The Naloxone Project

2024 Montana Opioid Abatement Trust Grants

The Naloxone Project

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Application Form

Region Selection

To collaborate with someone else on this request, click the blue "Collaborate" button in the top-right corner.

Project Name*

The Naloxone Project

Select Abatement Region and/or Metro Region*

Select the Multi-County Abatement Region **and/or** the Metro Region you are requesting grant funds from. Select all regions that apply, for example if you are collaborating with multiple Counties **and/or** Abatement Regions select each region the program/project will serve. Click HERE for a detailed map of Multi-County Abatement Regions and Metro Abatement Regions

Abatement Region 1
Abatement Region 2
Abatement Region 3
Abatement Region 4
Abatement Region 5
Cascade County
Flathead County
Gallatin County
Lake County
Lewis & Clark County
Missoula County
Ravalli County
Silver Bow County
Yellowstone County

Application Overview

About the Organization/Program*

Give a brief description of the Organization/Program/Project. Include the mission statement and the services provided.

Established in 2022, The Naloxone Project (TNP) is a clinician-led nonprofit organization with a mission to advance the health and dignity of people affected by substance use disorders, by creating a medical system that reduces stigma and provides equitable access to overdose education and naloxone distribution to patients at risk of opioid overdose. Our organization is building an evidence-based and humane response to the opioid crisis through the distribution of naloxone in medical spaces. We strengthen medical and emergency response systems, use policy advocacy to change practice, and raise awareness in communities. Our organization works toward a future where no one dies from opioid overdose and where stigma

surrounding addiction and naloxone is eliminated. We deploy a systems-change approach to the opioid crisis in the United States through our focus on healthcare, public policy, and the community.

Within each state chapter, TNP works with hospitals, Emergency Departments (EDs), birthing hospitals, and first responders to identify those at-risk of overdose and hand naloxone directly to them, with a message of hope and recovery. We work with policymakers to reduce regulatory and financial barriers to facilitate equitable access of naloxone. Our community outreach raises awareness and educates the public to build understanding and correct misconceptions.

The Montana Naloxone Project seeks to implement naloxone distribution programs in EDs, birthing hospitals, and through first responder agencies. Montana EDs saw an estimated 15,000 visits by patients at risk for opioid overdose in 2021. Substance use and overdose is also a leading cause of death for birthing people during the postpartum period. The Montana Naloxone Project is particularly interested in expanding to rural and critical access facilities in Montana in the future, emphasizing our focus on equitable access to naloxone for even the most remote communities.

What category does the program fit into*

Check the category/categories the program fits into. You may select more than one option.

Click **HERE** for a list of approved opioid remediation uses

Prevention

Exhibit E List of Opioid Remediation Uses

Schedule A - select all that apply

A. NALOXENE/OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES
C. PREGNANT & POSTPARTUM WOMEN
G. PREVENTION PROGRAMS

Exhibit E List of Opioid Remediation Uses

Schedule B - select all that apply

A. TREAT OPIOID USE DISORDER "OUD"
C. CONNECTIONS TO CARE
E. NEEDS OF PREGNANT/PARENTING WOMEN, BABIES W/ NEONATAL ABSTINENCE SYNDROME
H. PREVENT OVERDOSE DEATHS & OTHER HARMS (HARMS REDUCTION)
I. FIRST RESPONDERS
K. TRAINING
L. RESEARCH

How does the program meet the Opioid Remediation Guidelines*

In detail, describe how the program fits into the approved Opioid Remediation Guidelines selected in the above question.

Please be specific

The Naloxone Project will implement three programs as part of the Montana Naloxone Project:

Emergency Department Clinician Training and Naloxone Distribution Programs: TNP administered a survey to 21 Montana EDs before the establishment of the Montana Chapter and found that only 4 were distributing naloxone to at-risk patients. Currently, the Montana Naloxone Project has helped pilot naloxone distribution in 2 additional EDs (Bozeman Health and Big Sky Medical Center), training clinicians in overdose risk assessment, reducing the stigma of opioid use disorders, and distributing naloxone to at-risk patients. With this grant, we plan to expand to all EDs in all regions and also collaborate with existing programs.

Maternal Overdose Matters (MOMs) Initiative in birthing hospitals and perinatal spaces: In Montana, no birthing units are distributing naloxone to at-risk pregnant / postpartum individuals. TNP's well-developed MOMs initiative focuses on overdose prevention through anti-stigma training and distribution of naloxone to at-risk perinatal patients and families, and we will implement this program throughout Montana.

First Responder Harm Reduction and Naloxone Distribution Program: Our Prehospital Addiction Care Collaborative (PACC) trains first responders on overdose risk recognition, naloxone distribution, and linkage to community-based addiction care. TNP has experience working with police, fire and emergency medical services (EMS) on developing naloxone distribution programs, and we will implement this program throughout all regions in Montana.

Each of our initiatives includes TNP-designed clinician training and technical assistance from our , as well as robust data collection and program evaluation activities. Together these initiatives represent a concrete vision toward overdose prevention, stigma reduction and the creation of an effective and equitable response to the opioid crisis in Montana and across the nation.

New Program or Existing*

Is the funding intended for a new program or to expand an existing program?

A new program for your region.

Fiscal Information

Requested Amount*

$909,385.73

Program Budget*

How will the funds be allocated? Attach a detailed line item budget breakdown for the program. If the funds are intended for a multi-year program please specify the amount budgeted for each year.

All Regions_Counties Budget (1).xlsx

Source of Funding*

Does the program currently receive funding from another source? If yes, please explain in detail. (i.e. amount, funding source, etc.)

Grant funding is intended for the creation or expansion of opioid prevention, treatment, and recovery projects. The money is **NOT** meant to replace or supplant existing funding.

Currently, our Montana Chapter of the Naloxone Project does not receive direct, restricted funds. Our national nonprofit has several funding sources including state opioid response (SOR) dollars, opioid abatement dollars, behavioral health administration funds, perinatal quality collaboratives, foundations, and private donors. Many of the funds received by TNP are restricted to their funding states and programs. Our private donor funds are unrestricted and used by TNP to invest in new state chapters. As such, TNP has used some of these funds in Montana to conduct an in-person training with Montana American College of Emergency Physicians (ACEP) around naloxone distribution during their 2024 state meeting. We also provided 488 doses of naloxone, and continue to allocate time from our national project manager, executive director, and associate director to Montana. TNP sees Montana as a priority and natural partner in our efforts to expand across the Mountain West. The Montana Chapter is also supported by the generous initial volunteer hours of its physician chairs Dr. Bobby Redwood and Dr. Emily Martin.

Regarding naloxone access, MT 2017 HB 333 certainly fulfills some of the overdose prevention needs of Montana, but our overdose risk report and interviews with healthcare leaders show that hospitals, and birthing centers in particular, have an ongoing need for this medication beyond the 100 kits allocated to an individual organization. Furthermore, after 7 years, there is still a significant gap among healthcare organizations actually distributing no-cost naloxone to at risk patients. The Montana Naloxone Project can fill that gap and ensure sustainability of naloxone access to our most vulnerable residents.

A full national budget is available upon request.

Do you have a Fiscal Agent*

No

Program Abstract

Program Description*

Describe the objectives of this project. Provide a detailed overview of the program, including its purpose, priorities & objectives, and intended results.

Naloxone distribution programs from EDs, birthing hospitals, and first responders through the MNP aim to address the opioid overdose crisis by equipping individuals at risk, and their close contacts, with naloxone kits, reducing stigma, and providing overdose prevention education.With a priority of training frontline clinicians, hospitals, and agencies, TNP has vetted resources that will be tailored to Montana, including a

learning management system (LMS) to train clinicians, program-specific toolkits, videos, and patient-facing resources.

Objective 1: Establish Leadership Councils to oversee program implementation and inform quality improvement.
Intended Results:
A Leadership Council for each program (ED, PACC, MOMs) composed of key stakeholders, public health organizations, individuals with lived experience, and leaders.
Intended Results: The Leadership Councils meet quarterly, determining the vision for the program, securing endorsements, assisting with recruitment of sites, and reviewing data to inform program quality improvement

Objective 2: Montana Naloxone Project will recruit sites and agencies for each program.
Intended results:
ED - Enroll pilot hospital EDs in all grant approved counties by end of year 1. Add additional hospital EDs by the end of year 2. Open to all hospital EDs in year 3.
PACC - Enroll all EMS agencies in all grant approved counties by the end of year 3.
MOMs - Enroll all birthing hospitals in all grant approved counties by end of year 3.
In total, we hope to recruit at least 30 healthcare organizations in our first year.

Objective 3: Host Learning Collaboratives to review program progress, share lessons learned, and receive education or feedback from the MNP team.
Intended Results:
Form program-specific Learning Collaboratives that meet monthly (remotely) to start, then less frequently over time, made up of representatives from each participating site.

Objective 4: Program implementation:
Intended Results:
Go “live” with naloxone distribution in each enrolled site within 6 months of enrollment.
Track enrollment status, implementation status, and distribution status.
A total of 15,000 doses will be distributed to partners in year one, and in each subsequent year based on utilization and program growth to new facilities in the regions selected.

Objective 5: Ongoing, consistent, and accurate data collection
Intended Results:
Each enrolled site be submitting quarterly data (# of naloxone kits distributed/month) within 3 months of implementation.
Each enrolled site receives data reports back from the data team.

Objective 6: Program evaluation and quality improvement plans
Intended Results:
Data team generates monthly and/or quarterly program evaluation reports within 3 months of data submission.
QI champion identified within sites. MNP team works with each program through monthly collaborative calls, along with individual site coaching calls, to drive quality improvement through rapid PDSA cycles.

Program Reach

If you are requesting funds from multiple Abatement Regions please specify how your program serves each region. **Be specific.**

We are requesting funds for all regions in Montana as we initiate this program. In 2021, almost 50% of statewide EMS overdose calls occurred in Small Metro Counties, (Missoula, Yellowstone, and Gallatin County). However, rural areas are a critical focus, where at-risk patients may be hours from the nearest hospital. By reaching both urban and rural counties, we aim to meet the needs of all vulnerable populations.

TNP has experience running statewide programs, and we value local expertise. We will engage regional leaders, clinicians, and public health experts through leadership councils and collaboratives. Our target is to enroll hospitals, EMS agencies, and medical clinics across all regions to ensure a strong statewide presence. Drs. Redwood and Martin, well-connected emergency physicians, will guide this effort, ensuring effective representation in each abatement region. Dr. Redwood is also the president of the Montana Chapter of the American College of Emergency Physicians.

MNP plans to categorize all EDs in Montana into three groups: Already distributing, Not yet distributing but willing, and Reluctant to distribute. For those already distributing, our SMEs will facilitate implementation of naloxone distribution to partner EDs in their systems or peer-to-peer implementation with other EDs in their geographic radius. For those "not yet distributing but willing", our SMEs will help to secure naloxone cost-free, establish policies/protocols for distributing/tracking, and educate the staff on best practices. Finally, those that are "reluctant to distribute" that is typically an indication that hospital administration has a perception of medicolegal risk that our SMEs can help them work through or that there is stigma among the administration or medical staff that our SMEs may be able to help them overcome. These sites would receive an in person visit from one of our SMEs with an aim of education and implementation of partial or full naloxone distribution services.

For Example, MNP currently aids Barrett Healthcare in Dillon MT, where a pharmacy champion who is educating the staff on naloxone distribution and open to securing naloxone via the state's DPHHS portal. MNP supports this effort with educational materials and resources, aiming to extend the model to nearby critical access EDs.

This grant will accelerate our statewide initiative, making cost-free naloxone available to at-risk patients in every Montana county in the years ahead.

Specific Goals*

What are the specific goals of the program? List several goals the program hopes to accomplish and how the program intends to meet these goals.

Goal 1: Prevent opioid overdose deaths by increasing access to evidence based overdose prevention education and naloxone: We can reduce opioid overdose fatalities in Montana by ensuring that naloxone is readily available to those who may witness or experience an overdose. To achieve this goal, we will partner with at least 30 healthcare organizations and train at least 500 providers in our first year to distribute naloxone kits throughout selected counties and regions to individuals at-risk of opioid overdose and their communities.

Goal 2: Improve overdose education and training for clinicians and first responders: Provide resources, toolkits, and training to frontline clinicians who are providing care to patients at-risk of overdose. Train clinicians how to identify at-risk individuals, interact with and speak to patients in a compassionate and non-stigmatizing manner, offer naloxone, and provide overdose prevention and recognition education.
Goal 3: Recognize and address the stigma of opioid and other substance use disorders: Combat stigma associated with opioid and other substance use disorders by promoting harm reduction approaches that normalize naloxone distribution and accessing behavioral health care. By incorporating naloxone distribution into medical spaces, we encourage patients to access addiction, behavioral, and other healthcare resources.

Goal 4: Improve connection to treatment: Integrating harm reduction and naloxone distribution into medical spaces, where addiction treatment and connections to recovery resources are available, facilitates a potential link for at-risk individuals to access other addiction services. Our naloxone kits contain a dose of the medication, information on overdose risk, and community-based recovery resources tailored to the region in which the kit is distributed.

Goal 5: Program sustainability - To achieve lasting sustainability for the Montana Naloxone Project, we will recruit a taskforce to research how to create a longerm, sustainable solution to fund widespread naloxone distribution from medical spaces in Montana. We will also build on our successful history working to pass legislation and change regulatory requirements, and we will pursue other avenues of reimbursement for naloxone distribution.

Evaluation Method*

Describe how you plan to evaluate the effectiveness of the program and what the method for evaluation will be.

TNP has a robust data collection and program evaluation process in place for each state chapter and for our various programs. TNP utilizes a secure jotform for sites and agencies to upload quarterly data on the number of naloxone kits distributed each month. We use the data platform PowerBi to house the data and create reports with the submitted data and other data points available. TNP has historically partnered with state agencies (such as hospital associations, perinatal quality collaboratives, EMS registries, or other statewide data reporting system) to establish data sharing agreements to obtain de-identified data that quantifies at-risk encounters. If needed, we have also purchased statewide datasets. TNP has a Data Team that produces quarterly reports for individual sites and closely maintains an up-to-date data dashboard for all programs. All of these data-related strategies would be utilized to evaluate program effectiveness and drive quality improvement in Montana. (See attachment for report and dashboard examples.)

TNP also partners with a program evaluation team that advises on evaluating the effectiveness of each TNP program (ED, MOMs, and PACC), along with the impact of naloxone distribution within our target communities.

In addition, TNP partners with OpiRescue to host a smartphone application, which can be tagged to naloxone kits distributed via a unique QR code. Patients can use this application to not only walk them through an overdose response, how to administer naloxone, and other resources, but also as a tracking option for opioid reversals, providing valuable geo-tagged end-user information back to TNP.

In an effort to share information about programs, TNP has a subcommittee, made up of members of the Board of Directors, Advisory Council, Data Team, and staff that work together to release reports. TNP publishes an Annual Report each year (see in attachments), highlighting the progress of each state chapter and program. TNP also recently released a white paper on “Overdose Risk in the ED” (see in attachments), an effort at more comprehensively characterizing at-risk ED visits within each state in order to inform future efforts (such as this).

Data evaluation, scientific inquiry and provision of evidence-based recommendations and practice are a priority for TNP and our physician-led programs.

Awareness*

How do you plan to create awareness of this program? Briefly describe what action the program plans to take to create awareness in the community.

TNP has a nationwide presence and its leadership, from executive director through board of directors, represent some of the most prominent medical providers in the emergency medicine, harm reduction, and addiction medicine space. TNP prides itself in its ability to speak directly to front-line clinicians and create programs that serve patients and communities.

The Montana Naloxone Project and its leadership have deep connections in the Greater Gallatin Community. We plan to partner extensively to advance naloxone distribution across the state. The following individuals represent organizations and teams, who we have already identified and began conversations with in partnership, if awarded this grant.
American Medical Response (Contact: Dr. Bret Birrer, medical director)
Barret Healthcare Emergency Department (Contact: Dr. Greg Moore, medical director)
Big Sky Medical Center Emergency Department (Contact: Dr. Anna Carl, medical director)
Bozeman Health Emergency Department (Contact: Dr. Eric Lowe, medical director)
Bozeman Health Department of Internal Medicine (Contact: Dr. Philip Bain, physician education coordinator)
Bozeman Fire Department (Contact: Dr. Bret Birrer, medical director)
Greater Impact Inc. (Contact: Ashley Umbaugh, recovery director)
Ideal Option Addiction Services (Contact: Sheri Bagley FNP-BC, addiction medicine provider)
Ideal Option Community Outreach (Contact: Sayrd Iverson, community outreach coordinator)
Montana Chapter of the American College of Emergency Physicians (Contact: Dr. Ben Beasley, president-elect)
Montana State Health Improvement Plan (Contact: Maureen Ward, M.Ed., Injury Prevention Program Manager, MT DPHHS)
Montana Substance Use Disorders Task Force (Contact: Emma Perry, Health Education Specialist, MT DPHHS)
Music Villa, Bozeman (Contact: Brian Sweeney, ACEP Director, Data Science and Quality)

For community awareness, much occurs through the improvement of care provided by front-line clinicians and first responders. In addition, TNP works with organizations to advertise in clinical spaces, to be present and active on social media, and to create events where community members can engage with TNP. We have a core library of resources and strategies to build upon for the Montana Naloxone Project, which includes short videos, posters, social media collaborations with sites and communities, and dissemination to key state organizations through our program Leadership Councils.

Additional Documents

Use this section to upload or explain any additional information regarding the program/organization. ie. a detailed budget projection, program/organization history, etc.

Upload #1

2023 TNP Annual Report 3.pdf

Upload #2
Data Anaylysis Samples.pdf

Upload #3
Montana - Overdose Risk report 2024-02-22.pdf

Additional Information
The Naloxone Project (TNP) is a clinician-led nonprofit that expands equitable access to naloxone in communities and states across the nation. Our Montana Chapter (Montana Naloxone Project) is led by Montana Emergency Physicians Dr. Bobby Redwood and Dr. Emily Martin, with support from a national team of physicians, pharmacists, public health experts, and data scientists. TNP is building nation-leading, evidence-based naloxone distribution programs and overdose prevention interventions across the country.

Our proposal seeks to dramatically expand naloxone distribution across all 14 counties/regions in Montana. Modeled after our well-established and successful work in Colorado, TNP will partner with emergency departments (EDs), birthing hospitals, and first responder agencies to build an efficient and comprehensive statewide medically-based naloxone distribution system. These healthcare spaces offer significant opportunities to maximize impact by establishing effective programs in overdose education and prevention, as well as naloxone distribution directly to the populations they serve.

Montana has 67 emergency departments, 150 ground EMS agencies, and 26 birthing facilities. The Montana naloxone project's vision is for 100% of these organizations to receive training in overdose recognition, discussing overdose with at-risk Montanans, and the ability to facilitate linkage to community-based behavioral health resources.

