Washington State Department of HEALTH

Caring for People Who Use Drugs

Developed and Presented by:
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DOH 530-332 October 2025

Disclaimer:

The views expressed in this training are my own, which have been developed over years of lived experience with substance use and professional experience as a first responder and overdose researcher. They do not necessarily represent the views of the organizations I am affiliated with, including Boston Medical Center and Boston University School of Public Health.

Funder Disclaimer

- *This project was funded by the Overdose Data to Action for States grant from the Centers for Disease Control and Prevention and was created in collaboration with the Washington State Department of Health. The information or content, and conclusions are those of the author.*

Disclosure

- I have no financial disclosures or relationships with any ineligible companies
- I do, however, have a vanity plate that I pay for and do not receive any compensation to have…

hpp health promotion practice

Practice Notes

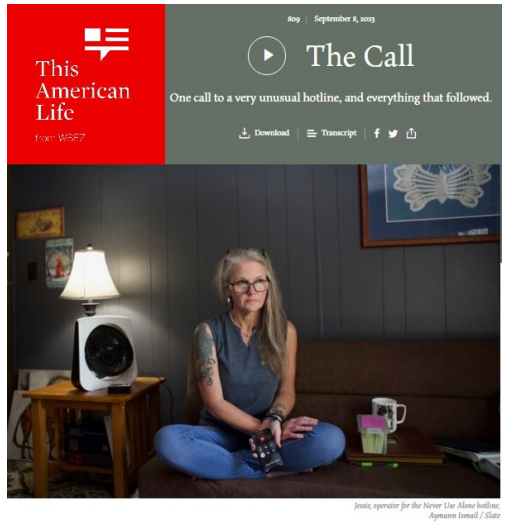
Caring for People Who Use Drugs: Best Practices for EMS Providers

Stephen Murray, MPH, NRP[1]
Alexander Y. Walley, MD, MSc
Brittni Reilly, MSW

Overdose Responder

- First responder since 2013, retired at the rank of Lieutenant and served as a paramedic in Northern Berkshire County
- American Heart Association / American Red Cross dual-certified CPR instructor
- Responded to over 100 overdoses during my EMS career, more than 30 fatal overdose field pronouncements
- Developed an evidence-based training for EMS and have trained thousands of providers across more than a dozen states

I identify as a person who uses drugs and I’m a multiple overdose survivor of both opioids and stimulants



Jessie, operator for the Never Use Alone hotline. Aymann Ismail / Slate

B2 **Metro** THE BOSTON GLOBE THURSDAY, SEPTEMBER 28, 2023

State plans to expand overdose helpline

By Travis Andersen
GLOBE STAFF

The Healey administration on Tuesday announced a partnership with Boston Medical Center and the nonprofit RIZE Massachusetts to "fund and expand" the Massachusetts Overdose Prevention Helpline.

The Department of Public Health said the state is the first in the nation to fund an overdose prevention helpline with a $350,000 investment to hire paid staff for the program, which has been a volunteer effort since it began in 2020.

The helpline uses a "spotting model" to prevent fatal overdoses, with trained operators talking on the phone with people using drugs and alerting authorities when callers become unresponsive, DPH said.

State officials said there were 2,357 overdose deaths in Massachusetts last year, a 2.5 percent increase over 2021, when 92 percent of overdose deaths occurred in private settings.

"By decreasing the frequency of unwitnessed overdoses, the Overdose Prevention Helpline reduces the number of overdose deaths," DPH said.

The funding will pay for employees that include a full-time operator, call center coordinator, part-time medical director, research director, data analyst, and program assistant, as well as efforts to raise awareness about the helpline for those who need it, according to DPH.

The prevention helpline can be reached at 1-800-972-0590. More information is available online at massoverdosehelpline.org.

So far this year, DPH said, the helpline has "has supervised 581 [drug] use events" and detected and facilitated the reversal of nine overdoses.

> 'This collaboration marks a new day in our mission to prevent fatal overdoses across Massachusetts.'
>
> STEPHEN MURRAY, *harm reduction manager of Boston Medical Center's Clinical Addiction Research and Education Unit and the director of the helpline*

The helpline is open 24 hours a day, seven days a week, and offers "compassionate, non-judgmental service," officials at Boston Medical Center said.

