for the Distribution of FDA-Approved Naloxone Products During the Opioid Public Health Emergency Guidance for Industry"

- We are agnostic about route of administration (injectable versus nasal).

- We are *not agnostic* about overdose profiteering, misallocation of resources and systemic marginalization of harm reduction programs and the people they serve.

- We have 4 paid staff and warehouses in Michigan and California, our 2022 budget was $1.4MM, 2023 budget was $5.7MM, 2024 is $17.1MM

- We use our priced tiers of naloxone to create our "free" supply and to return resources directly back to un-funded harm reduction programs through our Community Support Initiative.

Using Data for Action and Equity

OEND & evidence

- “OEND is an evidence-based intervention to prevent fatal opioid-involved overdose.”
  - The evidence is based on a model with key characteristics:
    - How much
    - By whom
    - To whom
  - Innovation & adjustments ONLY after EBM satisfied

Walley A Y, Xuan Z, Hackman H H, Quinn E, Doe-Simkins M, Sorensen-Alawad A et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis *BMJ* 2013; 346 :f174 doi:10.1136/bmj.f174

Naloxone Distribution In Practice

Needs-based distro

Low threshold

Celebrates & encourages secondary distro

Opt-in info/data collection

“Naloxone saturation” warrants some course correcting

- Action
  - Review the evidence
  - Prioritize resources to orgs that operate in alignment with the evidence- revisit this regularly
- Equity
  - Ensure that the people least likely to actually use naloxone are not the ones with the most expensive product or driving decision-making
  - Hire BIPOC PWUD
  - Quantify & pay for all the labor costs associated with OEND

Saturation: How do we know?!?

- Differentiate between community naloxone (distro through SSPs) vs naloxone acquired by police, schools, libraries, etc
- Use multiple metrics, e.g. community doses of naloxone per capita (Walley), doses per fatal overdose event (Bird), volume (Irvine)
- Metrics are a starting point, not the end point. Use to compare locations
- Focus as locally as possible (huge variation between cities or neighborhoods, urban vs rural, injecting vs smoking/snorting, etc)

Saturation requires abundance- Identifying an abundance mindset in an SSP

- Do you have enough naloxone to give every person as much as they ask for every time they ask for it?
- How often do you give participants 10+ kits at a time?
- How do you encourage secondary distribution?
- Do you use an opt-out approach?
- Do you “negotiate up”?
- How to do identify & eliminate barriers (like lengthy training/forms/etc)?

Best practices for community-based overdose education and naloxone distribution programs: results from using the Delphi approach

Lynn D. Wenger,[1] Maya Doe-Simkins,[2] Eliza Wheeler,[2] Lee Ongais,[1] Terry Morris,[1] Ricky N. Bluthenthal,[3] Alex H. Kral,[1] and Barrot H. Lambdin[1,4,5]

Action: Examine program characteristics

- Initial/screening
  - Program target population/access to PWUD
  - Dexterity with naloxone products
  - **Meaningful** role for peers
  - Encourage/discourage secondary distribution
- Ongoing information
  - Other types of services (syringes, snorting & smoking, drug checking)
  - Volume of naloxone
  - Hours of availability
  - Frequency & volume of expired

Secondary distribution

- Action
  - Ensure SSPs have sufficient nlx volume to allow for key participants to have bulk
  - Monitor SD for possible programmatic adjustments
- Equity
  - Incentivize secondary distribution
  - Acknowledge, appreciate, celebrate
  - Target POC, ppl who smoke

Smoking and snorting

CDC MMWR: smoking now ROA most common in OD deaths

- Action
  - Identify non-fed funds for smoking, snorting, and boofing supplies
  - Advocate to the feds to dedicate funds for smoking, snorting, and boofing supplies
- Equity
  - Fund SSPs to conduct focus groups with key populations
  - Fund SSPs to provide smoking, snorting, boofing supplies

Tanz LJ. Routes of Drug Use Among Drug Overdose Deaths—United States, 2020–2022. MMWR. Morbidity and Mortality Weekly Report. 2024;73.