The Montana Naloxone Project aims to distribute 15,000 naloxone kits to partner organizations, recruit 30 different healthcare agencies, and train over 500 healthcare providers in stigma reduction, naloxone distribution and effective transitions to addiction care. These rapid gains will rely on our organization's sound infrastructure, foundational experiences, successful programming, and strong partnerships, which can be effectively and rapidly leveraged in Montana.

File Attachment Summary

Applicant File Uploads

- All Regions_Counties Budget (1).xlsx
- 2023 TNP Annual Report 3.pdf
- Data Anaylysis Samples.pdf
- Montana - Overdose Risk report 2024-02-22.pdf

Montana 2024 Grant Program Budget

Organization Name	The Naloxone Project	
Term	Year 1 - Projected Grant Distribution Availability	
Request for Proposal Name	Montana Opioid Abatement Trust	
	County/Region Breakdown	Allocat
Allocation Availability Per Region:	Region 1	6.2
	Region 2	5.5
	Region 3	3.7
	Region 4	7.1
	Region 5	4.0
	Butte-Silver Bow	5.6
	Cascade County/Great Falls	8.2
	Flathead County/Kalispell	10.4
	Gallatin County/Bozman	6.0
	Lake County	3.6
	Lewis and Clark County/Helena	6.6
	Missoula County/Missoula	12.4
	Ravalli County	3.6
	Yellowstone County/BIllings	16.4

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y

Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y
Hourly Employees		
Position Title	**Description of Work**	**Does this**
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y
	Other / Miscellaneous	
Item	**Description**	**Does this**
	TOTAL DIRECT COSTS (Supplies & Ope	
	Indirect	
Item	**Description**	
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add	
	T	
	TOTAL AMOUNT REQUESTED FROM OPIOID ABATE	

9,000,000.00			
tion %	Year 1 Present- June		Regional
6%	$562,964.51		$56,881.85
6%	$500,594.53		$50,580.00
8%	$340,288.17		$34,382.67
2%	$640,636.71		$64,729.84
1%	$361,274.78		$36,503.15
1%	$504,911.34		$51,016.17
6%	$743,137.47		$75,086.50
49%	$943,894.96		$95,371.01
4%	$543,307.13		$54,895.68
2%	$325,575.89		$32,896.14
7%	$600,186.31		$60,642.74
46%	$1,121,268.53		$113,292.81
9%	$332,161.37		$33,561.54
44%	$1,479,798.29		$149,518.61
			$909,358.73
Quantity	Per Item Cost	Requested	
15,000	33.00	$495,000.00	
1	5,000	$5,000.00	
1	5,000	$5,000.00	
Total Food and Supplies		$505,000.00	
Quantity	Per Item Cost	Requested	
2,500	1	$2,500.00	
10,000	1	$10,000.00	
10,000	0.66	$6,600.00	
28	200	$5,600.00	
Total Operating Expenses		$24,700.00	
Percent of	Salary + Fringe	Requested	
100%	$85,150.00	$85,150.00	@ 31%fringe

100%	$85,150.00	$85,150.00	
25%	$220,000.00	$55,000.00	
25%	$91,159.00	$22,789.75	
10%	$24,000.00	$2,400.00	hour for 20 hours a
Hours	**Hourly Rate**	**Requested**	
20	75	$1,500.00	
200	175	$35,000.00	
100	100	$10,000.00	
Total Personnel Services		**$296,989.75**	
Quantity	**Per Item Cost**	**Requested**	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$826,689.75**	
		Requested	
litional supplies, general		$82,668.98	
TOTAL INDIRECT COSTS		**$82,668.98**	
EMENT FUNDS GRANT		**$909,358.73**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

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Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

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Salary Employees

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Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

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Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$30,963.05	
1	5,000	$312.76	
1	5,000	$312.76	
Total Food and Supplies		**$31,588.56**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$156.38	
10,000	1	$625.52	
10,000	0.66	$412.84	
28	200	$350.29	
Total Operating Expenses		**$1,545.02**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$5,326.27	31%fringe
100%	$85,150.00	$5,326.27	
25%	$220,000.00	$3,440.34	
25%	$91,159.00	$1,425.54	
10%	$24,000.00	$150.12	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$93.83	
200	175	$2,189.31	
100	100	$625.52	
Total Personnel Services		**$18,577.19**	
Quantity	Per Item Cost	from Montana Opioid	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$51,710.78**	
		from Montana Opioid	
ditional supplies, general		$5,171.08	
TOTAL INDIRECT COSTS		**$5,171.08**	
EMENT FUNDS GRANT		**$56,881.85**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

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Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$27,532.70	
1	5,000	$278.11	
1	5,000	$278.11	
Total Food and Supplies		**$28,088.92**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$139.05	
10,000	1	$556.22	
10,000	0.66	$367.10	
28	200	$311.48	
Total Operating Expenses		**$1,373.85**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$4,736.18	31%fringe
100%	$85,150.00	$4,736.18	
25%	$220,000.00	$3,059.19	
25%	$91,159.00	$1,267.60	
10%	$24,000.00	$133.49	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$83.43	
200	175	$1,946.76	
100	100	$556.22	
Total Personnel Services		**$16,519.05**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$45,981.82**	
		from Montana Opioid	
ditional supplies, general		$4,598.18	
TOTAL INDIRECT COSTS		**$4,598.18**	
EMENT FUNDS GRANT		**$50,580.00**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$18,715.85	
1	5,000	$189.05	
1	5,000	$189.05	
Total Food and Supplies		**$19,093.95**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$94.52	
10,000	1	$378.10	
10,000	0.66	$249.54	
28	200	$211.73	
Total Operating Expenses		**$933.90**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$3,219.50	31%fringe
100%	$85,150.00	$3,219.50	
25%	$220,000.00	$2,079.54	
25%	$91,159.00	$861.68	
10%	$24,000.00	$90.74	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$56.71	
200	175	$1,323.34	
100	100	$378.10	
Total Personnel Services		**$11,229.12**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$31,256.97**	
		from Montana Opioid	
ditional supplies, general		$3,125.70	
TOTAL INDIRECT COSTS		**$3,125.70**	
EMENT FUNDS GRANT		**$34,382.67**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$35,235.02	
1	5,000	$355.91	
1	5,000	$355.91	
Total Food and Supplies		**$35,946.84**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$177.95	
10,000	1	$711.82	
10,000	0.66	$469.80	
28	200	$398.62	
Total Operating Expenses		**$1,758.19**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$6,061.14	31%fringe
100%	$85,150.00	$6,061.14	
25%	$220,000.00	$3,915.00	
25%	$91,159.00	$1,622.22	
10%	$24,000.00	$170.84	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$106.77	
200	175	$2,491.36	
100	100	$711.82	
Total Personnel Services		**$21,140.28**	
Quantity	Per Item Cost	from Montana Opioid	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$58,845.31**	
		from Montana Opioid	
ditional supplies, general		$5,884.53	
TOTAL INDIRECT COSTS		**$5,884.53**	
EMENT FUNDS GRANT		**$64,729.84**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$19,870.11	
1	5,000	$200.71	
1	5,000	$200.71	
Total Food and Supplies		**$20,271.53**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$100.35	
10,000	1	$401.42	
10,000	0.66	$264.93	
28	200	$224.79	
Total Operating Expenses		**$991.50**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$3,418.06	31%fringe
100%	$85,150.00	$3,418.06	
25%	$220,000.00	$2,207.79	
25%	$91,159.00	$914.82	
10%	$24,000.00	$96.34	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$60.21	
200	175	$1,404.96	
100	100	$401.42	
Total Personnel Services		**$11,921.66**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$33,184.68**	
		from Montana Opioid	
ditional supplies, general		$3,318.47	
TOTAL INDIRECT COSTS		**$3,318.47**	
EMENT FUNDS GRANT		**$36,503.15**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$27,770.12	
1	5,000	$280.51	
1	5,000	$280.51	
Total Food and Supplies		**$28,331.14**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$140.25	
10,000	1	$561.01	
10,000	0.66	$370.27	
28	200	$314.17	
Total Operating Expenses		**$1,385.70**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$4,777.02	31%fringe
100%	$85,150.00	$4,777.02	
25%	$220,000.00	$3,085.57	
25%	$91,159.00	$1,278.53	
10%	$24,000.00	$134.64	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$84.15	
200	175	$1,963.54	
100	100	$561.01	
Total Personnel Services		**$16,661.50**	
Quantity	Per Item Cost	from Montana Opioid	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$46,378.34**	
		from Montana Opioid	
ditional supplies, general		$4,637.83	
TOTAL INDIRECT COSTS		**$4,637.83**	
EMENT FUNDS GRANT		**$51,016.17**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$40,872.56	
1	5,000	$412.85	
1	5,000	$412.85	
Total Food and Supplies		**$41,698.27**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$206.43	
10,000	1	$825.71	
10,000	0.66	$544.97	
28	200	$462.40	
Total Operating Expenses		**$2,039.50**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$7,030.91	31%fringe
100%	$85,150.00	$7,030.91	
25%	$220,000.00	$4,541.40	
25%	$91,159.00	$1,881.77	
10%	$24,000.00	$198.17	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$123.86	
200	175	$2,889.98	
100	100	$825.71	
Total Personnel Services		**$24,522.69**	
Quantity	Per Item Cost	from Montana Opioid	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$68,260.46**	
		from Montana Opioid	
ditional supplies, general		$6,826.05	
TOTAL INDIRECT COSTS		**$6,826.05**	
EMENT FUNDS GRANT		**$75,086.50**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$51,914.22	
1	5,000	$524.39	
1	5,000	$524.39	
Total Food and Supplies		**$52,963.00**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$262.19	
10,000	1	$1,048.77	
10,000	0.66	$692.19	
28	200	$587.31	
Total Operating Expenses		**$2,590.47**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$8,930.30	31%fringe
100%	$85,150.00	$8,930.30	
25%	$220,000.00	$5,768.25	
25%	$91,159.00	$2,390.13	
10%	$24,000.00	$251.71	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$157.32	
200	175	$3,670.70	
100	100	$1,048.77	
Total Personnel Services		**$31,147.46**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$86,700.92**	
		from Montana Opioid	
ditional supplies, general		$8,670.09	
TOTAL INDIRECT COSTS		**$8,670.09**	
EMENT FUNDS GRANT		**$95,371.01**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$29,881.89	
1	5,000	$301.84	
1	5,000	$301.84	
Total Food and Supplies		**$30,485.57**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$150.92	
10,000	1	$603.67	
10,000	0.66	$398.43	
28	200	$338.06	
Total Operating Expenses		**$1,491.08**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$5,140.29	31%fringe
100%	$85,150.00	$5,140.29	
25%	$220,000.00	$3,320.21	
25%	$91,159.00	$1,375.76	
10%	$24,000.00	$144.88	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$90.55	
200	175	$2,112.86	
100	100	$603.67	
Total Personnel Services		**$17,928.52**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$49,905.16**	
		from Montana Opioid	
ditional supplies, general		$4,990.52	
TOTAL INDIRECT COSTS		**$4,990.52**	
EMENT FUNDS GRANT		**$54,895.68**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$17,906.67	
1	5,000	$180.88	
1	5,000	$180.88	
Total Food and Supplies		**$18,268.43**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$90.44	
10,000	1	$361.75	
10,000	0.66	$238.76	
28	200	$202.58	
Total Operating Expenses		**$893.52**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$3,080.31	31%fringe
100%	$85,150.00	$3,080.31	
25%	$220,000.00	$1,989.63	
25%	$91,159.00	$824.42	
10%	$24,000.00	$86.82	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$54.26	
200	175	$1,266.13	
100	100	$361.75	
Total Personnel Services		**$10,743.63**	
Quantity	Per Item Cost	from Montana Opioid	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$29,905.58**	
		from Montana Opioid	
ditional supplies, general		$2,990.56	
TOTAL INDIRECT COSTS		**$2,990.56**	
EMENT FUNDS GRANT		**$32,896.14**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$33,010.25	
1	5,000	$333.44	
1	5,000	$333.44	
Total Food and Supplies		**$33,677.12**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$166.72	
10,000	1	$666.87	
10,000	0.66	$440.14	
28	200	$373.45	
Total Operating Expenses		**$1,647.18**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$5,678.43	31%fringe
100%	$85,150.00	$5,678.43	
25%	$220,000.00	$3,667.81	
25%	$91,159.00	$1,519.79	
10%	$24,000.00	$160.05	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$100.03	
200	175	$2,334.06	
100	100	$666.87	
Total Personnel Services		**$19,805.46**	
Quantity	Per Item Cost	from Montana Opioid	
	Total Other	**$0.00**	
erating, Personnel, Other)		**$55,129.76**	
		from Montana Opioid	
ditional supplies, general		$5,512.98	
TOTAL INDIRECT COSTS		**$5,512.98**	
EMENT FUNDS GRANT		**$60,642.74**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$61,669.77	
1	5,000	$622.93	
1	5,000	$622.93	
Total Food and Supplies		**$62,915.62**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$311.46	
10,000	1	$1,245.85	
10,000	0.66	$822.26	
28	200	$697.68	
Total Operating Expenses		**$3,077.26**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$10,608.45	31%fringe
100%	$85,150.00	$10,608.45	
25%	$220,000.00	$6,852.20	
25%	$91,159.00	$2,839.27	
10%	$24,000.00	$299.00	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$186.88	
200	175	$4,360.49	
100	100	$1,245.85	
Total Personnel Services		**$37,000.58**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$102,993.47**	
		from Montana Opioid	
ditional supplies, general		$10,299.35	
TOTAL INDIRECT COSTS		**$10,299.35**	
EMENT FUNDS GRANT		**$113,292.81**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$18,268.88	
1	5,000	$184.53	
1	5,000	$184.53	
Total Food and Supplies		**$18,637.94**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$92.27	
10,000	1	$369.07	
10,000	0.66	$243.59	
28	200	$206.68	
Total Operating Expenses		**$911.60**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$3,142.62	31%fringe
100%	$85,150.00	$3,142.62	
25%	$220,000.00	$2,029.88	
25%	$91,159.00	$841.10	
10%	$24,000.00	$88.58	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$55.36	
200	175	$1,291.74	
100	100	$369.07	
Total Personnel Services		**$10,960.95**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$30,510.49**	
		from Montana Opioid	
ditional supplies, general		$3,051.05	
TOTAL INDIRECT COSTS		**$3,051.05**	
EMENT FUNDS GRANT		**$33,561.54**	

Budget Categories

Supplies

Item	Description of Item	Does this
Naloxone	Naloxone - to distribute to all programs,	Y
Patient facing education	Creation of patient facing material with	Y
Provider Education Materials	Creation of presentations, advertising, education	Y

Program Operating Expenses

Item	Description of Item	Does this
Shipping, office supplies	Budget for office supplies and to ship naloxone,	Y
Promotional Materials	For program	Y
Travel	Travel to between sites in Montana.	Y
Lodging	To to montana specific trainings	Y

Personnel and Administrative Services

Salary Employees

Position Title	Description of Work	Does this
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Montana Naloxone Project Manager	Oversee and aid in expansion to first responder	Y
Medical Director (Dr. Bobby	Dr. Redwood is an emergency medicine physician.	Y
Senior National Project Manager	Over	Y
Financial Manager	Oversees all financial aspects of the grant to	Y

Hourly Employees

Position Title	Description of Work	Does this
Graphic Designer | Website	trainings.	Y
Data Manager & Analyst	Data management, Collection from Montana EDs,	Y
Program Evaluation and Reports	Evaluation of program effect, and creation of	Y

Other / Miscellaneous

Item	Description	Does this

TOTAL DIRECT COSTS (Supplies & Ope

Indirect

Item	Description
Indirect rate (if applicable):	Indirect Costs: 10% for indirect costs, covers insurance, add

T

TOTAL AMOUNT REQUESTED FROM OPIOID ABATE

Quantity	Per Item Cost	from Montana Opioid	
15,000	33.00	$81,388.91	
1	5,000	$822.11	
1	5,000	$822.11	
Total Food and Supplies		**$83,033.13**	
Quantity	Per Item Cost	from Montana Opioid	
2,500	1	$411.06	
10,000	1	$1,644.22	
10,000	0.66	$1,085.19	
28	200	$920.76	
Total Operating Expenses		**$4,061.22**	
Percent of	Salary + Fringe	from Montana Opioid	
100%	$85,150.00	$14,000.54	31%fringe
100%	$85,150.00	$14,000.54	
25%	$220,000.00	$9,043.21	
25%	$91,159.00	$3,747.14	
10%	$24,000.00	$394.61	20 hours a month for 12
Hours	Hourly Rate	from Montana Opioid	
20	75	$246.63	
200	175	$5,754.77	
100	100	$1,644.22	
Total Personnel Services		**$48,831.66**	
Quantity	Per Item Cost	from Montana Opioid	
		Total Other	**$0.00**
erating, Personnel, Other)		**$135,926.01**	
		from Montana Opioid	
ditional supplies, general		$13,592.60	
TOTAL INDIRECT COSTS		**$13,592.60**	
EMENT FUNDS GRANT		**$149,518.61**	

ANNUAL REPORT

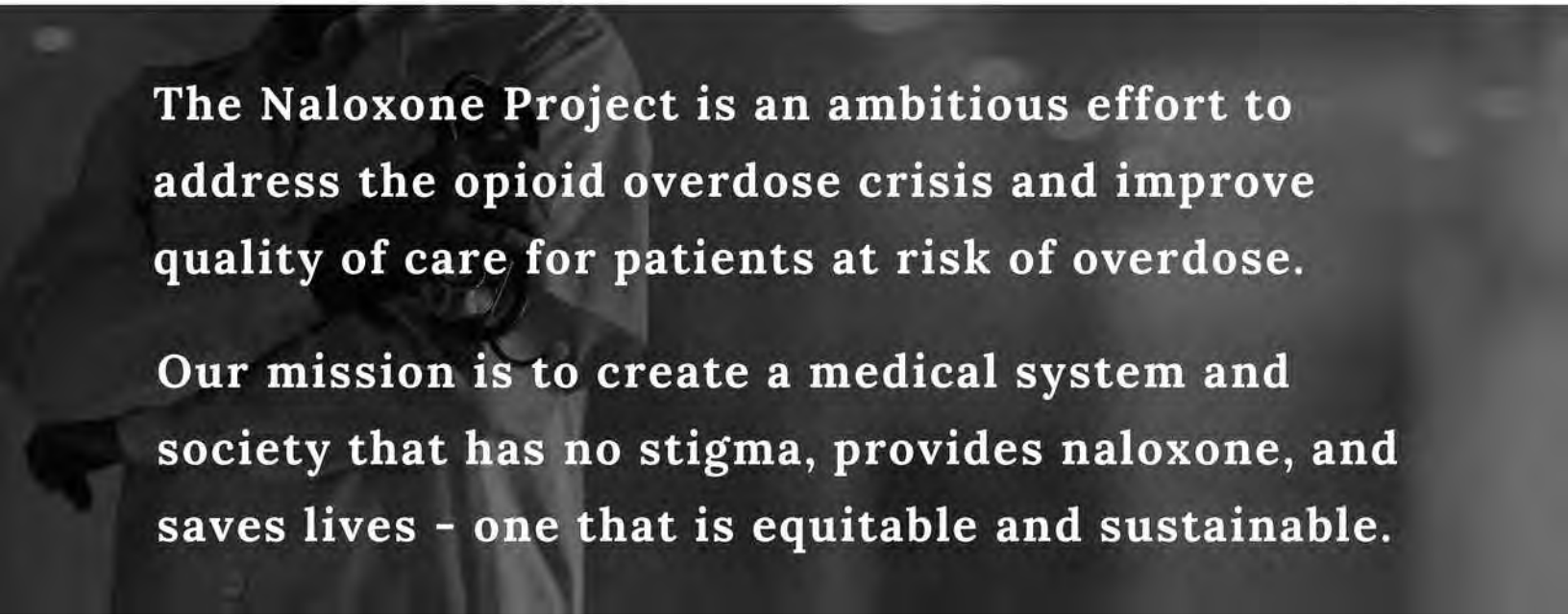
2023

THE NALOXONE PROJECT

ABOUT THE NALOXONE PROJECT

The Naloxone Project (TNP) is a collaborative effort of clinicians, funders, state and national agencies, and harm reduction experts. Implementation, technical expertise, and leadership is provided by the Executive Director, Board of Directors, state chapter Chairs, and project management team. The core TNP team provides support to hospitals and other organizations to establish medically-based overdose education and naloxone distribution programs.