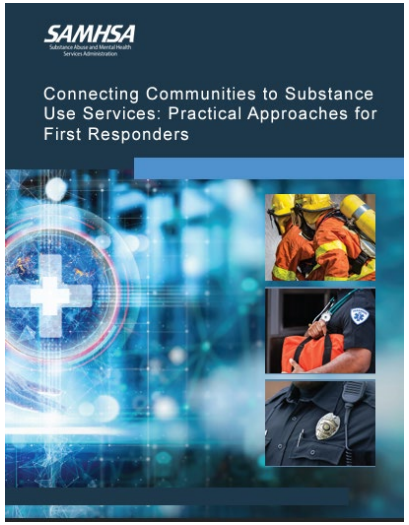
"This collaboration marks a new day in our mission to prevent fatal overdoses across Massachusetts," Stephen Murray, harm reduction manager of the hospital's Clinical Addiction Research and Education Unit and the director of the helpline, said in a statement.

"All overdoses are preventable — naloxone and rescue breathing work," Murray said. "Yet the great majority of people who die from overdose die alone without someone present and ready to rescue them. This overdose prevention line makes sure that people using alone get help in time."

Governor Maura Healey said the overdose crisis takes a toll on families.

"I've met too many grieving families whose lives have been torn apart by overdose deaths," Healey said in a statement. "This trauma and heartbreak are preventable. By providing people with an alternative to using alone, the Overdose Prevention Helpline saves lives."

Travis Andersen can be reached at travis.andersen@globe.com.



Federal Policymakers Should Urgently and Greatly Expand Naloxone Access

Raagini Jawa, MD, MPH, Stephen Murray, BBA, Marco Tori, MD, MSc, Jeffrey Bratberg, PharmD, and Alexander Walley, MD, MSc

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Raagini Jawa is with the Grayken Center for Addiction and Clinical Addiction Research and Education Unit, Section of General Internal Medicine and the Section of Infectious Disease, Department of Medicine, Boston University School of Medicine, Boston, MA. Stephen Murray is with the Clinical Addiction Research and Education Unit, Section of General Internal Medicine, Department of Medicine, Boston University School of Medicine and a trainee at Boston University School of Public Health. Marco Tori is with the Division of General Internal Medicine, Boston University School of Medicine. Jeffrey Bratberg is with the College of Pharmacy, University of Rhode Island, Kingston. Alexander Walley is with the Grayken Center for Addiction and with Clinical Addiction Research and Education Unit, Boston University School of Medicine.

programs focusing on harm reduction, (3) permanently eliminating insurance copayments and prior-authorization requirements, and (4) mandating coprescribed and codispensed naloxone with all higher-risk opioid prescriptions and medications for opioid use disorder.

OVER-THE-COUNTER NALOXONE

First, we call for an intranasal naloxone formulation to be switched to an OTC status and for mandates for insurers to cover OTC cost.[6] Traditional naloxone access points, such as local pharmacies, health care facilities, and syringe service programs, are not universally available in all communities and often lack round-the-clock availability. We

Learning Objectives

After completing this training, the EMS provider will:

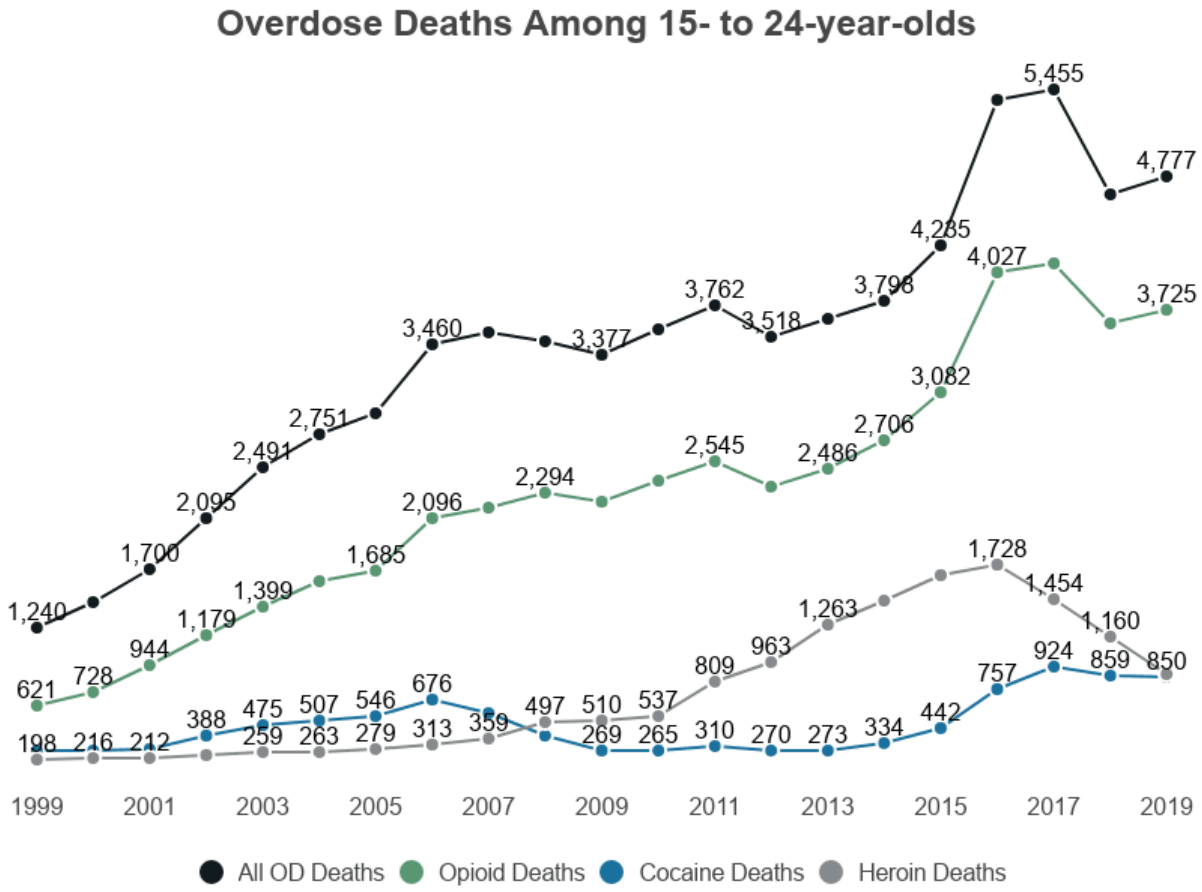
1. **Identify current drug supply issues and state the role of harm reduction plays in the health of people who use drugs**
2. **Identify ways in which EMS providers can improve treatment outcomes for people who use drugs**
3. **Explain the role of language, hand-off reports, and documentation in treatment efficacy**
4. **Explain the role of EMS in community programs, public health and combating fentanyl myths**