Remember: OEND is *already* known to be an EBP

We can make some assumptions about its effects without gathering tons of data

Essential data for OEND M&E

- Number of OENDs; how many SSPs?
- Geographical distribution of OEND
- Proportion of OENDs that target PWUD
- Volume of naloxone distributed
- Portion of naloxone distributed to PWUD

Remedy Alliance & NEXT Distro created a data blind spot

- ...but we are happy to share info!

Overdose reversal reports

- Notoriously unreliable quant data
- Time intensive, possibly coercive, possibly traumatic
- What we can say
  - Narrative value
  - Trusted/essential program
  - Tailor future interventions/offerings
  - Program QA
- What we cannot say
  - Number of lives saved
  - What drugs were used
  - Indication of clinically necessary
  - Any trends

"We do not measure the effectiveness of flu vaccine efforts by the number of people who come back and report that they did not get the flu."

M & E iterative actions

- How does data & reporting affect these OEND best practices:
  - **Needs-based distro**
  - **Low threshold**
  - **Celebrates & encourages secondary distro**
  - **Opt-in info/data collection**
- Does info collection influence equity?
- Is it necessary?
- Will we use it for sure and now?
- Is it reliable?
- Can it be removed?

Remember: OEND success depends *entirely* on PWUD

Action
Targeted naloxone distribution to achieve effective saturation

Equity
PWUD must be central to the design, development, purchasing & distribution of all OD prev programming