Our goal is for all hospitals, labor and delivery units and emergency departments to distribute naloxone to at-risk patients, placing this life-saving medication in patients' hands prior to their departure from the hospital.



The Naloxone Project is an ambitious effort to address the opioid overdose crisis and improve quality of care for patients at risk of overdose.

Our mission is to create a medical system and society that has no stigma, provides naloxone, and saves lives - one that is equitable and sustainable.

OUR SIX PRINCIPLES OF CHANGE

1 Stigma is a powerful force that prevents care for patients with opioid use disorder and those at risk of overdose. Naloxone saves lives, not only through its actions to reverse an opioid overdose, but also through its effect of decreasing stigma. Naloxone is a symbol of care and sends a message that fosters further treatment and recovery.

2 Patients with opioid use disorder and those at risk for overdose matter. We must take the necessary steps to assure safety, treat overdose, and save lives through effective and sustainable naloxone distribution and overdose prevention and education.

3 Clinicians must learn to identify patients at risk for overdose and commit to placing naloxone in patients' hands prior to their departure from the hospital or emergency department.

4 Hospitals and emergency departments must commit to stocking and dispensing naloxone to at-risk patients.

5 Payers and regulators must reimburse hospitals for dispensing naloxone, covering the costs of the medication so that there is no negative financial impact for hospitals that provide this service. Regulatory barriers for dispensing naloxone from hospitals and emergency departments must also be removed so naloxone dispensing is easy and can be implemented without fear of penalty.

6 By banding together, we can build a system of care that effectively identifies patients at risk of opioid overdose and reliably dispenses naloxone to such patients. Naloxone can also serve as a bridge and incentive for patients to return for definitive treatment with medication for opioid use disorder. Together, we can save lives and build the addiction treatment system that our communities not only need, but deserve.

"I've seen more and more patients brought by ambulance to our ED where a [lay] person on scene gave the non-breathing patient naloxone. I know some of this naloxone is what we've distributed from our ED thanks to the CNP, and helped save a life!"

2023 SUMMARY:
OUR SUCCESSES

Since TNP started, participating facilities have dispensed **10,208** **naloxone kits** to patients at increased risk of overdosing from opioids.

116 **participating hospital facilities** in Colorado, trained in overdose recognition and naloxone provision.

The Naloxone Project has **32** **government, nonprofit, and other partners** supporting its Colorado programs.

50 **labor and delivery units** (L&D) in Colorado birthing hospitals are participating in the new MOMs Initiative to dispense naloxone to obstetric patients at risk for overdose.

The Naloxone Project has expanded across the country, with new state chapters opening in **10** **states.**

THE NEED CONTINUES...

In Colorado in 2022, there were **1,160** overdose deaths from opioids.

2,773 hospitals admissions and emergency department visits in 2022 in Colorado were for treatment of an opioid overdose.

Nationally, overdose deaths from opioids in 2022 reached over **80,000**

88% of those deaths involved synthetic opioids like **fentanyl.**

Overdose deaths in pregnant and postpartum people has risen over **80%** in the last three years.

OUR NEWEST PARTNERS

Life-saving naloxone can only make it into the hands of patients who need it because of support from our extraordinary partners. These partnerships have grown alongside TNP's expansion of the Colorado chapter as new partners have stepped up to help our new maternity outreach program blossom.

COLORADO ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR COLORADO

THE AMERICAN ACADEMY OF PEDIATRICS

Hard Beauty

COLORADO MEDICAL SOCIETY EST. 1871

CHoSEN QIC

cpcqc

illuminate
Building Brighter Childhoods

the elephant circle

COLORADO
Behavioral Health Administration

TOUGH as a MOTHER
STRONGER THAN ADDICTION

ACOG
The American College of Obstetricians and Gynecologists

COLORADO PHARMACISTS SOCIETY

AWHONN
COLORADO
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

OUR FINANCIAL SUPPORTERS

COLORADO
Behavioral Health
Administration

FFF enterprises
Helping Healthcare Care®

COPIC®
Better Medicine • Better Lives

TOUGH as a MOTHER
STRONGER THAN ADDICTION

CarePoint Health®

Brownstein Hyatt Farber Schreck, LLP

COLORADO CHAPTER
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Hard Beauty.

OUR NALOXONE DONORS

Direct Relief

ZIMHI®
(naloxone HCl Injection)
5mg/0.5mL
FAST WHEN IT MATTERS MOST

OUR CONTINUED PARTNERS

Colorado Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

Recover Simply · Recover the Fun

SANDGAARD FOUNDATION

Band Together

Colorado Psychiatric Society

COLORADO CONSORTIUM
for Prescription Drug Abuse Prevention

DENVER HEALTH
est. 1860

CDHS
COLORADO
Office of Behavioral Health
Department of Human Services

c|h|a
Colorado Hospital Association

COLORADO RURAL HEALTH CENTER
The State Office of Rural Health

COLORADO HEALTH INSTITUTE

ADVOCATES for RECOVERY Colorado

COLORADO PHARMACISTS SOCIETY

COLORADO CHAPTER
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

DORA
COLORADO
Department of Regulatory Agencies
Division of Insurance

OpiRescue

HARM REDUCTION ACTION CENTER

ENA
Colorado State Council

CPS
COLORADO PAIN SOCIETY

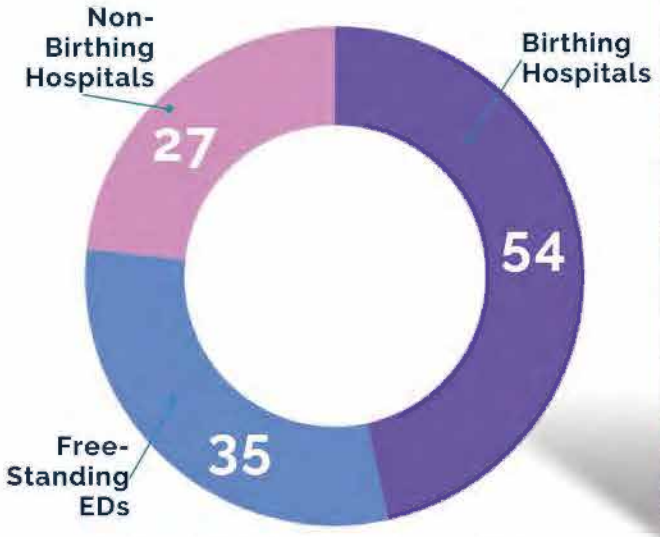
COLORADO MEDICAL SOCIETY EST. 1871

Telligen®

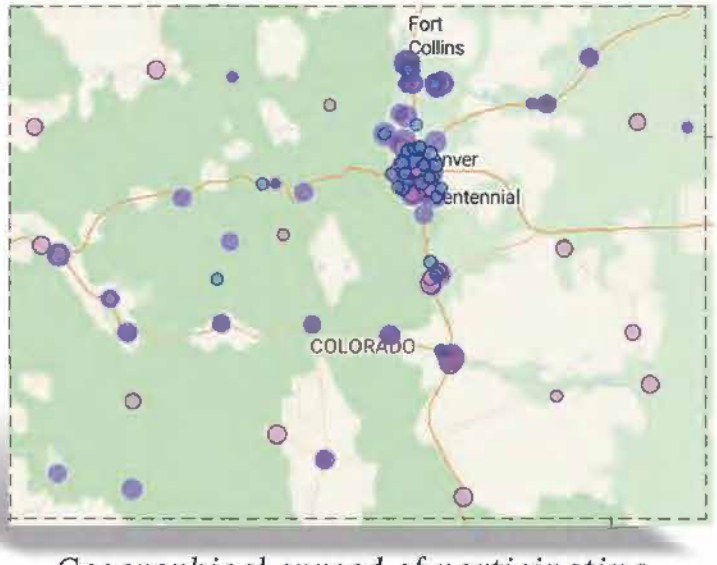
HOW WE HELP

Colorado Participation

Colorado Naloxone Project (CNP) and MOMs currently have **116** hospitals and free-standing emergency departments (FSEDs) participating. Over **85%** of Colorado hospital facilities have joined, including over **90%** of all birthing hospitals.



Proportion of participating facilities by type.



Geographical spread of participating hospital facilities sized by kits received.

From August 2022 through July 2023, these facilities have dispensed

4,645

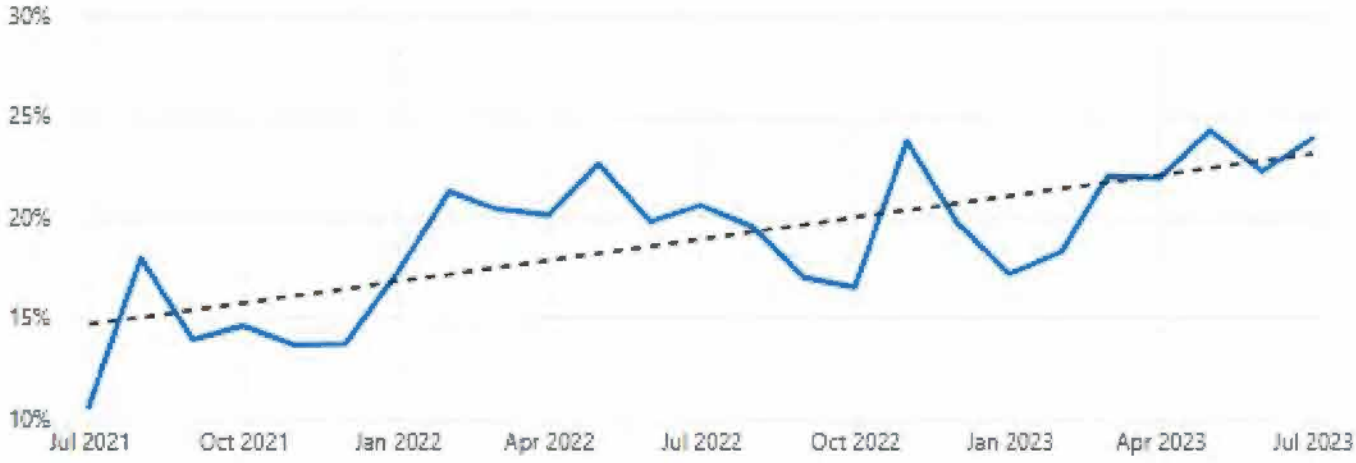
life-saving naloxone kits to at-risk patients visiting their hospitals.

REACHING THE PATIENTS WHO NEED NALOXONE

Our goal is to ensure that every patient who needs naloxone gets it. TNP created clinical guidelines for identifying patients with an increased risk of overdose. Using data from the Colorado Hospital Association, we can estimate how many patients meeting these clinical criteria have been seen at our participating facilities.

The numbers of kits providers are dispensing covers about **24%** of the estimated at-risk visits.

Estimated percent of at-risk patient ED visits where naloxone is dispensed



We have more than **doubled** the proportion of at-risk visits where providers successfully dispense naloxone to a patient who needs it.

This increase is necessary, but not sufficient. We still have a ways to go to reach our goal of 50% of at-risk visits dispensing naloxone. Part of our 2024 plan is to increase outreach, training, and active support of providers in identifying at-risk patients and successfully dispensing.

A LETTER FROM OUR CHAIR

As excited as I was 1 year ago when I agreed to join TNP as the Chair of the Board, I underestimated the number of lives we would touch and the passion I would encounter on this journey. Our country and our communities are confronted with a grave challenge. Needlessly and too often, individuals are dying of opioid overdose. At TNP we believe we can do something about this tragedy and in the past year, the progress we have made has been extraordinary, especially when measured against the youth of our organization. I will highlight some of those accomplishments in this report, but I want to open and close with a statement of gratitude to our TNP volunteers, staff, board of directors, participating hospitals, and front-line clinicians. Through your work to distribute naloxone and be part of TNP, you are saving the lives of patients, family members, friends, and individuals with addiction. You are providing voice, compassion, and importance to a group of individuals who are too often marginalized and neglected. You are also working to change a culture in medicine from possible adversaries to advocates and create a system that cares rather than judges. Thank you.

TNP's mission continues to evolve, but fundamentally focuses on our three principles:

1. Create a system within Hospitals to identify without stigma those at risk for possible overdose. Through this process, we open the door to rehabilitation by ensuring life.
2. To directly hand at-risk individuals the lifesaving drug, Naloxone, at discharge, from any area of the hospital. To aid in removing all hurdles to creating a low-barrier, sustainable system.
3. To ensure sustainability, and engagement from Hospitals through reimbursement for this system, thus avoiding an "unfunded mandate".

Experience and effort have led to the realization that in many cases legislation is necessary. Along those lines, we have created model wording for State laws, while watching such legislation advance the effort in many states such as Colorado, Washington, Ohio, and others.

Our largest effort has been Federal, where we are working with Representative Brittany Pettersen in crafting the Hospitals As Naloxone Distribution Sites (HANDS) Bill, HR#5506. We hope to continue to advance this legislation with bipartisan consensus in 2024 and will need your support to encourage Congressional leaders to pass this life-saving legislation.

As a physician-run organization, TNP is deeply interested in the science and data of naloxone distribution. In the past year, we have invested heavily in both. You can enlist support by "doing what is right," but data is essential in both steering, driving, and sustaining change. Through our Director of Data & Analytics, Ms. Alexandra Mannerings, and funding from the FORE Foundation, we have begun to answer a fundamental question: "What is the opportunity and need for Naloxone distribution from Hospitals in each state?" TNP has begun partnering with organizations to obtain state data. In the next year, we will be able to provide insights into the exact numbers of at-risk lives that are being seen in hospitals across the nation and use this data to drive and inform our work and mission.

As Chair, I have been particularly inspired by the work done by TNP in addressing the maternal overdose crisis through the MOM's (Maternal Overdose Matters) initiative. The efforts of Dr. Kaylin Klie & Dr. Rachel Duncan, our Colorado Naloxone Project, and MOMs Co-Chairs cannot be overstated. Through their work to bring naloxone distribution to birthing hospitals, they have helped lead an intervention that holds the promise of saving two lives and strengthening families who struggle with opioid use disorders. Our MOMS initiative has begun to garner national attention. This, along with an overview of TNP in general are sessions at this year's National RX & Illicit Drug Summit in Atlanta in April 2024. We hope to grow this program to new states and regions in the coming year.

TNP has always valued collaboration and the wisdom that systems must be built collaboratively if they are to succeed and endure. This spirit has manifested itself in our 10 new TNP chapters and from the formalization of partnerships both local and nationally. We have cherished the opportunity to partner with groups as local as Hard Beauty in Colorado and The Columbus Medical Society in Ohio to large national partnerships with groups such as the American College of Emergency Physicians and the American Society of Addiction Medicine. Being able to foster this unified effort is critical to our mission.

As Chair, I want to continue to grow our coalition and invite any organization from emergency medicine, obstetrics, pediatrics, mental health, addiction medicine, peers, affected families, and public health to join TNP in its mission.

State by State, TNP has committed to solving local challenges with national collaboration. TNP has leveraged a strong relationship with Direct Relief and manufacturers to bridge supplies in communities where naloxone has begun to run out or be in short supply. Leaders like our Ohio Naloxone Project Chairs, Dr. James Neuenschwander and Dr. Jason Kolb, have enriched our organization and spearheaded efforts to introduce new legislation that will radically increase the availability of naloxone in their state. In Massachusetts, Dr. Scott Weiner has led efforts to perform a state needs assessment and distribute naloxone. Each of our state chairs has been instrumental in informing TNP of local barriers and working concretely to address them, while also contributing to our national mission. To each of our state chairs, I am deeply grateful.

As I look forward to TNP's next year, I am eager to grow TNP's reach across the nation and to new frontiers within and outside the medicinal system. In Colorado, we have formally launched the Colorado Prehospital Addiction Care Consortium and will seek to radically expand EMS "Leave Behind Programs." TNP's Colorado Chapter has also hired new staff, who will continue to advance our efforts in Colorado and across the nation.

A special, personal thanks to the Herculean efforts of Senior National Project Manager Ms. Nikki King for her efforts to coordinate national expansion. To our founder, friend and Executive Director, Dr. Don Stader - you are an inspiration. The remaining members of our Board of Directors have all been instrumental in their unique efforts to make TNP a success. But ultimately, we are at the beginning of our journey and not its end. Our mission is far from complete. Our success hinges on our connections, donations (of time, talent, or treasure), and personal effort to work as a team to save lives. I have no doubt that if we remain steadfast and committed, we will prevail and TNP will continue to save lives and create a better system of care.

For those of you who know my story and motivation, thank you from the bottom of my heart.