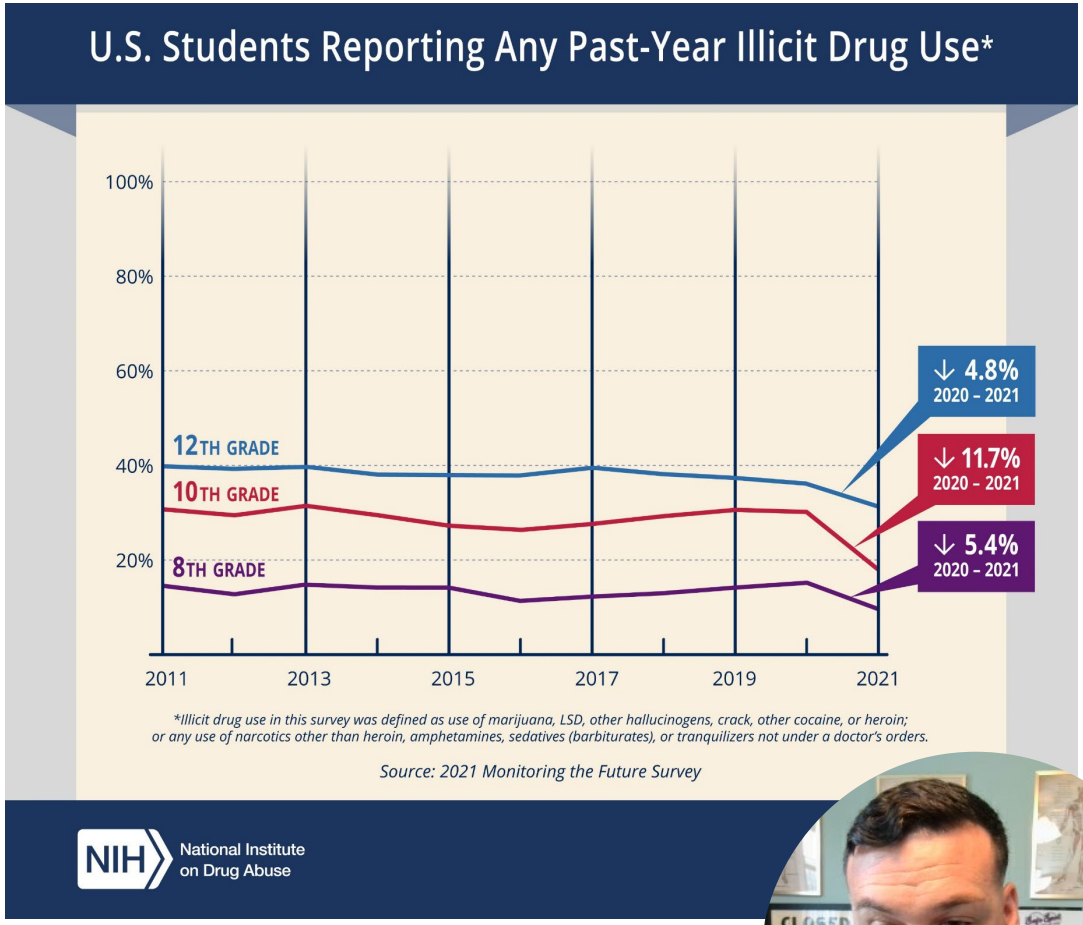

CLOSED

MYTH: “WE ARE IN AN ADDICTION CRISIS”

- Drug use ≠ addiction
- Drug use is not inherently dangerous—criminalization makes it dangerous
- Overdose does not only happen to people with addiction
- The risk pool is all people who use drugs

We are not in a substance use disorder or addiction crisis





What are some reasons having a substance use disorder might protect you from overdose?

Here is my list -

- Tolerance
- Medications for opioid use disorder
- Drug knowledge
- Established routines and safety techniques
- More stable supply sourcing (better communication with supplier about potency)
- Harm reduction access
- Knowledge of safer use practices
- Using with experienced friends (spotting)
- Naloxone distribution

Drug use is not a moral failure

People experiencing homelessness may use stimulants at night to stay awake for **safety**, in fear they might be assaulted or robbed if they fall asleep

People use drugs to **self-medicate** their untreated chronic physical pain

People use drugs to **cope** with emotional and physical trauma

People use drugs **socially** for the same reasons you may drink alcohol

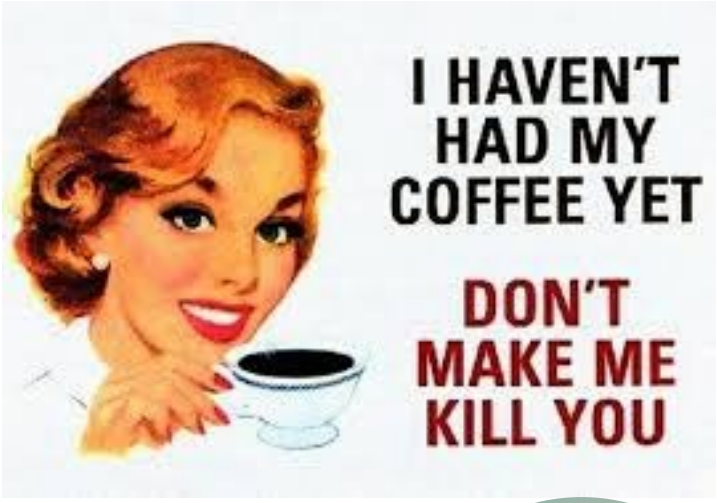
People use drugs to increase their **productivity** or enhance studying