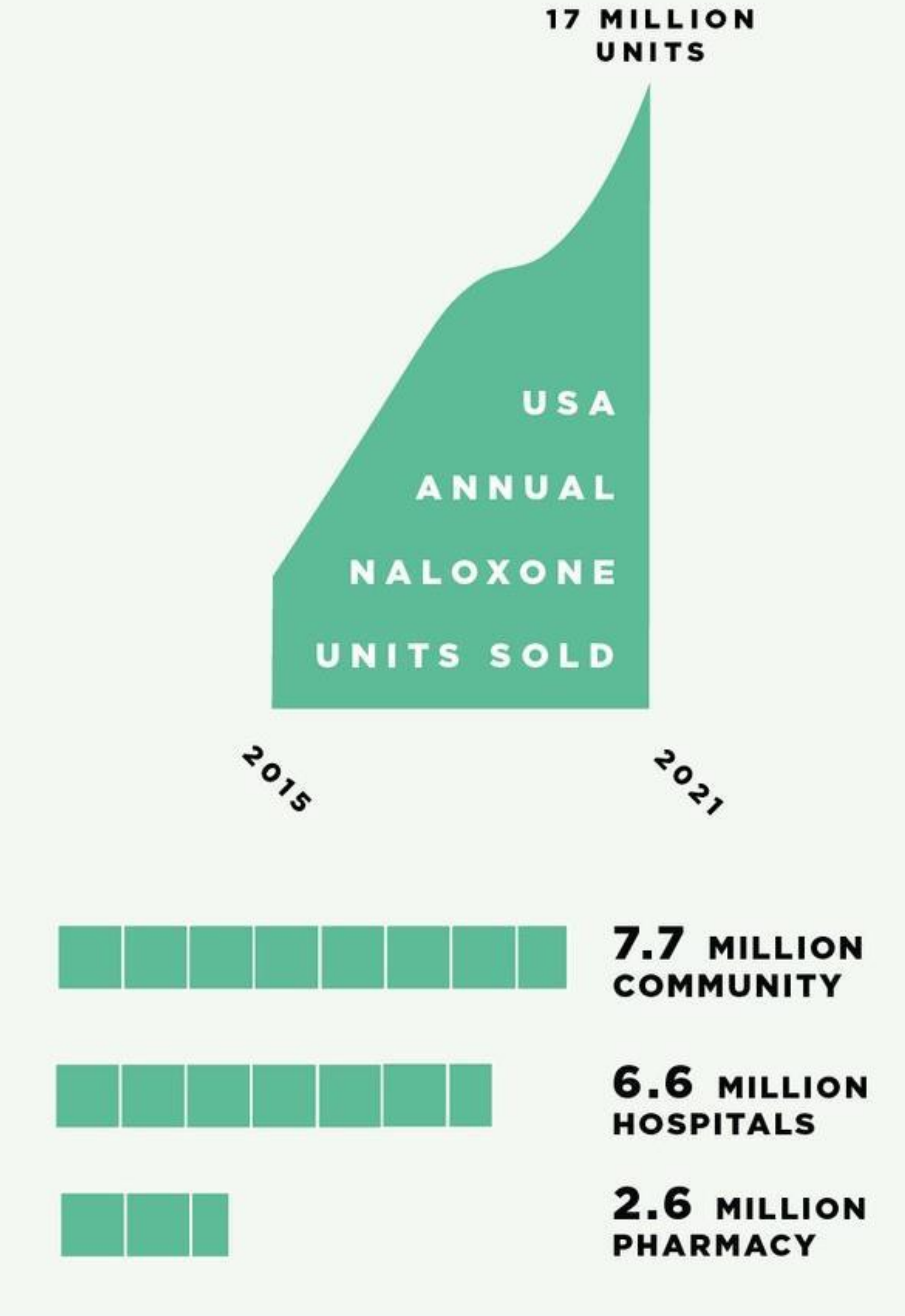
Money, marketing & sustainability

Key cost & sustainability strategies

- Mix of naloxone products
- Prioritize SSPs & harm reduction programs
  - $25 vs $43/kit dispensed + medicine cost via SSP vs not SSP
  - CBOs sig higher SSP measures than DPH SSPs…even those w/o funding!!
- Vary funding
- Implement policies & infrastructure for triaging target populations
- Plan for funding reductions by bifurcating resource allocation