Stephen H. Anderson MD, FACEP
Chair of the Board, The Naloxone Project

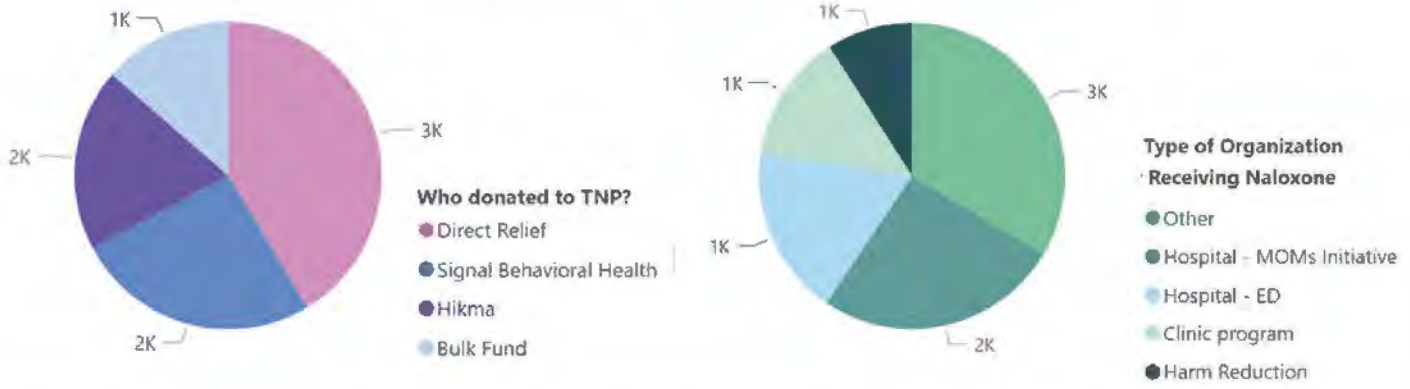
SOURCING NALOXONE

A core operation of The Naloxone Project has been sourcing naloxone doses for our participating organizations to give to patients at increased risk of overdose. New this year has been donations for our MOMs Initiative, which has allowed us to get donated naloxone to front-line providers caring for perinatal patients, infants, and families at Colorado birthing hospitals.

To date, TNP has received **22,936** donations of intranasal and injectable naloxone doses, valued at over **$1.2 million**.

This year, we received **8,276** doses from four partner organizations.

Sourcing and Sharing Naloxone, 2023



But relying on donated naloxone is not sustainable long-term. Another focus of TNP has been advocating for direct reimbursement models for naloxone. TNP was instrumental in passing new Colorado legislation this year that finally created a pathway for hospitals and healthcare providers to be reimbursed for dispensing naloxone.

> ***Treating patients at our federal safety-net hospital requires a mindset: you may be the last line of treatment for this vulnerable patient. Having funded naloxone in our ED is huge, as it provides a last line of safety for someone or their family who may be struggling.***

INTERNATIONAL OVERDOSE AWARENESS DAY

August 31, International Overdose Awareness Day, is the world's most extensive annual campaign to end overdose. TNP hosted its inaugural fundraising event for IOAD at The Lodge at Woods Boss on August 31, 2023. This event showcased education, entertainment, and community; U.S. Representative Brittany Pettersen attended and spoke about her newly introduced federal legislation, the *Hospitals As Naloxone Distribution Sites (HANDS)* Act. **We welcomed over 60 new individuals** into the broader TNP family, raised nearly **$29,000**, packaged hundreds of naloxone keychains, and even took to the streets afterward to ensure that no catered food went to waste. This event was not only financially successful but effectively fostered conversations around reducing stigma and the critical need for naloxone to be in the hands of everyone.

WE ARE EXPANDING:

THE *MOMs* INITIATIVE

This year we launched the MOMs (Maternal Overdose Matters) Initiative in Colorado, an innovative program to tackle one of the leading causes of maternal death. Maternal mortality in Colorado and nationwide are overwhelmingly driven by suicide and accidental overdose. By expanding naloxone distribution to obstetric units in nearly every birthing hospital in Colorado, we are giving a life-saving medication *and* the message that our birthing patients, infants, and Colorado families are worth protecting.

1 IN 5

pregnancy-associated deaths nationwide from 2017 to 2020 was due to overdose.

80%

of these deaths were deemed preventable; through better medical, mental health, and substance use disorder care.

Birthing hospitals, where over 90% of infants in Colorado are born, are the first line of defense to prevent maternal overdose. By becoming naloxone distribution sites, we can save lives and create connection with patients and families affected by substance use.

What has started in Colorado is now expanding nationwide, with several state chapters reaching out to launch similar L&D naloxone distribution programs.

A LETTER

From Our Colorado Co-Chairs on MOMs Initiative

The opioid overdose crisis is killing pregnant and postpartum people and destroying families. Suicide and overdose have emerged as the top causes of maternal mortality in Colorado and across the nation for the past several years. The innovation proposed by the MOMs Initiative can directly reduce maternal overdose deaths, by helping birthing hospitals identify perinatal patients at risk of overdose and providing those patients and families with naloxone and overdose education.

> **We need to decide that moms, babies, and families are worth saving.**

While simple in concept, the steps needed to accomplish this key intervention have been significant; hospital recruitment, fundraising, navigating regulatory requirements for direct dispensing, addressing stigma and bias, building sustainability, supplying naloxone, and meeting the training, implementation, and educational needs of our Colorado birthing hospitals and frontline staff.

All together, 50 facilities honored us with their commitment representing over 90% of Colorado birthing hospitals. We helped implement two "opt out" perinatal naloxone distribution programs, one in the outpatient setting and one in the hospital, that are piloting a model that provides naloxone universally to all birthing patients. The success in accomplishing all of this, despite obstacles and challenges, has been nothing short of miraculous.

Dr. Kaylin Klie, MD, MA, FASM & Dr. Rachael Duncan, PharmD
Co-Chairs, Colorado Naloxone Project, MOMs Initiative

CNP OUTPATIENT CLINIC NALOXONE DISTRIBUTION PROGRAM

The Naloxone Project's newest program expansion has been to start partnering with health clinics across Colorado to provide them with naloxone. This was born out of a need expressed by clinics to provide naloxone to uninsured or underinsured patients, those with poor access to healthcare, and those at risk of opioid overdose. TNP prioritizes working with rural clinics and clinics that see a significant number of patients with substance use disorders and/or patients on chronic opioid therapy. As of September 2023, TNP is working with 45 clinics across the state to distribute naloxone to patients, and we hope to increase that number throughout the year and into 2024!

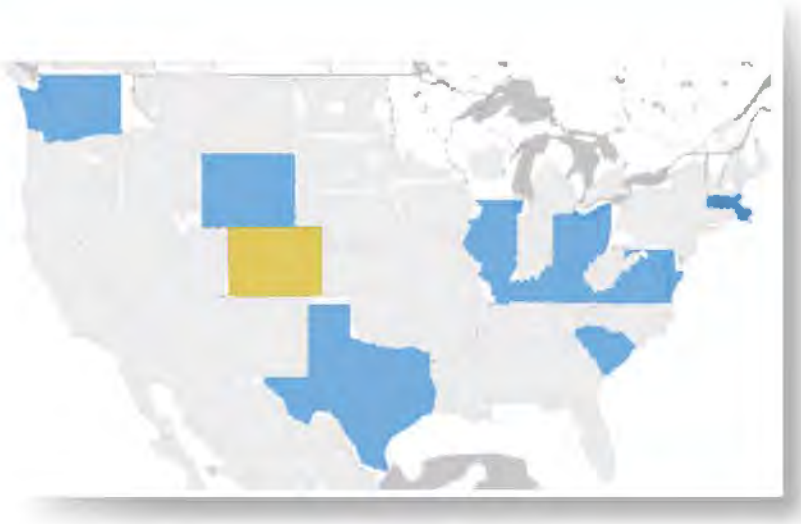
"HardBeauty believes that Naloxone is neighborly. I should be able to knock on my neighbors' door and ask for this life saving drug like I would borrow a cup of sugar. We would not have Naloxone to disseminate in our community without the Naloxone Project. Thanks Naloxone Project!"

Racquel Garcia

NATIONAL GROWTH: NEW STATE CHAPTERS

This year, The Naloxone Project opened ten new state chapters:

- **Illinois**
- **Kentucky**
- **Massachusetts**
- **Maryland**
- **Ohio**
- **South Carolina**
- **Texas**
- **Virginia**
- **Washington**
- **Wyoming**



Through generous funding from several national partner organizations, TNP is now expanding across the county. A diverse and influential 10-person Board of Directors (BOD) was formed to support the national TNP mission and expansion, convening for the inaugural BOD annual meeting in January 2023. By connecting with motivated state leaders, the TNP BOD and support staff have established ten new state chapters and will continue to recruit additional states. Using the implementation model that has proven successful in the inaugural Colorado chapter, new state chapters are beginning their journeys to expand equitable and sustainable naloxone distribution to their communities.

MASSACHUSETTS

The Massachusetts chapter of the Naloxone Project has been working on expanding access throughout the Commonwealth. As a first step, we obtained support from the Massachusetts College of Emergency Physicians for the initiative. We then leveraged their ED directors electronic mailing list to query leaders of EDs across the state about their current naloxone distribution practices. Hospitals that didn't respond to the query were called. We were able to ascertain that 32 of the state's 60 EDs (53.3%) currently provide naloxone to at-risk individuals. Seven of the hospitals that do not currently provide naloxone are part of one health system, and we are working with their leadership to supply them with donated product. The next steps will be to find a sustainable source of naloxone. We plan to introduce the model legislation to ensure coverage and reimbursement for dispensed naloxone as soon as it becomes possible to do so.

Scott Weiner . MD . MPH . FAAEM . FACEP . FASAM

WYOMING

The biggest success so far for this project has been removing the reporting requirement from the PDMP for naloxone. This makes it easier for staff to distribute naloxone in a clinical setting. We are currently working with the Wyoming Hospital Association to change our rules to more of a distribution model versus the current dispensing model. Wyoming ACEP is going to be meeting with the program to gain physician sponsorship and distribute the hospital survey.

Angela Vaughn . DHSc . MPH

MARYLAND

The Maryland Naloxone Project led by Dr. R. Gentry Wilkerson from the University of Maryland School of Medicine is focused on the education of medical staff regarding Take Home Naloxone in order to reduce barriers to the distribution of this life-saving medication to people at greatest risk of experiencing an opioid overdose. The Maryland State Legislature passed the Statewide Targeted Overdose Prevention (STOP) Act in 2022, which mandates that all hospitals distribute naloxone at no cost to at risk patients as of June 30, 2023. The Maryland Naloxone Project is positioning itself to help hospitals to implement this mandate and work with them to educate and train their staff. The Maryland Naloxone Project was certified by the state as an Overdose Response Program (ORP), which allows us to receive shipments of no-cost naloxone from the state. Our first training session was at a regional drug treatment program where about 20 staff members were trained and given naloxone. Next, all interns in the University of Maryland Emergency Medicine Residency were trained (~15). This was followed by training for all incoming first year medical students as well as the rising second year medical students (~310 total trainees). In late September, Dr. Wilkerson is scheduled to give a grand rounds lecture on the opioid epidemic to the Department of Obstetrics & Gynecology where he will also be doing naloxone training and distribution. Next steps include submitting grant applications to obtain funding to support our mission through development of training materials and providing branded kits, which will include educational materials, gloves, face shield, as well as the naloxone.

R. Gentry Wilkerson, MD

WASHINGTON

Washington State had a head start on much of the country as an early follower of the Colorado Naloxone Project successes. Now 2 years into the passage of State bill 5195, this mandated Hospitals to create programs to identify at risk individuals and directly dispense Naloxone from the EDs. The efforts particularly of the Dept. of Health (Dr. Herbie Duber, MD, FACEP and Chair of WA ACEP along Liz Wolkin RN) working with the WA State Hospital Association eventually solved the first big hurdle, "How to have Hospitals reimbursed". No one likes to play with unfunded mandates, so it took over a year to create CPT codes for Medicaid & Private Insurers to be billed. With those now in place, Hospitals have begun to build out the system. Challenges remain primarily in three areas:

1) Provider engagement- WA ACEP's annual conference included a session on Naloxone distribution and 5195, and helped jump start the efforts. What remains to be seen is efforts to grow within EDs, and other specialties (OB, Inpatient Internists, etc.).

2) Tracking metrics/ outcomes/ successes. Working with the WA State Hospital Association, WSMA, picking metrics besides just "Is your program up and running" will need to be tracked. WSMA has initially taken on the role of tracker, and TNP is happy to work with Ryan Robertson who has been helpful. Stay tuned for data results. What is not clear is...

3) "Who is the Sheriff?". Will there be a way to coerce hospital's and providers into participation if programs are slow to engage? Without a hammer, most States will ultimately face the same question.

All in all, if Colorado is an A+ in leading the way on efforts to initiate HANDS (Hospitals As Naloxone Distribution Sites), Washington is lucky to be a B+ or A- in my opinion.

Stephen H. Anderson MD . FACEP

OHIO

Ohio has had successes so far and good momentum moving forward! We have signed letters of support from the Ohio State Medical Association, Ohio Chapter American College of Emergency Physicians, Ohio Pharmacy Association, Columbus Medical Association, and Ohio American Society of Addiction Medicine. We have a solid supporter/sponsor in the Ohio Senate, Dr. Terry Johnson. We will reconnect with him when the senate reconvenes after summer break. Our largest barrier so far is reluctance from the Ohio Hospital Association and expected resistance from the insurance lobby. We also have had trouble, despite diligent effort, in connecting with Dr. Papp of the NE Ohio Hospital Opioid Consortium to ask for support. Moving forward, we have made contact with and expect support from Summa Health System, Ohio Chapter American College of Obstetrics and Gynecology, and the Ohio Academy of Family Physicians. Finally, we plan to reach out to Project DAWN and BirdieLight which are harm reduction organizations in Ohio.

James Neuenschwander . MD . FACEP . FASAM
Jason Kolb . MD

VIRGINIA

In Northern Virginia Inova Fair Oaks Hospital has expanded its criteria for Naloxone. The criteria now matches the national Naloxone Project's criteria. Naloxone is also built into the same order set as Suboxone for discharge within the Epic order sets. Although there are similar order sets in the Inova system, we are hoping for expanded use by adoption of the Naloxone project criteria, at additional facilities, to reach a wider patient population. In the coming months, we will reach out to the EMS systems to hopefully expand distribution to the population at risk.

Mark Franke MD FACEP
Brandon Wills . DO . FACEP . FAACT

TEXAS

In the state of Texas, we have organized a team consisting of leadership in pharmacy, medical staff, and community advocates. We continue to arrange meetings with Legislatures and provider groups. Naloxone has FDA over the counter approval, and we aim to improve accessibility of this medication for those with opioid use disorder in our rural and metropolitan areas.

Aldo Andino . MD . FASAM

A WORD FROM OUR EXECUTIVE DIRECTOR

Part I. On Systems

"A bad system will beat a good person every time"

- W. Edwards Deming

In the past year, we lost nearly 110,000 Americans to drug overdoses. That is a life lost every 5 minutes, three hundred lives a day. The tragedy is compounded by the fact that most of the individuals who die are young and the disease of addiction, from which many are dying, is treatable. Nearly 100% of those deaths are reversible and preventable with naloxone. Several patient populations in particular demand our hearts and our attention. Overdose is now the top killer of pregnant and peripartum patients in the US, and adolescent overdoses have increased by 133% from 2019 to 2022. In many of the hardest struck communities, we are losing a generation of Americans.

People often ask *why*? Why in one of the worlds' wealthiest, most medically advanced countries, are so many dying? The answer is as simple as it is sobering. *Our system is producing exactly the results it was meant to create.*

To clarify, the system we currently have is a bipolar one. The system of addiction and loss consists of cartels and the illicit drug market. This system has been defined by intense innovation, increasing efficiency, product growth, diversification and seemingly inexhaustible supply. Illicit fentanyl, methamphetamine and increasingly xylazine are now present in nearly every community - and accessing these illicit drugs has never been easier. Thanks to cross contamination and climbing potency, our drug supply has never been more fatal.

Our protective systems consist of medical, harm reduction, and law enforcement agencies. While there are multiple legal and enforcement considerations to the overdose crisis, it is important to focus on the fact that addiction is a medical disease. Overdose is a physiologic process, one amenable to medical intervention. So what of our medical and harm reduction systems? These systems have been defined by misconceptions, slow growth, sluggist change, regulatory obstacles, bureaucratic inefficiency and poor uptake by medical providers. Medication for opioid use disorders and naloxone remain difficult to access for most patients with opioid use disorders; many clinicians refuse to write prescriptions for them and many pharmacies don't stock them. Stigma and discrimination against persons who use drugs remain pervasive in medical systems and communities. Harm reduction interventions such as overdose prevention sites, needle exchanges, fentanyl test strips and naloxone remain taboo in many spaces, and forbidden by law in others.

The fight for the health, wellness and lives of our brothers, sisters and neighbors who struggle with addiction is not a fair fight. And the system which exists now is driving outcomes that are as predictable as they are tragic. The urgent question is if we have the desire and resolve to change our systems for the better.

Part 2. Naloxone Heals

"Naloxone is not just an antidote to overdose, it's a gateway drug to recovery."

- *The Naloxone Project*

There is work to do. As a nation, we must build the treatment and harm reduction systems that our patients and communities deserve. The Naloxone Project has chosen to start with the antidote. Naloxone is a miraculous compound. When used for opioid overdoses, it reliably and effectively restores breathing and consciousness. It prevents death. In the face of an opioid overdose crisis, naloxone provides us with the most immediate and direct way to begin saving lives. When citizens are armed with naloxone and the knowledge of how to use it, we empower them. We also enlist them as agents of change, who are not only aware of the opioid crisis but engaged in addressing it. Naloxone is not just an antidote to overdose, it is an antidote for ignorance and apathy.

One of the primary goals of TNP is to build robust medical harm reduction and naloxone distribution systems - starting with hospitals and emergency departments (EDs). For most disease processes, EDs and hospitals represent the apex of clinical care. They represent the safest place in the world for individuals with life threatening illness – unless that illness is addiction. In the case of addiction, medical spaces have often been defined by neglect, stigma and discrimination. By building naloxone distribution and dispensing programs in EDs and hospitals, we begin to correct a historic and systematic wrong.

On a human level, we must change the hearts, minds and behaviors of front line medical staff. As an emergency physician, I can say that the apathy shown toward patients with addiction is one born from trauma. Medical staff have often experienced verbal and physical assault at the hands of patients who are intoxicated, in withdrawal, or whose behaviors have been hijacked by their addiction. Trauma can lead us to dehumanize, withdraw, neglect and hold contempt for those who have traumatized us. In action, it leads us to provide substandard medical care, which at best is distant and lacking compassion and at worst is discriminatory and filled with veiled aggression. The results are systems of trauma, where medical staff and patients with substance use disorders continually traumatize one another to the moral, psychological and physical detriment of all parties.