People use drugs for **pleasure** and to **rest**


No
COFFEE
NO
Workee
Life begins
after
coffee

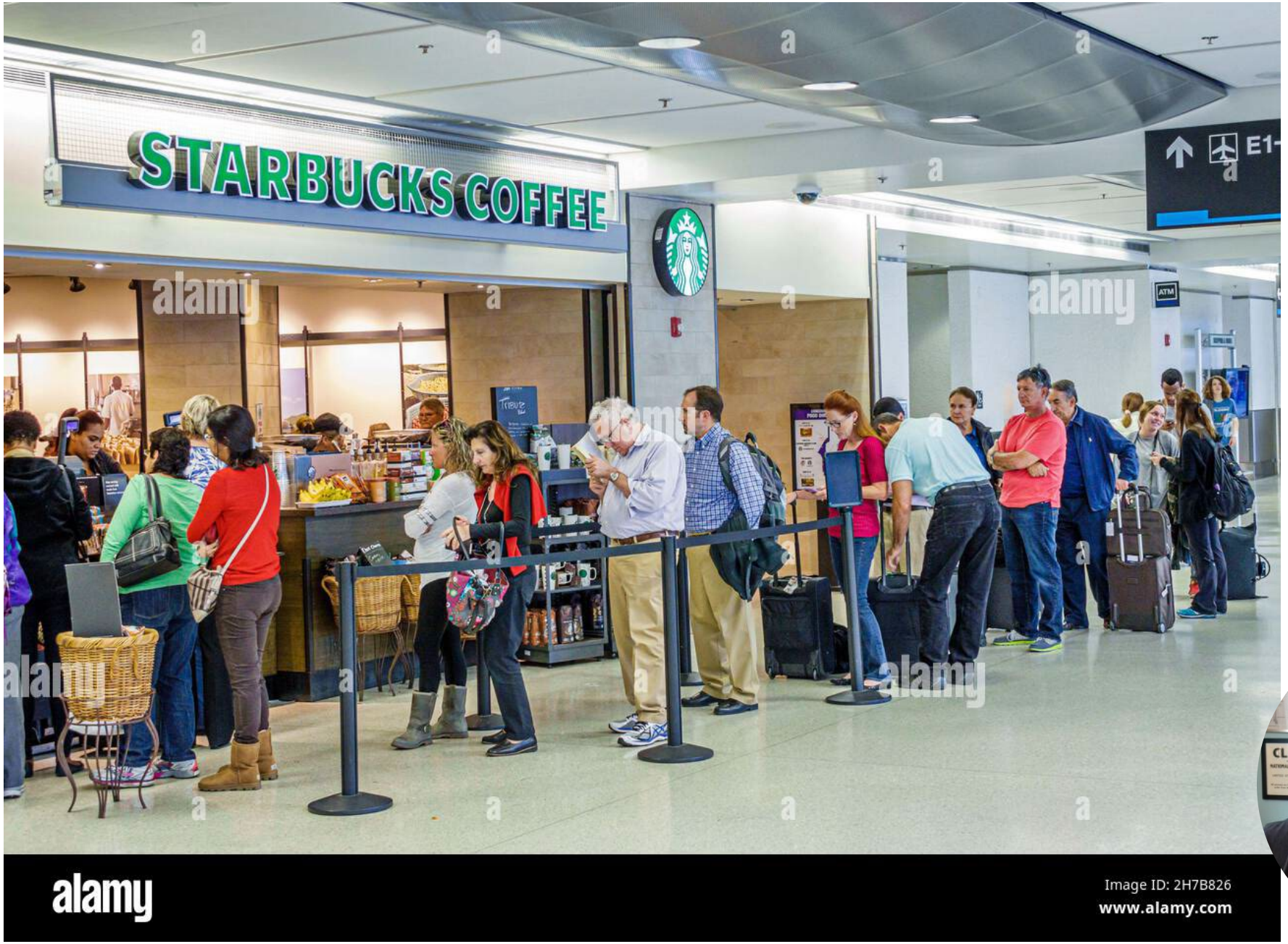

I TRIED STARTING
A DAY WITHOUT
COFFEE ONCE.....
MY COURT DATE
IS PENDING.


Coffee,
I can't start
without You
MONDAY


I HAVEN'T
HAD MY
COFFEE YET
DON'T
MAKE ME
KILL YOU


Why, yes, I
could start my
day without
coffee. But I
like being able
to remember
things like
how to say
words and put
on pants.
Nanea Hoffman


A DAY WITHOUT
Coffee
IS LIKE
JUST KIDDING
I HAVE NO IDEA


STARBUCKS COFFEE
ATM
alamy
Image ID: 2H7B826
www.alamy.com

Even caffeine can be lethal if not safely sourced

Man dies from caffeine overdose after drinking equivalent of 200 cups of coffee

By Rachael Rettner published 2 days ago

The man made an error when measuring caffeine powder that resulted in him consuming a fatal dose of caffeine.

- Personal trainer Tom Mansfield died in January 2021 after taking caffeine powder in Wales
- Dad-of-two Mr. Mansfield tried to weigh a dose of the powder within a range of 60 milligrams to 300 milligrams using a scale that had a weighing range of 2g-5,000g, meaning he ended up consuming several grams
- A coroner report found Mansfield had caffeine levels of 392 milligrams per liter of blood in his system - one cup of coffee generates an average of 2 to 4 milligrams of caffeine per liter of blood.