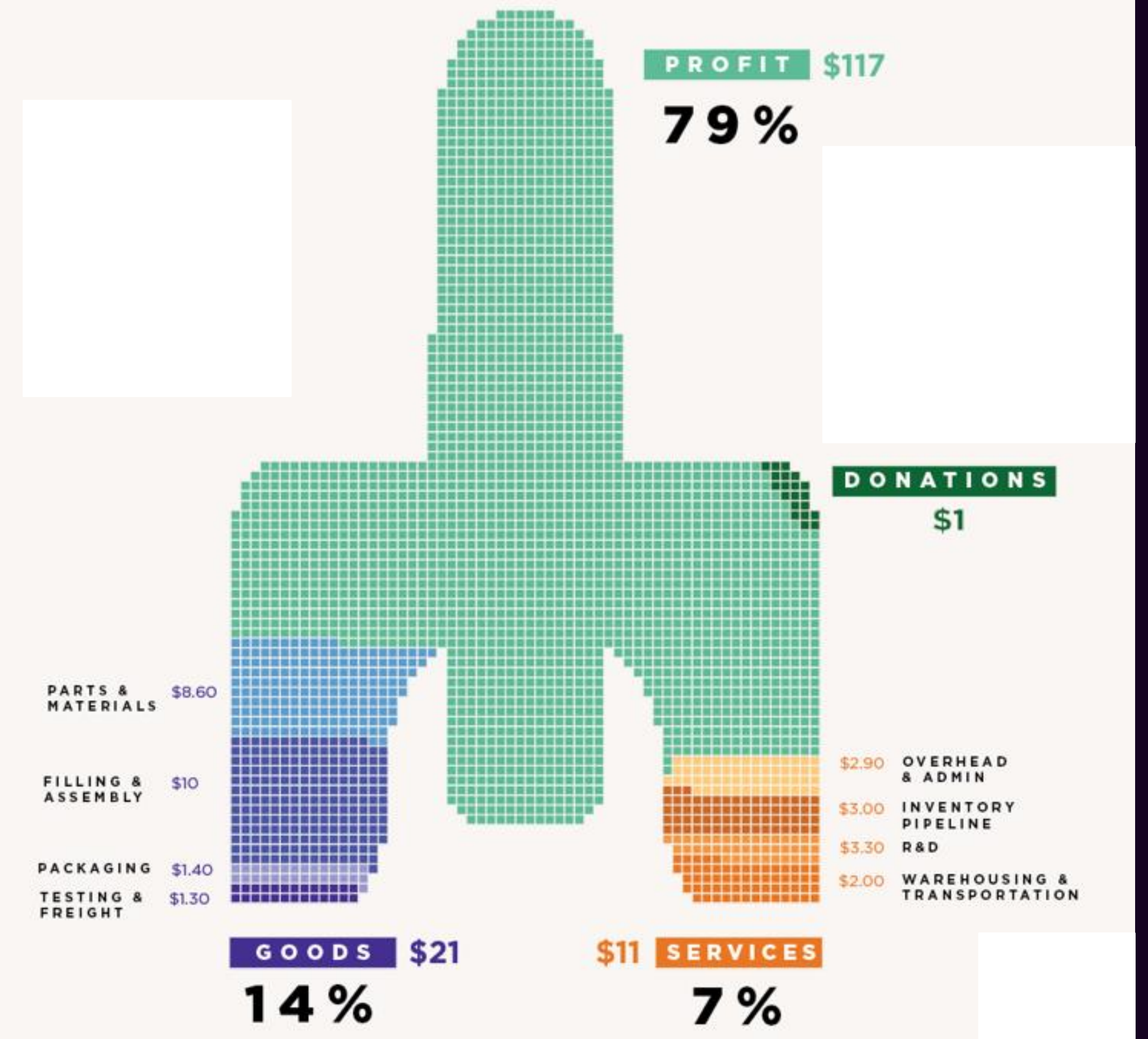
Since 2015, naloxone is big business

(like, BIG business- ~$500MM/year)



Demystifying naloxone costs

Retail price: $150 (2015-2022)



Nasal will never be anywhere as cheap as injectable

SUPPLY CHAIN INSIGHTS

THE PLASTIC DEVICE FOR ALL NALOXONE NASAL SPRAYS COMES FROM ONE FRENCH VENDOR

RAW NALOXONE COSTS <25¢

Low-cost naloxone is necessary to scale

RETAIL NASAL $150

"PUBLIC INTEREST PRICE" NASAL (2015-22) $75

"PUBLIC INTEREST PRICE" NASAL (2023) $48

NON-PROFIT NASAL (10% DONATED) $36

RETAIL INJECTABLE $16

OUR PRICES

Naloxone Injection USP 0.4mg/ml

Remedy Alliance For The People

HEALTH DEPT. NON-PROFIT INJECTABLE*

$7.60

HARM REDUCTION NON-PROFIT INJECTABLE AT-COST* $3.20

Saturation requires abundance

Volume & cost: IM nlx from RA/FTP

Remedy Alliance` in WI

- 94,980- IM vials since Aug 2022
- Cost if state paid for it- $356,175
- Cost if they were RA's IN- $1,709,640
- Cost if they were other's IN - $1,947,090

“Free” IM naloxone from RAFTP

1,400 doses since 8/22

$28,700 in current nasal prices

Pros & cons of centralized purchasing

Examining the true cost

- Person-power for outreach
- Data collection for high volume
- Kit packing time accounts for more $$ than the materials: buying nlx for programs w/o funding them is a ***net loss*** for programs
  - EX: the # of vials sent to WI = $237,450 in assembly labor alone
- Storage & logistics

Solving many problems: assembled IM kits

- Logistics
- $$ to programs
- More volume for the money vs IN

Choice & preference

- There is no “best” product
- Preference is often influenced by familiarity
- Preference is influenced by availability
- Preference is *strongly* influenced by staff
- Choice & preference are influenced by marketing…which constituents are most profitable???

Dose & fentanyls, xylazine, nitazine & whatever comes next

- Who asked for longer, stronger antagonists?
- Number of doses has not changed
  - National EMS
  - Pittsburgh, PA
  - SLC, UT
  - MO- statewide
  - KY- statewide
- The role of rescue breathing is central
- Abundance mindset = allow for more than one kit/box

Questions & Comments?
Thank you!

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