Naloxone distribution can transform systems of trauma, back into systems of care and therapeutic alliance. The act of considering someone's vulnerability and risk connects medical providers back to their intent to heal. The act of giving naloxone is an act of caring and compassion. Giving naloxone to someone with opioid use disorder, with a message of hope and recovery, transforms the interaction. The act of being cared for and seen, allows patients to re-establish trust with a medical system that they often fear. Naloxone's value lies beyond the pharmacologic properties of the compound, but includes the sacred act of connection. It is a gift, one that enriches both parties.

Once medical systems and clinicians begin having more therapeutic connections, we see medical providers and patients start to move past their trauma and reunite themselves with purpose and mission. We see systems become more willing to provide and expand addiction treatment services. We see naloxone as a gateway drug to recovery, for both patient and clinician.

"We see naloxone as a gateway drug to recovery, for both patient and clinician. "

Part 3. A New System

"The best way to predict the future is to build it."

- Peter Drucker

The Naloxone Project has a vision of creating a medical system and society that has no stigma, provides naloxone, and saves lives - one that is equitable and sustainable. We are committed to building a future where naloxone will be provided in all medical spaces, a future where clinicians will be leaders in providing compassionate and evidence based care to people at risk of overdose. In this last section of this executive director's report, I will celebrate some of our past years' successes and expand on our future plans to deliver on the promise to create a better, more compassionate and effective system.

In 2023, TNP's Colorado Chapter focused on the crisis of overdose in perinatal patients and on growing our mission to additional states. Thanks to the amazing leadership of our Colorado Chairs, Dr. Rachael Duncan and Dr. Kaylin Klie, and the tireless work of our senior project managers, Ms. Ryan Tsipis and Ms. Nikki King, we have recruited 50 of Colorado's 52 birthing hospitals to our Maternal Overdose Matters (MOMs) Initiative. Many of these hospitals have begun dispensing naloxone to at-risk perinatal patients. Several, with TNP's support, have begun opt out programs, where all pregnant persons are offered naloxone. These 50 birthing hospitals join over 109 Colorado emergency departments in creating a more comprehensive system of harm reduction and care. The Naloxone Project has also welcomed Ms. Racquel Garcia to our national board of directors and elected her as our vice-chair. As a woman and mother in long term recovery, she has helped us more deeply understand the issues around maternal substance use and how to best care for pregnant persons with SUD. Thanks to these amazing women, hospitals will be more welcoming, compassionate spaces, better able to care for families affected by substance use.

The Naloxone Project also launched several new state chapters including Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Ohio, South Carolina, Texas, Virginia, Washington and Wyoming. In each of these states, local leaders stepped forward to start chapters based on the needs of their communities. The ability to bring together and collaborate with leaders from across the nation has enriched and informed TNP's efforts and has already borne early results in many states.

In Louisiana and Wyoming, TNP has helped advance regulatory change that has made naloxone distribution possible. In Ohio and Massachusetts, we are in discussions to launch legislative efforts. In Virginia and Washington, our teams have forged partnerships and hosted educational opportunities for hospital systems and clinicians. Thanks to a grant provided by the Foundation for Opioid Response Efforts (FORE), The Naloxone Project will be purchasing data from across the country and working on providing insights into how to advance the science and practice of hospital based naloxone distribution. The Naloxone Project continues to grow into a nonprofit with national reach.

One of the greatest accomplishments of this past year was the announcement of the Hospitals as Naloxone Distribution Sites (HANDS) Bill (HB 5506). The HANDS Bill was announced on Overdose Awareness Day, in a joint press conference with Colorado Representative Brittany Petterson. The HANDS Bill would mirror some of the legislation we have championed in Colorado, mandating that federal payers (Medicare, Medicaid and Tricare) reimburse hospitals for dispensed naloxone and direct the FDA to issue regulatory guidance to strip away barriers to naloxone distribution and dispensing from hospitals. TNP has already received support from the American Society of Addiction Medicine, American College of Emergency Physicians, Association of State and Territorial Health Officials, and the American Association of Physician Assistants. If passed, the HANDS bill will be a quantum leap in our efforts to make every hospital a naloxone distribution point and provider of life saving care for patients at risk of overdose.

As we look toward 2024 and beyond, TNP stands on the threshold of tremendous and meaningful growth. In the past year TNP has been the fortunate recipient of several private grants. Chief among our supporters, Mr. Patrick Schmidt and FFF have supported TNP's mission, and also have provided us with wisdom and insight. Direct Relief, Hikma, Amadis and Emergent BioSolutions have provided us with donations of Naloxone to provide to patients. TNP has also received grants from the Colorado Behavioral Health Administration that resulted in the hiring of 4 new staff members. TNP is ecstatic to welcome Mr. Ian Keith, Ms. Kristen Ashworth, Mr. Micheal Barrow and Mr. Joshua Jacoves into our organization. They will oversee a meaningful expansion into areas within and outside of medicine. In the next year, this staff will help TNP grow to hospital inpatient units, medical clinics, surgical units and into the community. In 2024, TNP has chosen a new primary focus area, namely prehospital providers and environments.

This fall, TNP launched the Colorado Prehospital Addiction Care Consortium (CPACC). CPACC will focus its efforts on championing naloxone distribution and addiction care by EMS, Fire, Crisis Response and Police agencies. First responders have a unique insight into their communities, and awareness of high risk populations that are underserved and have poor access to medical care. By engaging and empowering first responders to distribute naloxone, we can open a new frontier of access and care for our patients. TNP's CPACC initiative will have the opportunity to pilot and advance these efforts in 2024, thanks to The Denver Department of Public Health & Environment (DDPHE). DDPHE has selected TNP for a grant to work with Denver EMS, Fire, Crisis Services and Police - who have committed to working with TNP to make universal naloxone distribution by first responders a reality.

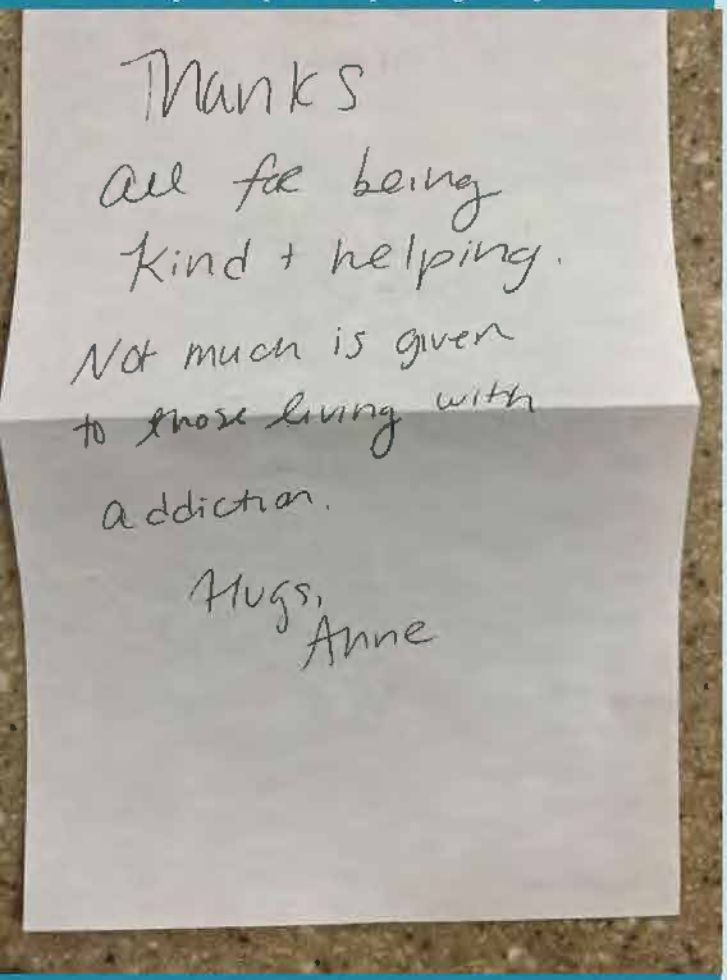
I'd like to end this report with a statement of gratitude. The work we have accomplished over the past year is a direct result of the dedicated staff, volunteers, donors and supporters. It is an honor to lead an organization that sees the inherent value of people who have an opioid use disorder and all at risk of overdose. TNP is addressing the opioid crisis, changing the landscape of medical care and saving lives. If our mission resonates with you, my ask is that you join, and support our efforts. I have no doubt that our work is making an impact, one that will continue to grow.

Sincerely,

Don Stader MD, FASAM, FACEP
Addiction & Emergency Medicine Physician
Executive Director, The Naloxone Project

If you are interested in donating to The Naloxone Project or in volunteering to advance our mission, please contact us through scanning this code.

A note from a patient at one of our participating hospitals



How you can help

1. Join TNP. Support our mission to remove stigma and make take-home naloxone programs an equitable and sustainable reality in every hospital.

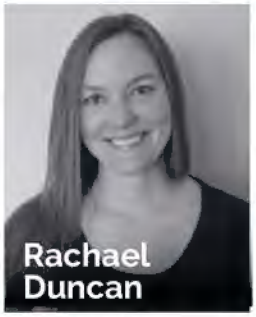
2. Donate or volunteer. TNP depends on the generosity of like-minded individuals and groups with a desire to end the opioid epidemic in Colorado and across the nation.

3. Support the Hospitals As Naloxone Distribution Sites (HANDS) Act, a newly introduced piece of federal legislation that promotes a nationwide reimbursement model.

Our Team

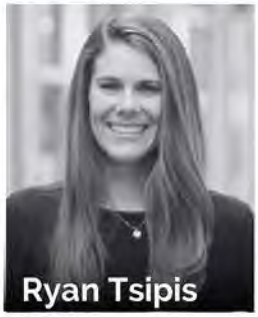
The Naloxone Project team has been growing to meet the expanding scope of our ambitious plans.

MD, FACEP
Executive Director TNP



PharmD
Co-Chair CNP

MD, MA, FASAM
Co-Chair CNP



MPH
Project Manager CNP

MSW
Project Manager CNP

MSW
Project Manager TNP

Project Manager, Senior Designer TNP

M.DIV
Community Engagement Officer CNP

PhD
Director of Analytics TNP

Strategic Assistant TNP

MPH
Project Manager EMS & Emergency Medicine

The Naloxone Project

Data Introduction

In any research or data-driven project, the data we collect is the foundation for analysis, decision-making, and insights. Understanding what data to collect, how to collect it, and why it is essential are critical steps to ensure the project's success. Collecting the correct data in a systematic and ethical manner is crucial for leveraging its full potential. It provides the insights needed to drive success and ensures that actions are aligned with actual needs and conditions. At the heart of our work lies a commitment to excellence, and we pride ourselves on our data quality. Our dedication to the quality of our data is unwavering. By prioritizing accuracy, consistency, completeness, timeliness, and relevance, we ensure that the data we collect and analyze meets the highest standards of excellence. This commitment drives the success of our project.

Please find attached samples of the types of data collected for our various initiatives.

Summary of The Naloxone Project

Last Data Refresh Date
7/16/2024

Select all	CLI	EDS	MOM	Other

System
All

Organization Name
All

Date
1/1/2021 6/1/2024

Total Kits Dispensed

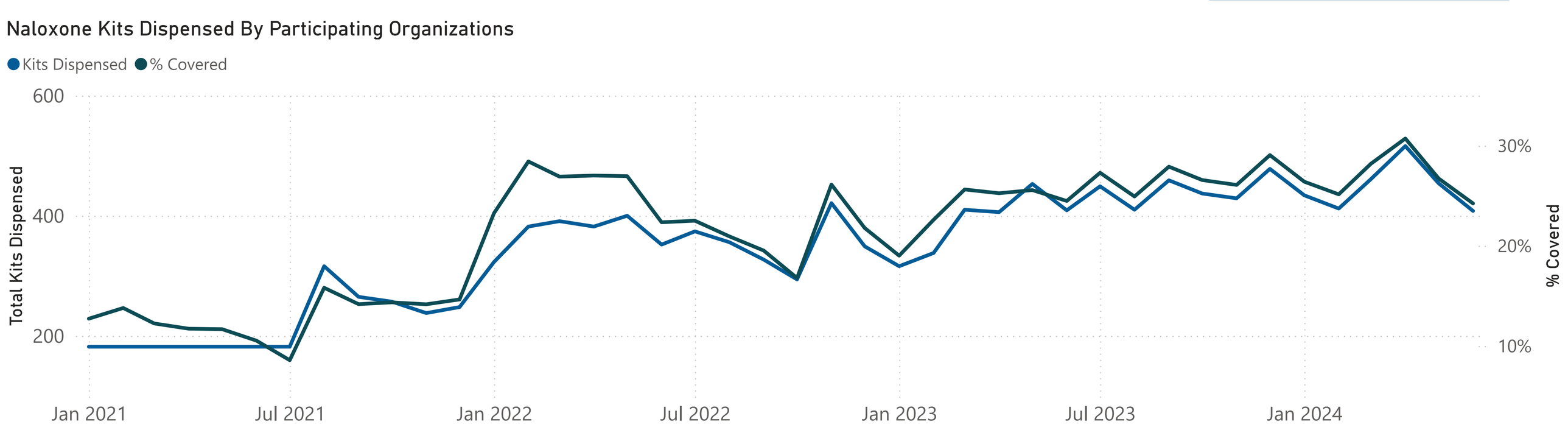
14,628

Total At-Risk Visits

68,560

% At-Risk Visits Covered

21.3%



Emergency Department Progress Report for

Sample Hospital

May 2024

Since the program began, we have dispensed 14,194 naloxone kits to at-risk patients seen in the ED.

This month, we have dispensed 449 naloxone kits to at-risk patients seen in the ED.

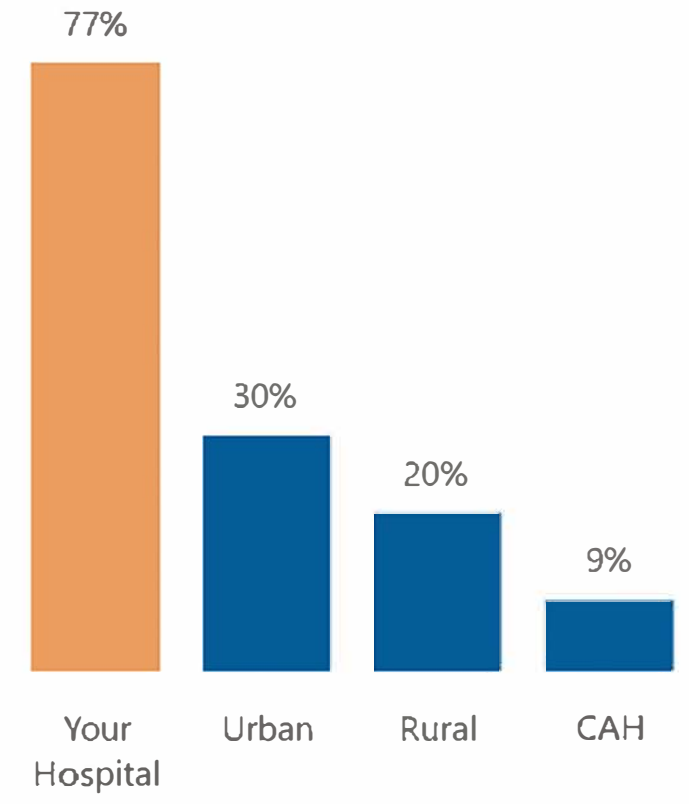
We hope to have all hospitals reaching an estimated 50% of at-risk visits with naloxone. We understand there are many reasons why a patient may not receive a naloxone kit during a visit. This report is meant to help you understand your general trends and where there may be opportunity.

	Dispensed Kits	# of At-Risk	Est. At-Risk Visits Covered	Kits needed to reach goal
This Month	136	348	39%	38
Last 12 Months	1,920	2,452	78%	At Goal

Percent of At-Risk Visits Receiving Naloxone Kits

Peer Group Comparisons

Limited to last 6 months



This report was automatically generated for your facility from the monthly dispensing data submitted by your facility as well as a monthly average from CHA's claims database to estimate at-risk patient visits to the emergency department and the proportion of coverage.

Generated on

6/27/2024

Number of Naloxone Kits Dispensed in the ED

Detailed Table of Reported Dispensed by Your Facility

Year	Sum of Kits Dispensed	Sum of At Risk Visits
2023	**1,702**	**2,089**
January	92	145
February	119	148
March	137	163
April	134	190
May	169	209
June	162	190
July	140	174
August	123	174
September	138	174
October	150	174
November	139	174
December	199	174
2024	**869**	**1,218**
January	190	174
February	149	174
March	217	174
April	177	348
May	136	348
Total	**2,571**	**3,307**

Please don't hesitate to reach out to Ryan at ryan@naloxoneproject.com if there is anything the support staff at the Colorado Naloxone Project can do to support your tremendous efforts in getting naloxone into the hands of patients who may need it. If you have any questions about this report, you may email Alyssa Fuller, data manager for the Colorado Naloxone Project, at alyssa@merakinos.com

Generated on

6/27/2024

Methods and Notes

Please note **this report is for internal use only.** It contains sensitive data, and should not be shared publicly. If you wish to use the results of the report outside your facility, please contact us first. This report is created automatically using data submitted by your facility's data contact (see details below), as well as aggregated and deidentified data from the Colorado Hospital Association. We are estimating at-risk emergency department visits from CHA claims data using a set of ICD10 codes that look for long-term opioid management as well opioid drug use, abuse, dependency or overdose.

We estimate your percentage of covered at-risk visits by dividing the number of kits you reported dispensing by this number of flagged claims. We understand there are a number of reasons that a patient may not get a kit during a visit, and we currently do not connect each kit with specific at-risk visit. This "at-risk coverage" percentage is meant to give you a general idea of your progress, rather than exact counts.

As a program, our goal is to reach an estimated 50% of at-risk visits with naloxone. We indicate if you are far below this goal with red (<25%), nearing the goal with yellow (25-49%) or meeting the goal with green (at 50% or greater).

CHA collects claims at the hospital level, which means that we cannot disaggregate visits for free-stranding EDs and thus cannot calculate 'at-risk coverage' for FSEDs. For hospitals, if you do not see an 'at-risk' percentage or number of at-risk visits, it means that there were fewer than 10 at-risk visits for that year or we were otherwise unable to get claims data for your facility. If you would like to see your at-risk percent coverage, you can submit at-risk visits counts each month alongside your dispensed kit numbers.

We want to support you in all that you do to help patients reduce the risk of opioid overdoses. Please feel free to contact our Naloxone Project team for additional training, support materials, progress assessment, and more. Email Ryan Tsipis at ryan@naloxoneproject.com or scan the QR codes below to access the TNP toolkits for the ED Program.

Have any questions about the data your facility has submitted? Here is the person who submits your data each month. Feel free also to reach out to Alyssa at alyssa@merakinos.com with any questions about this report.

Data Contact:	Data Contact Email

Summary of The Naloxone Project

Last Data Refresh Date
7/16/2024

Select all | CLI | EDS | MOM | Other

System
All

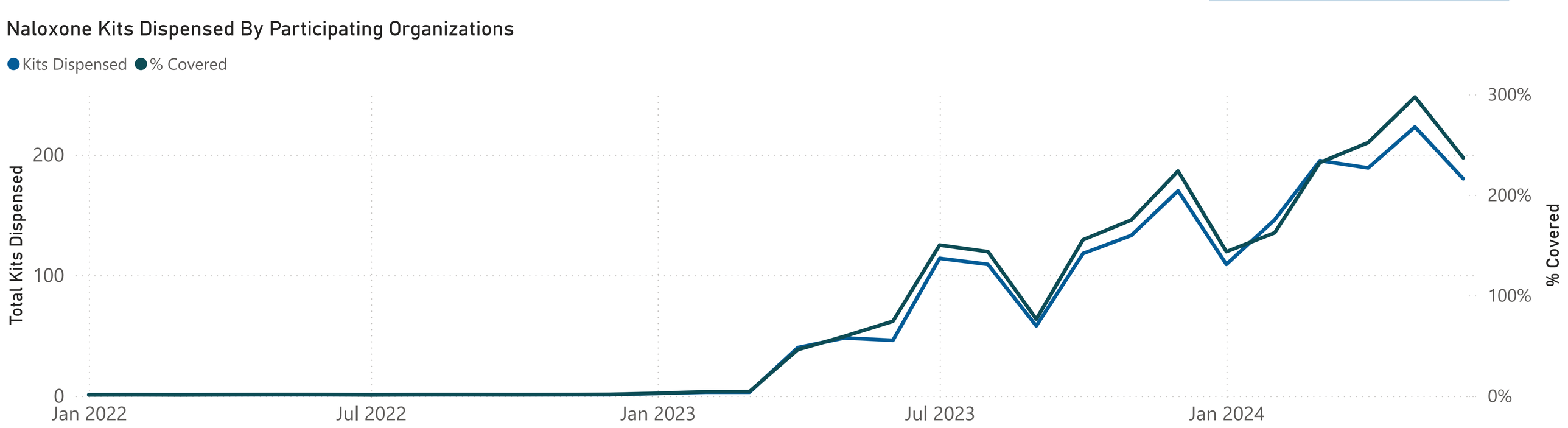
Organization Name
All

Date
1/1/2021 — 6/1/2024

Total Kits Dispensed
1,898

Total At-Risk Visits
2,424

% At-Risk Visits Covered
78.3%



Total CPACC Distributed Kits

Agency Name: All

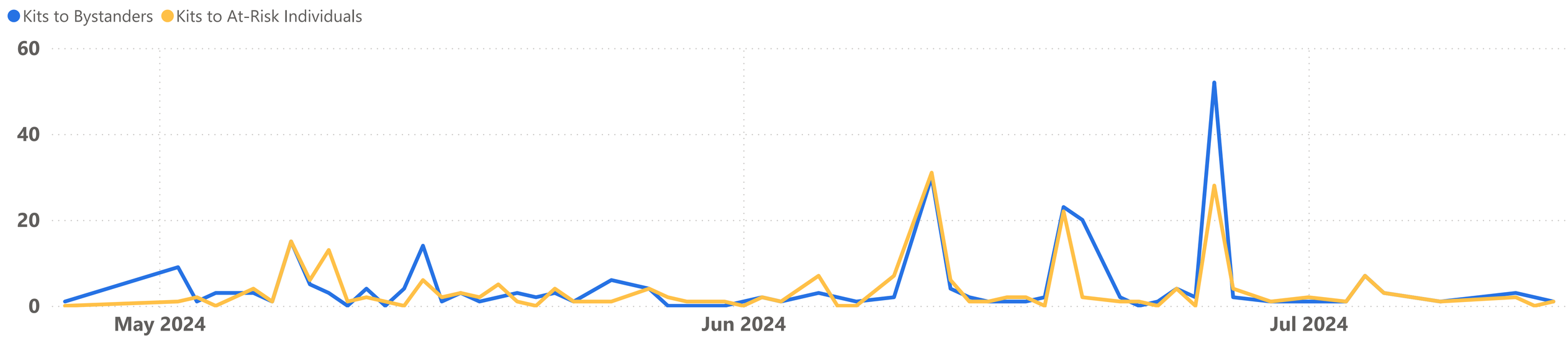
Systems Groups: All

County Category: All

Date: 4/26/2024 – 7/14/2024

	Total Kits to At-Risk Individuals	Total Kits to Bystanders	Total Kits	Avg. Kits per Incident
Last 30 Days	82	129	211	4.91
This Year	219	268	487	3.83

Kits by Recipient Type



Trends in Distribution

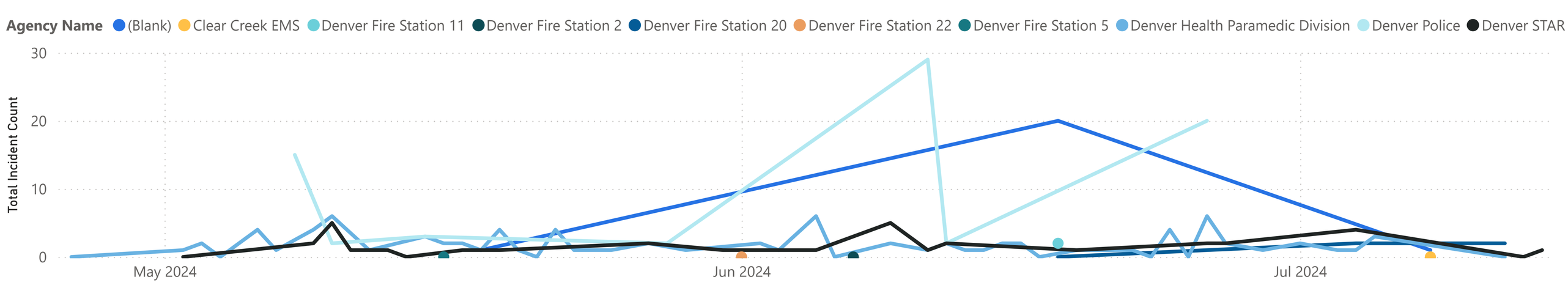
Agency Name: All

Systems Groups: All

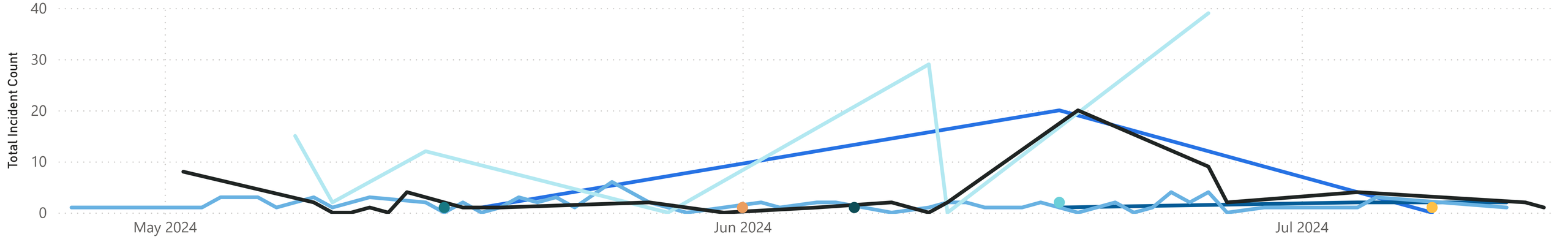
County Category: All

Date: 4/26/2024 – 7/14/2024

At Risk Kits



Bystander Kits



Trends in Distribution

Agency Name: All

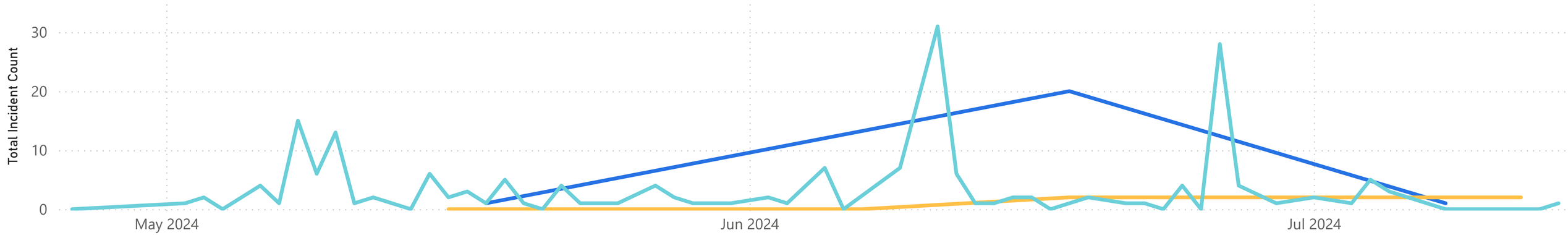
Systems Groups: All

County Category: All

Date: 4/26/2024 – 7/14/2024

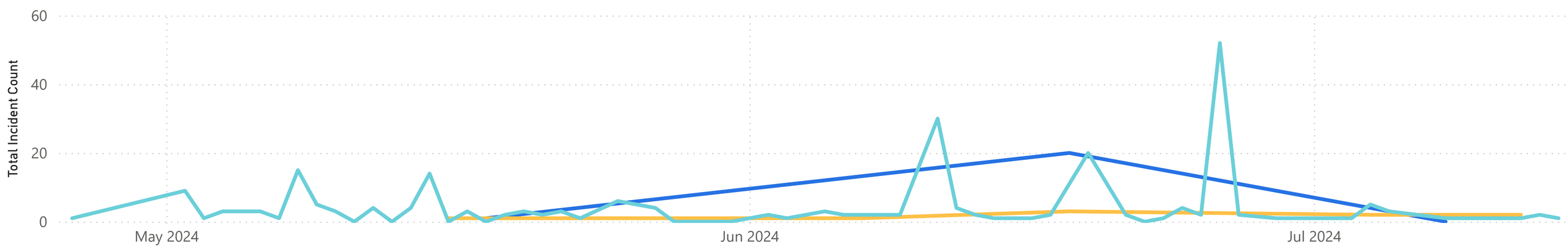
At Risk Kits

Systems Groups (Blank) DenverFire Independant



Bystander Kits

Systems Groups (Blank) DenverFire Independant



Total Administrations & Transports

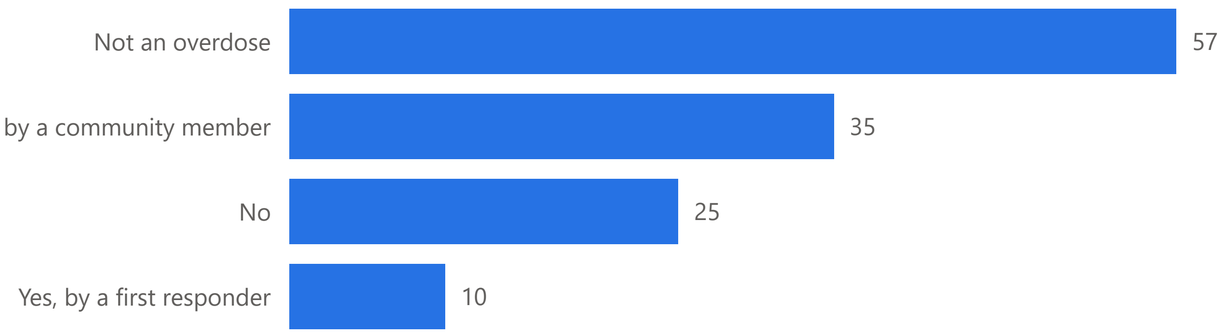
Agency Name: All

Systems Groups: All

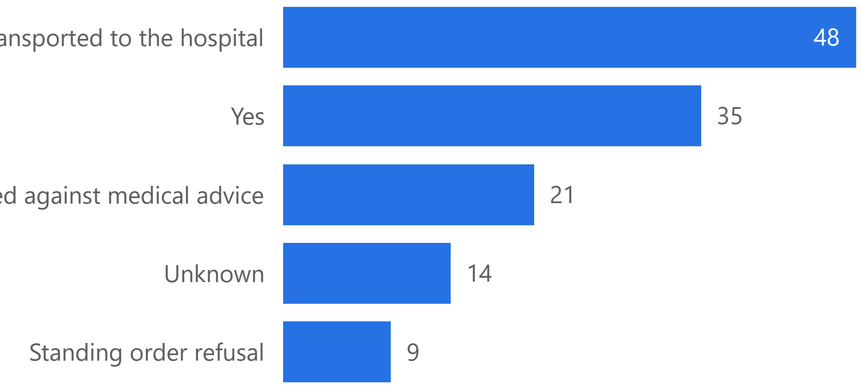
County Category: All

Date: 4/26/2024 – 7/14/2024

Did the individual at risk of overdose receive an administered dose of naloxone prior to your arrival?



Was the individual transported to the hospital?



Transportation Status

Naloxone Administration Status	No, individual was not transported to the hospital	No, the individual refused against medical advice	Standing order refusal	Unknown	Yes	Total
Not an overdose	32	2	6	11	6	**57**
Yes, by a community member	6	10	2		17	**35**
No	10	7	1	2	5	**25**
Yes, by a first responder		2		1	7	**10**
Total	**48**	**21**	**9**	**14**	**35**	**127**

Trends in Administration & Transportation

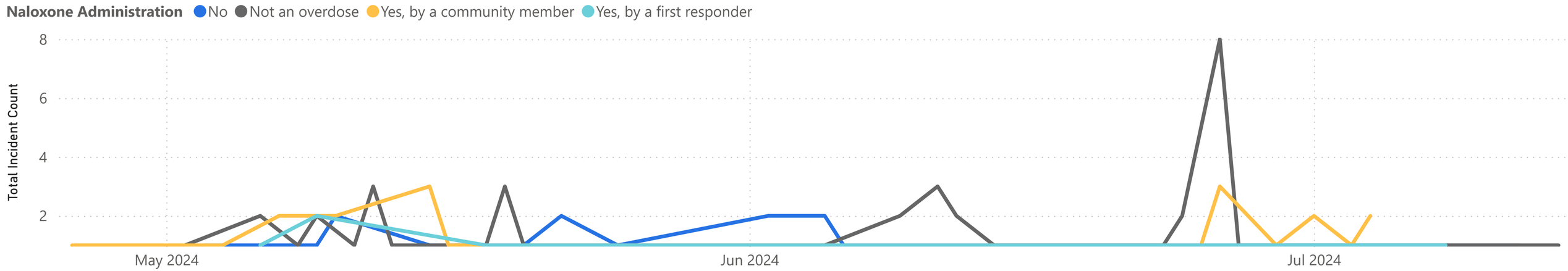
Agency Name: All

Systems Groups: All

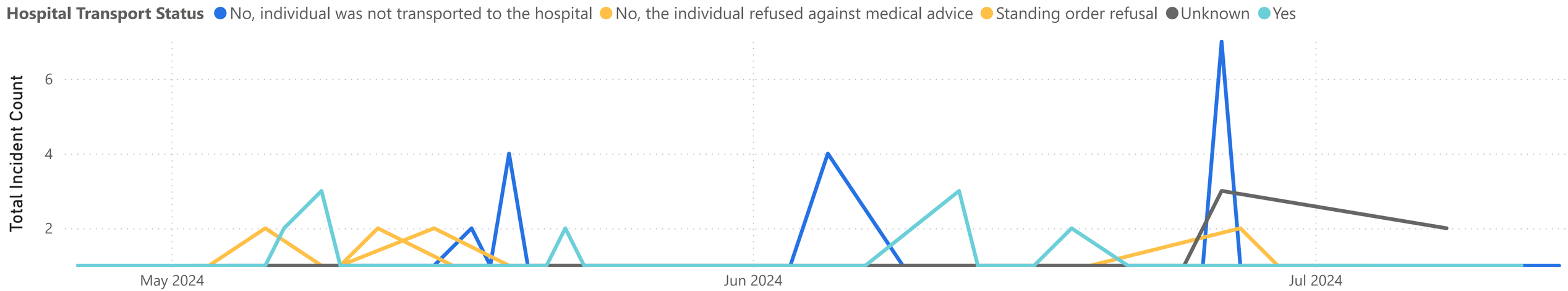
County Category: All

Date: 4/26/2024 – 7/14/2024

Did the individual at risk of overdose receive an administered dose of naloxone prior to your arrival?



Was the individual at risk transported to the hospital?



THE NALOXONE PROJECT

Overdose Risk in the ED

2024

A comprehensive report on opioid overdose vulnerability and opportunities for intervention in U.S. emergency departments

The report was developed by The Naloxone Project, a nonprofit dedicated to creating an equitable and sustainable medical system and society that has no stigma, provides naloxone, and saves lives.

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Foundation *for* Opioid Response Efforts

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INTRODUCTION

The Naloxone Project is a nonprofit organization dedicated to addressing the overdose crisis through efficient, sustainable, stigma-free naloxone distribution from hospitals and other places of healthcare. Substance use disorders are medical conditions, and as such, medical systems should be at the forefront of confronting the overdose and opioid addiction crisis.

This report represents the first quantitative study on visits by individuals at risk of opioid overdose in U.S. emergency departments (EDs). Previous studies have focused on volumes of patients being actively *treated* for overdose; this approach not only underestimates the opportunities for outreach but also by definition has missed the critical chance to ensure someone has naloxone *before* an overdose occurs. This report aims to illuminate the true scope of the challenge and opportunity faced by EDs. The findings offer a data-driven foundation for strategic interventions such has the provision of naloxone, harm reduction education, treatment for opioid use disorder, peer recovery engagement, and referral to care.

EDs are at the forefront of the burgeoning crisis of overdoses in our country. People at risk of overdose, such as those with opioid use disorder, chronic pain treated by opioid therapy, and poor access to health care due to socioeconomic factors, frequently seek care in EDs - at times as primary access

points for healthcare. The 2017 Delaware Drug Overdose Mortality Surveillance Report offers key insights into opportunities for intervention. This survey found that 80% of patients who died of an opioid overdose interacted with the healthcare system in the year before their death. Almost half interacted with the healthcare system within a month of their death. The emergency department represented the most frequently utilized area; over half of patients who died of overdose (54.2%) were seen in the ED in the year prior (see fig. 1 below). Over 70% of patients were seen in ED at some point in the two years before death.

Nationally, previous studies examining ED overdose risk have focused on quantifying ED-related overdose visits. The CDC's DOSE Dashboard measures nonfatal ED overdose visits and inpatient hospitalization in 21 states and provides valuable information for public health officials about healthcare visits related to overdose. The DOSE Dashboard showed 96,332 visits in those 21 states in 2022, with a rate of 62.4 (ED) visits for nonfatal opioid overdoses per 100,000 persons. Combining these insights with the Delaware study emphasizes why we need an expanded definition for 'risk' with ED visits; in Delaware, only 10% of patients who died of overdose had an ED visit due to *overdose* in the year before death. Put in another way, if we only focus on overdose, we miss 90% of patients who are candidates for an ED-based intervention such as naloxone distribution.

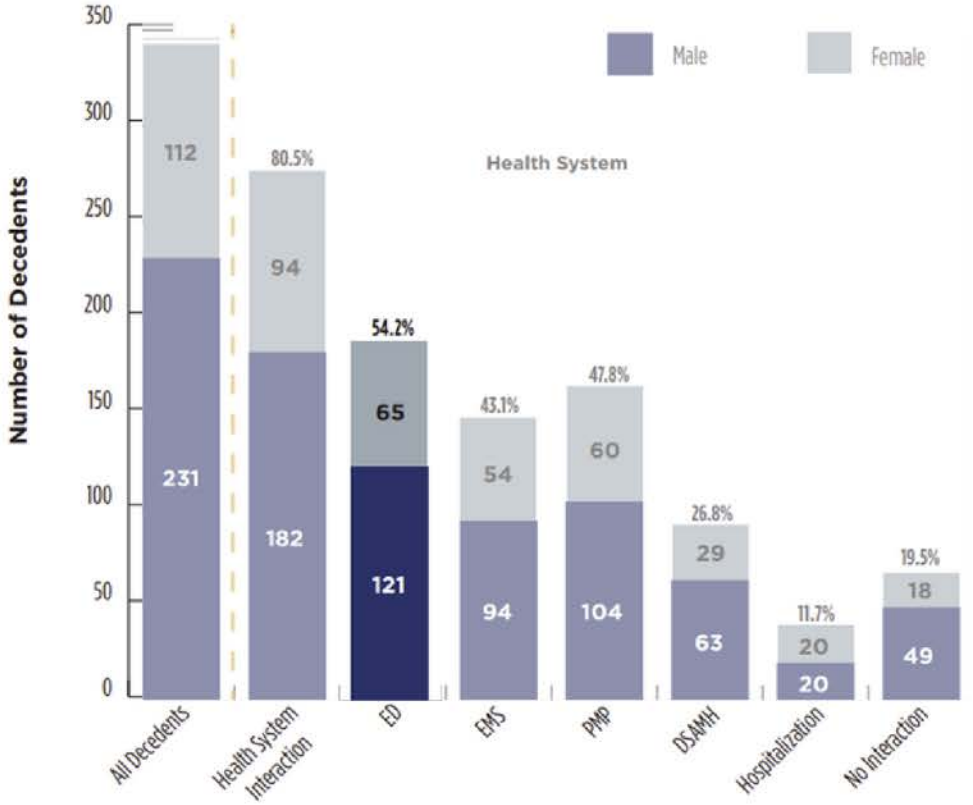


Figure 1: *Number and percentage of drug overdose decedents who had an interaction with a Delaware system in the year prior to death by sex, Delaware 2017. Emergency departments were the most common source of healthcare system interaction prior to overdose death.*

Source: Drug Overdose Mortality Surveillance Report, Delaware, 2017.

Our study represents an effort to better quantify ED patients at risk of overdose. Our panel of physicians and experts has crafted a list of discharge diagnoses that we believe represents a more holistic view of overdose risk (see Methods section for more detail). This report is published with the intent of fostering greater knowledge and resolve for intervention. The Naloxone Project believes that every patient at risk of overdose should be provided with naloxone in a manner that is integrated with emergency departments and health systems.

In addition, hospital- and ED-based naloxone distribution should have a sustainable funding model and be paired with evidence-based addiction treatment (i.e. medication for opioid use disorder) when appropriate. Emergency departments can and must play a critical role in distributing naloxone. We hope the insights garnered from this effort inform policies, guide clinical practices, and catalyze a united emergency medicine front against the crisis of overdoses in the United States.

This report will be followed up by a national survey of all US hospitals and their naloxone distribution and dispensing practices, along with a policy survey of regulations permitting or disallowing hospital- and ED-based naloxone distribution and dispensing.

SUMMARY OF FINDINGS

We estimate that in 2021, U.S. emergency departments saw *at least* **4.4 million ED** visits by patients at increased risk for opioid overdose, which constituted **over 3% of all ED visits**.

This analysis dramatically redefines what we should be considering 'at risk' for overdose in the ED. Of note, visits for active opioid overdose treatment make up less than 5% of these at-risk visits. Nearly half of at-risk visits are flagged due to current or historical nonopioid drug use, "abuse", or dependence. Over 18% of at-risk visits were by patients who are on long-term prescription opioid therapy.

Special populations were also examined using this broadened definition. Many potentially preventable maternal deaths in the US are related to substance use disorders. Our analysis estimated at least 40,000 annual ED visits by at-risk pregnant or postpartum patients.

While we have broadened the clinical definition of those patients who should be considered at risk, **these estimates are likely still substantial undercounts.** Incomplete or missing documentation, gaps in patient history, inaccessible medical notes, and other data realities make it impossible to capture all patients who are truly at risk.

NATIONAL OVERVIEW

While the total number of at-risk visits dropped from 4.08 million in 2019 to 3.86 million in 2020, the proportion of all ED visits considered at risk increased slightly from 2.8% to 3.2%. We also estimate, using total ED visit data, that at-risk visits likely jumped to 4.4 million in 2021. These visits are covered by Medicaid 38% of the time (fig. 2) and are most likely to be considered at risk due to nonopioid drug use or long-term opioid therapy (fig. 3).

Figure 2: *Proportion of at-risk ED visits covered by different health insurance types.*

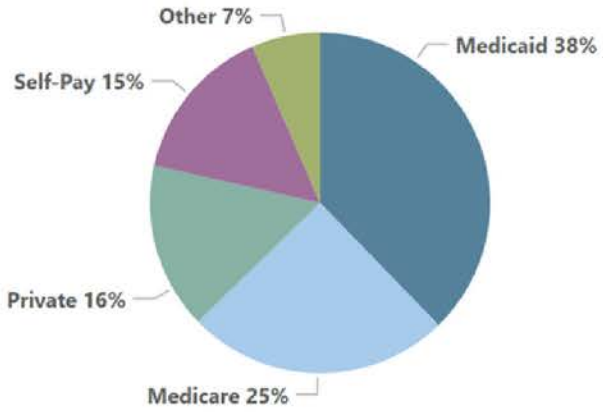
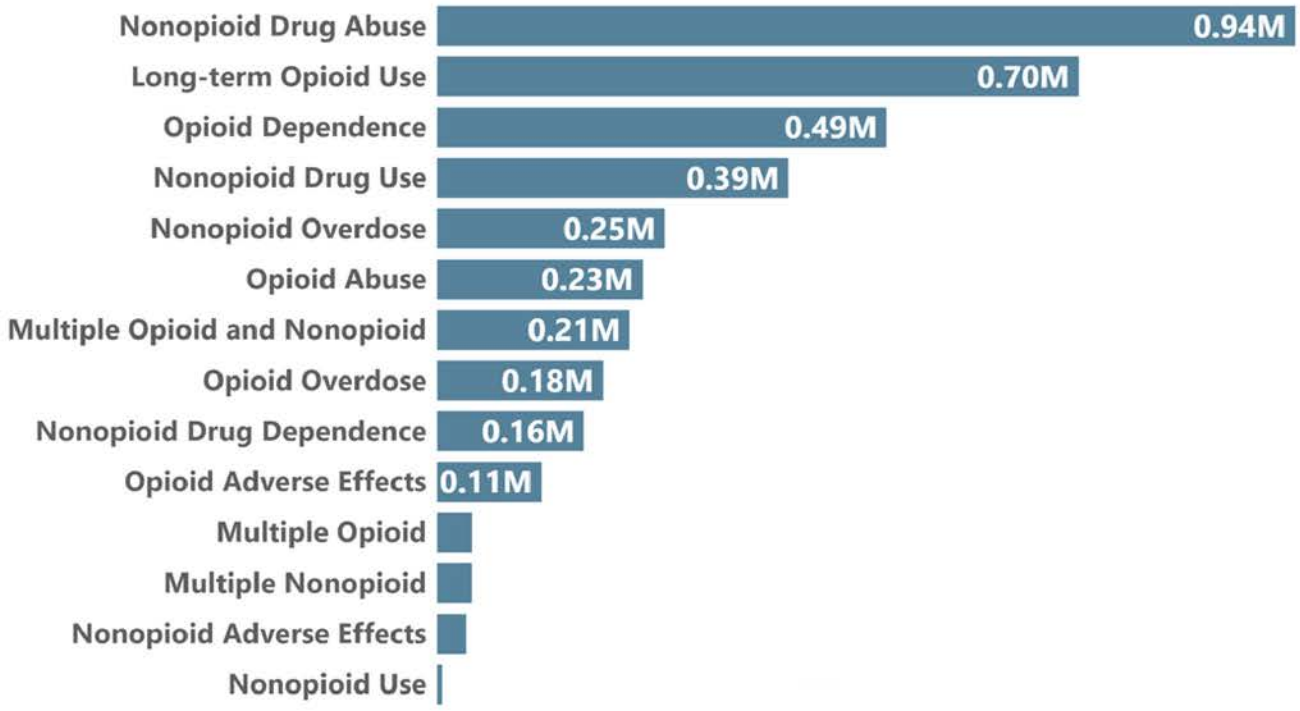


Figure 3: *Number of ED visits by reason for risk.*



A note on terminology: ICD10 diagnosis codes maintain three categories for classifying a patient's interaction with drugs: use, dependency, and abuse. The term "abuse" is indicative of a stigmatized view of patients suffering drug addiction, but because it is the current ICD10 terminology, we have retained it here in this report.

Over 13% of at-risk visits have codes for both opioid and nonopioid risk factors (fig. 4). Coding can often focus solely on the conditions driving billing, and codes can only be included for supplemental information when properly documented in the EMR. Thus, this overlap is likely an significant undercount.

Figure 4: *Proportion of visit by risk code type*

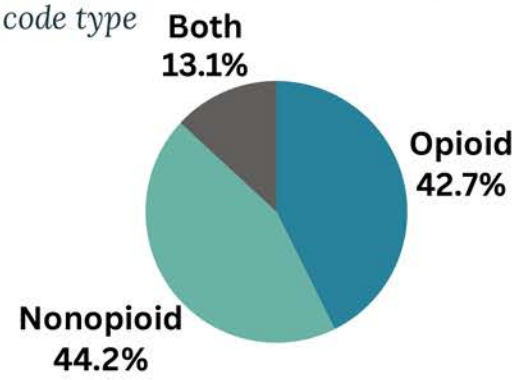
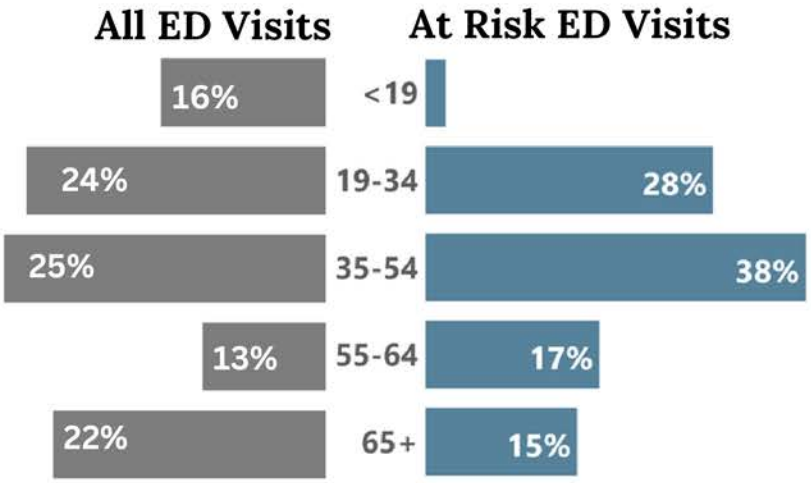
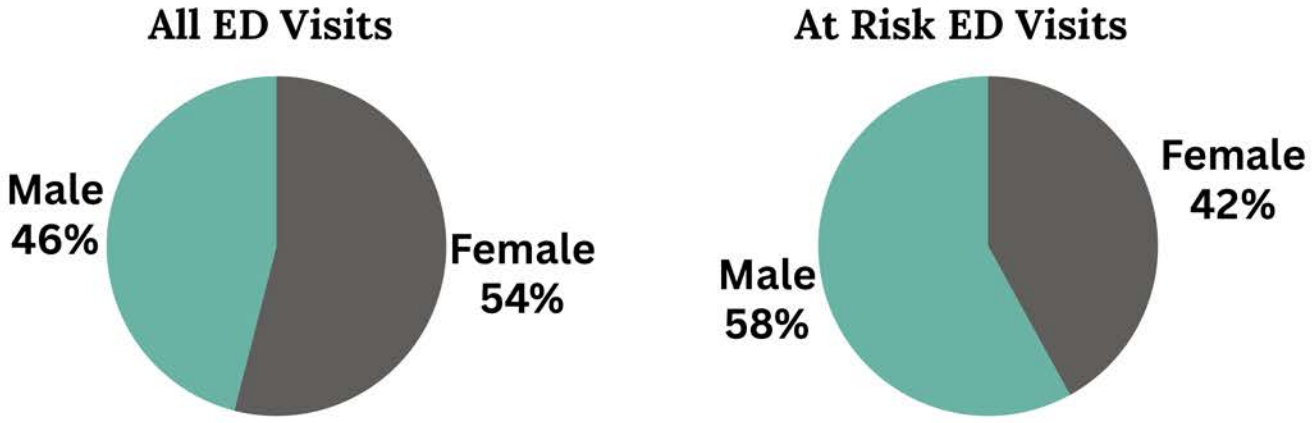


Figure 5: *Proportion of visit type by age category.*



At-risk patients visiting the ED show differences in demographics compared to all ED visit patients. For example, at-risk patients are less likely to be under 19 years old and more likely to be 35-54 years old than general ED patients (fig. 5). They are also more likely to be male (fig. 6). However, we still estimate 40,000 at-risk perinatal patients visit EDs every year.

Figure 6: *Proportion of visit type by patient sex.*



REGIONAL ANALYSIS

The National Emergency Department Sample dataset used for this analysis represents data from 40 states. While individual state identities are not included, the states are grouped into to one of four regional areas in the United States (fig. 7).

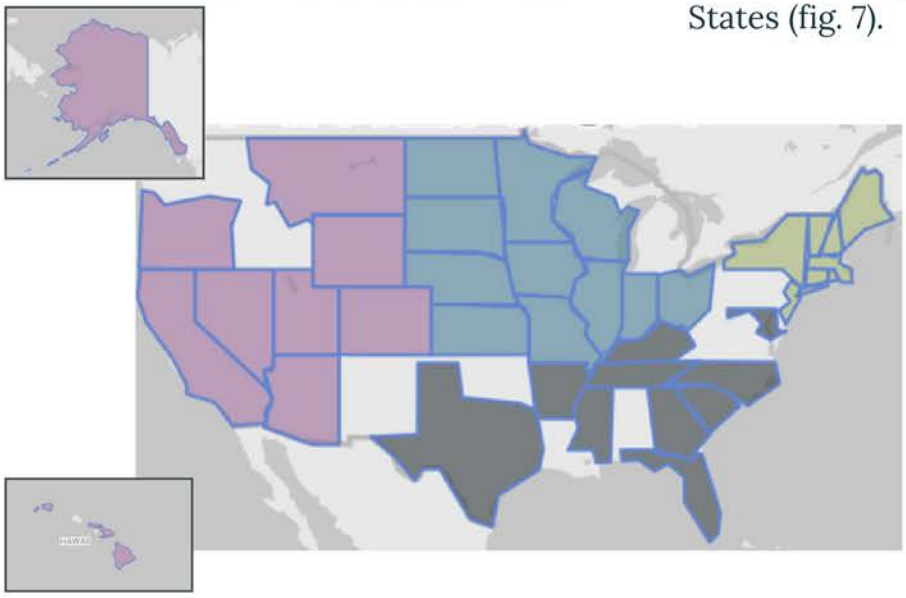


Figure 7: *Participating HCUP states by regional assignment.*

Regional differences exist in the rates and absolute volume of visits by patients at increased risk of opioid overdose.

Western states have the lowest rates and volume of ED at-risk patient visits (figs. 8a and b).

Figure 8a: *Regional at-risk ED visits per 100,000 population*

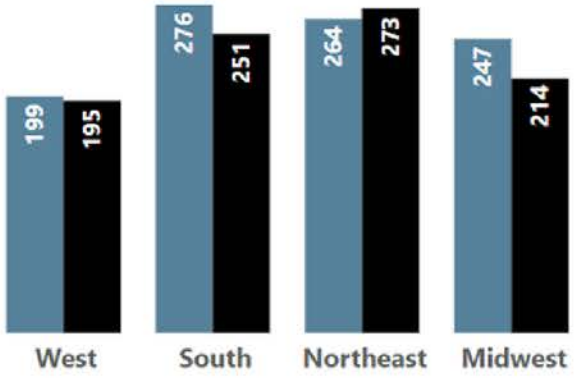
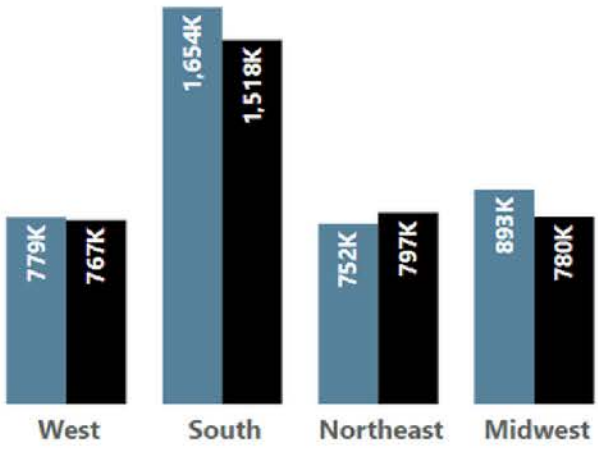


Figure 8b: *Regional at-risk ED visit counts*



ED visits by at-risk patients are significantly more likely to be uninsured and much less likely to be covered by Medicaid in the South than in the rest of the nation (fig. 9). This may be related to differences in Medicaid Expansion across the U.S., as the majority of states that elected not to expand Medicaid coverage are southern states. Regional variation in at-risk visits also reflects differences in regional populations. Southern and Midwestern states have higher poverty rates and lower incomes, and similarly at-risk visits are more likely to be from lower income zip codes than in western or northeastern states (fig. 10).

Figure 9: *Regional variation in proportions of at-risk visits by Medicaid vs uninsured patients.*

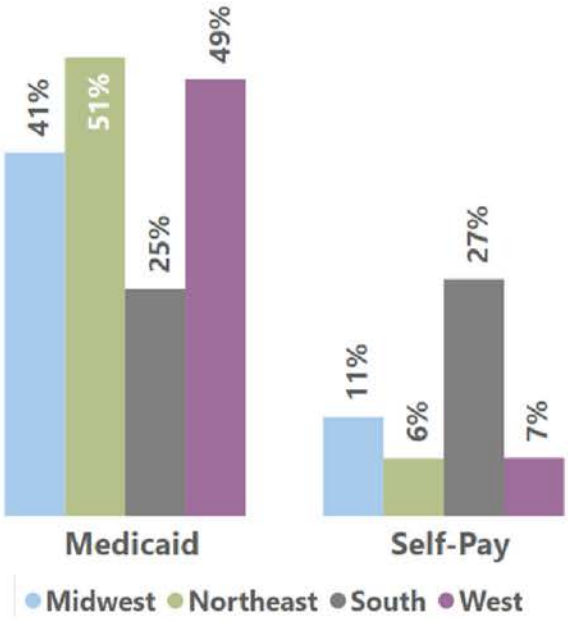
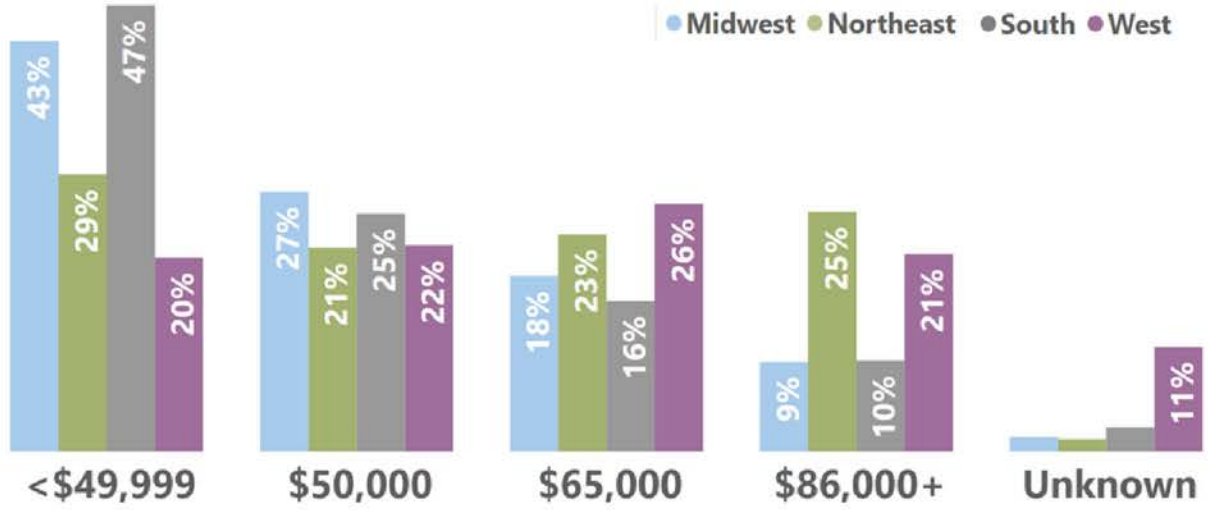


Figure 10: *Percent of at-risk ED visits based on the income quartile of the patient's resident zip code.*



THE NALOXONE PROJECT

United States

Estimated At-Risk Visits to EDs

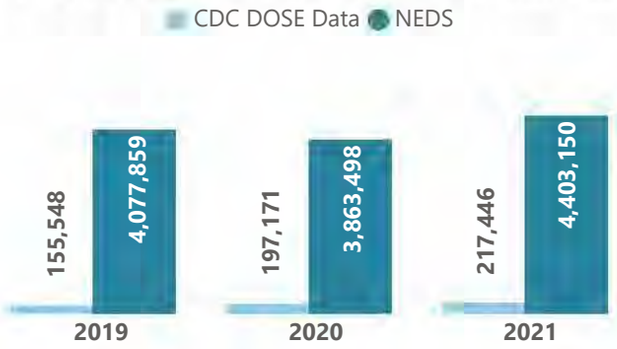
In 2021, US emergency departments saw at least **4,403,150** visits by patients at risk of opioid overdose.

Overdose is a leading cause of perinatal deaths. **14,834** of at-risk visits are by perinatal patients.

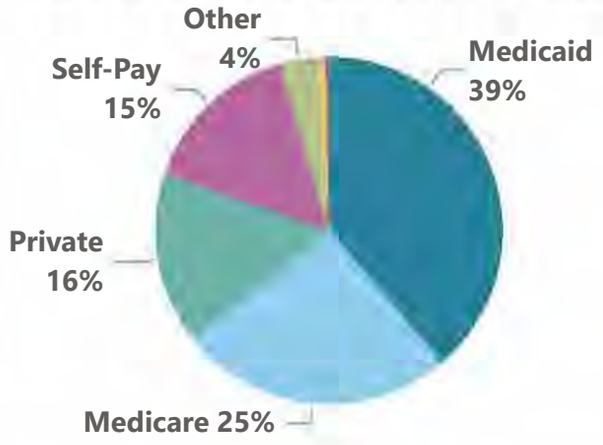
Overdose deaths in adolescents increased by 109% from 2019 to 2021. **80,942** of at-risk visits are by adolescents.

Death rates increased 44% among Black populations and 39% among Native Americans. **1,654,551** of at-risk visits are by people of color.

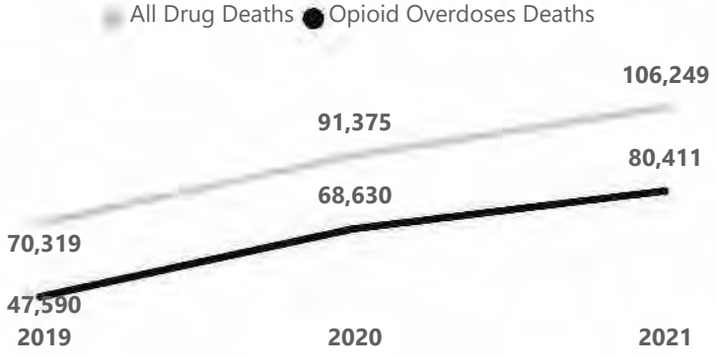
At-Risk ED Visits by Source of Estimate



At-Risk ED Visits by Patient Insurance



Total Overdose Deaths



In 2021 in the US,

28 people per 100k pop. died from opioid overdoses.

THE NALOXONE PROJECT

Montana

Estimated At-Risk Visits

Our state's emergency departments saw at least **14,656** visits by patients at risk of opioid overdose in 2021.

Overdose is a leading cause of perinatal deaths.

48 of at-risk visits are by perinatal patients.

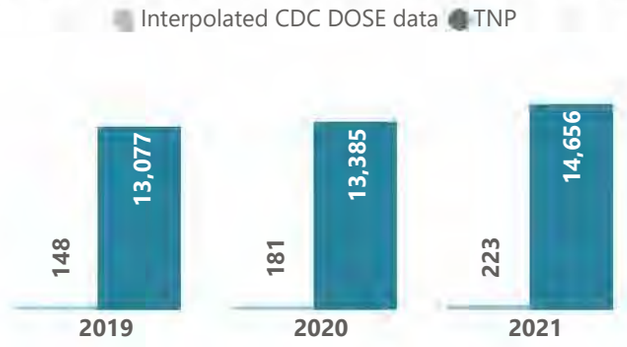
Overdose deaths in adolescents increased by 109% from 2019 to 2021.

347 of at-risk visits are by adolescents.

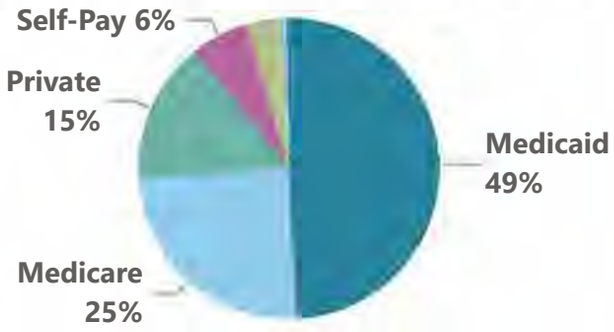
Death rates increased 44% among Black populations and 39% among Native Americans.

7,309 of at-risk visits are by people of color.

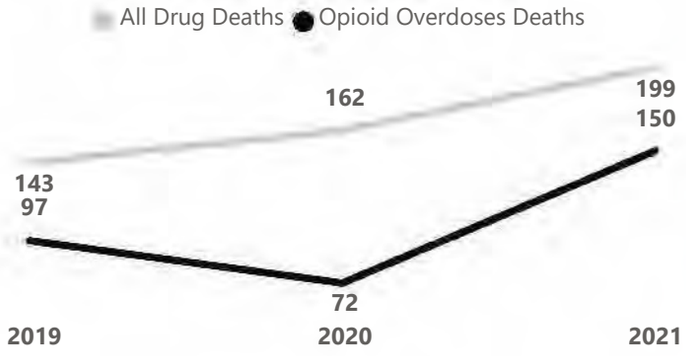
At-Risk ED Visits by Source of Estimate



At-Risk ED Visits by Patient Insurance



Total Overdose Deaths



Montana has a **Drug Overdose Death Rate** of **15** deaths per 100k pop.

which is the **42nd** highest rate in the US.

FUTURE STEPS & OPPORTUNITIES

This analysis shows that the opportunity for EDs to address the opioid overdose crisis is substantial. EDs can and should be a pathway for ensuring those at risk of opioid overdose are identified, provided naloxone, and given education on overdose recognition and reversal.

While ED naloxone distribution may seem like a common sense and pragmatic approach, many still barriers exist in our current system.

A complex interplay of factors must often be addressed at the hospital, state, and national levels to make naloxone distribution a reality. A multifaceted approach is often needed, from patient bedside to regulatory agencies to legislative bodies.

The Naloxone Project has built its six principles of change based on this dynamic approach (on the next page), which serve as a rough road map for states to construct naloxone distribution systems.

For interested citizens and organizations, the Hospitals as Naloxone Distribution Sites or HANDS Act (H.R. 5506) was introduced in 2023 by Representatives Pettersen, Schrier, and Budzinski. The HANDS Act would require naloxone reimbursement by federal payors and direct the FDA to issue guidance to pharmacy, nursing and medical boards to eliminate barriers to distributing and dispensing naloxone from hospitals. More information on the bill and opportunities to support can be found at **www.joinhandsbill.org.**

Many states have already taken concrete steps toward building naloxone distribution systems, but most of these systems remain poorly developed. The Naloxone Project invites clinicians, public health leaders, and others passionate about addressing the overdose crisis to collaborate and participate in building sustainable, equitable, and effective naloxone distribution systems. There are opportunities for organizations to join as supporters of The Naloxone Project, for individuals to volunteer, for interested parties to start new state chapters, and for anyone to support our mission via philanthropic donations. For those interested in becoming more involved, we invite you to correspond with us at **info@naloxoneproject.com**.

WAYS TO GET INVOLVED

Start giving out naloxone.
Healthcare providers and hospitals can start a naloxone distribution program. Resources are available at www.naloxoneproject.com.

Help get laws changed.
Support the HANDS Bill (H.R. 5506) or similar legislative solutions that remove disallowances for naloxone distribution and facilitate providers to help.

Get involved.
Work with or volunteer with The Naloxone Project, state chapters, or other organizations helping to distribute naloxone to those who need it.

Donate to The Naloxone Project or another harm reduction nonprofit.
Help support our work by providing funds for physician training, program outreach, education events, patient materials, and more.

Bring naloxone to your state.
Begin a state chapter of the Naloxone Project or join your local state chapter.

We'd love to hear from you! Get in touch with The Naloxone Project here.

THE NALOXONE PROJECT'S SIX PRINCIPLES OF CHANGE

1

Stigma is a powerful force that prevents care for patients with opioid use disorder and those at risk of overdose. Naloxone saves lives, not only through its actions to reverse an opioid overdose, but also through its effect of decreasing stigma. Naloxone is a symbol of care and sends a message that fosters further treatment and recovery.

2

Patients with opioid use disorder and those at risk for overdose matter. We must take the necessary steps to assure safety, treat overdose, and save lives through effective and sustainable naloxone distribution and overdose prevention and education.

3

Clinicians must learn to identify patients at risk for overdose and commit to placing naloxone in patients' hands prior to their departure from the hospital or emergency department.

4

Hospitals and emergency departments must commit to stocking and dispensing naloxone to at-risk patients.

5

Payers and regulators must reimburse hospitals for dispensing naloxone, covering the costs of the medication so that there is no negative financial impact for hospitals that provide this service. Regulatory barriers for dispensing naloxone from hospitals and emergency departments must also be removed so naloxone dispensing is easy and can be implemented without fear of penalty.

6

By banding together, we can build a system of care that effectively identifies patients at risk of opioid overdose and reliably dispenses naloxone to such patients. Naloxone can also serve as a bridge and incentive for patients to return for definitive treatment with medication for opioid use disorder. Together, we can save lives and build the addiction treatment system that our communities not only need, but deserve.

"It's not about the compound, it's about the connection"

Dr. Don Staden
Executive Director of
The Naloxone Project

Naloxone is the first step to preventing overdose, but it should not be the only step. As we show in this report, patients at risk for opioid overdose are regularly seen in American EDs. Each visit is an opportunity to provide education, outreach, advice, and connection that can save lives. There are many approaches that can effectively reduce opioid deaths, and each can begin in the ED.

Show that every life matters.
One anecdote from The Naloxone Project came in the form of a note from a patient saying "Thank You" to the ED staff for her naloxone kit - but more importantly expressing gratitude for showing that her life was worth saving. Whether through the connection of dispensing naloxone or through a conversation, providers have an opportunity each time they treat a patient to show that every life matters.

Reduce unnecessary opioid prescriptions.
Many opioid overdoses are the terminal event of a chain that began with an opioid prescription. EDs have a dual duty to treat pain effectively, and reduce risk of unnecessary opioid exposure. This can be accomplished through the adoption of multimodal pain pathways and clinician education. By following an "alternatives to opioids" approach EDs can adequately and safely address pain, often without using opioid.

Offer Medication of Opioid Use Disorder (MOUD) and evidence-based addiction treatment options.
EDs have a unique opportunity to begin treatment for patients with OUD. Medical providers are the only entities that can both distribute naloxone and initiate MOUD with buprenorphine, methadone, or IM naltrexone. Treatment of OUD with evidence-based medications decreases mortality by as much as 50% in patients with OUD, and is an essential service that our nation's emergency departments can and should provide. Naloxone can help establish therapeutic connection between patients with OUD and medical providers.

"Naloxone is the gateway drug to recovery."

Dr. Don Staden
Executive Director of
The Naloxone Project

METHODS

Existing analyses of at-risk visits by state have focused only on patients being treated for an active opioid overdose. But by the time a patient has overdosed, we have already missed an opportunity to increase their chances of survival by equipping them with naloxone prior to the overdose. Our innovative approach looks for patients who have a history or active documentation of opioid use, opioid dependence, opioid poisoning/overdose, long-term opioid pain management, and other clinical signs of increased risk of opioid overdose. We then add in "adjacent" codes for nonopioid drug use, abuse, or dependence that could still pose a risk of fentanyl contamination, as well as indicate a likelihood of multiple drug use.

Data Sources

This analysis leverages a number of publicly available datasets. The primary dataset is the Nationwide Emergency Department Sample (NEDS) from the Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality. This dataset represents a 20% stratified random sample from 40 US states for the years 2019 and 2020.

For states that participate, we pulled total opioid overdose deaths from the SUDORS program. For missing states, we supplemented total overdose deaths from the CDC Wonder program.

Total emergency department visits were calculated from a Kaiser Family Foundation report, which in turn used proprietary data from the American Hospital Assocation.

Analysis

Our analysis flagged at-risk visits by reviewing both the primary and all secondary diagnosis codes for the presence of any of at-risk ICD10 diagnosis codes.

All at-risk ICD10 diagnosis codes are available here. Our choice to include drug use of illicit nonopioid substances was informed by experts and advisors with lived experience. All too often, and increasingly so, nonopioid drugs are contaminated with fentanyl, so users of nonopioid drugs are still at increased risk of opioid overdose. Additionally, many patients with drug use or addiction will cross-use drugs, and this cross-use may not be always captured on medical claims. Therefore, we consider any indication of drug usage a risk factor for opioid drug use as well.

We used the NEDS data to generate counts of ED visits by at-risk patients and all patients. These estimates were transformed into regional proportions of at-risk visits, both for overall and subpopulations, per total emergency department visits in a region. As total ED visits were not available for sub-populations, these proportions were

calculated using the overall total number of ED visits. The appropriate region's proportion was then applied to the total number of ED visits per state to estimate the number of at-risk ED visits overall and per subpopulation.

2020 data were the most recent data available in NEDs but this was not a typical year for ED utilization. We thus estimated 2021 total numbers of visits by at-risk by applying the mean rate of such visits from 2019 and 2020 to the actual total number of ED visits in 2021, which saw more usual volumes.

Limitations

Claims data offer a rich and accessible way of identifying clinical patterns across large patient samples. However, claims are generated to facilitate payments rather than research, and have known limitations. Diagnosis codes may be excluded if a physician fails to provide sufficient required documentation, or if the code does not impact payment. *Racial demographic data is especially incomplete, with no consistent protocol for how a patient's race is determined or recorded. Claims must be standardized and abstracted, which can lead to errors or lost data.

We also know our data are still likely underestimating the true scope. Studies and experience show that current and historical drug use is underreported and documented. Additionally, our clinical and coding experts focused on identifying codes that would nearly always unambiguously represent an at-risk patient. This choice ensures that virtually all of the visits flagged were "true positives." However, this choice also meant that we excluded codes for conditions that often, but not always, represented increased risk for overdose, as well as conditions that would be hard to determine risk from claims alone. As such, we likely have higher "false negatives" of visits that were truly at risk but not included in our analysis. For example, many patients having hip replacements receive doses of opioids that would warrant an accompanying distribution of naloxone due to the increased risk of overdosing on the supplied medication. But because medication prescriptions are not available in the claims data, we could not confirm whether any given hip replacement met the at-risk criteria and therefore did not consider any of these visits at risk for this analysis.

Subpopulation counts are based on the regional proportions and cannot currently be adjusted for population variations within a given state, while in reality states have substantially different demographics. This means that the subpopulation numbers will not reflect local demographics, but instead regional demographics scaled for the size of each state's population.

The pandemic and associated lockdowns heavily influenced healthcare patterns, and trends have yet to return to true "normal". Drops in at-risk visits can be seen during 2020 that do not necessarily reflect a reduction in risk of overdose.

More details on the methods and limitations are available in this appendix.

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