Source: https://www.livescience.com/caffeine-overdose-200-cups-of-coffee

The Philadelphia Inquirer

Panera will discontinue its Charged Lemonade drinks blamed for deaths, including a Philly college student

The family of Sarah Katz, a 21-year-old University of Pennsylvania student, filed a lawsuit against Panera in October, claiming the beverage contributed to her death.

A customer carries a Charged Lemonade from Panera Bread Co. at the Rego Center shopping mall in the Queens borough of New York in December.

Bing Guan / Bloomberg

by Nick Vadala

Updated May 8, 2024, 12:30 p.m. ET | Published May 8, 2024, 12:25 p.m. ET

We are all drug users – some of us just have the privilege of safety with the drugs we are using


CLOSED

People who use drugs are denied basic consumer protections – health vs safety


PEANUTS
PEANUTS

There are no bad drugs or good drugs

- The "good drug" vs. "bad drug" binary is harmful. It fuels stigma, moralization, and ineffective policies.
- Many risks come from prohibition, not the substances themselves. A safer supply and regulation reduce harm more effectively than criminalization.
- All substances have benefits and risks. The effects depend on context, dosage, and individual use.

So what's with fentanyl?

- Heroin has a duration of action that is approximately 3-4 hours, which would require **injecting 4-8 times per day**
- Fentanyl has a shorter duration of action of roughly 30-60 minutes. PWUD **inject up to 10-18 times/day**
- **Fentanyl is no longer an <u>adulterant</u> to the drug supplies of most states – it is the <u>dominant</u> and <u>primary</u> opioid available**
- Dealers at all levels of the chain **do not have choice when it comes to which opioid they will sell** – this is an international/national supply issue
- Fentanyl's potency makes it difficult to accurately measure and easy to cause cross-contamination with other drugs

This image is frequently used by media outlets – it is really not accurate, as lethal doses vary greatly by opioid tolerance, and drugs are not sold in a pure form and therefore are impossible to measure by a visual interpretation

Fentanyl is found in cocaine, crack, and counterfeit pills

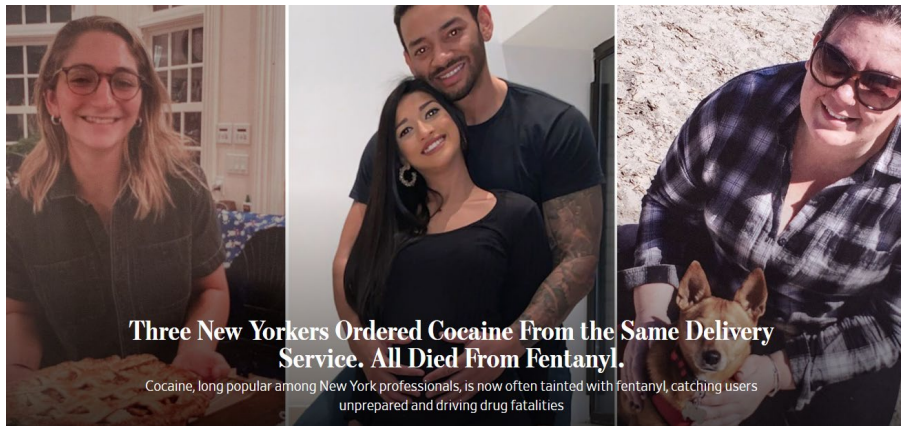
Boston warns of surge in overdoses linked to cocaine laced with fentanyl

February 24, 2023 | By Martha Bebinger

Schenectady officials tie 8 Wednesday overdoses to 'adulterated cocaine'

by: Giuliana Bruno

Posted: Jan 28, 2021 / 11:56 AM EST / Updated: Jan 28, 2021 / 03:11 PM EST

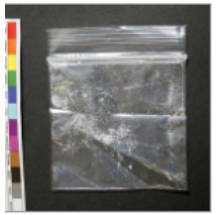


Tainted cocaine in Argentina leaves 17 dead

Story by Reuters

Updated 6:23 AM ET, Thu February 3, 2022

Cocaine | **Sold as: Coke** | **ID: 14636**



ID:	14636
Name:	Cocaine
Other Names:	
UniqueCode:	AC2022B0587
Marquis:	Unknown
Liebermann	Unknown
Froehde	Unknown
Fentanyl Test Strip (FTS):	Positive
GC/MS:	

- Cocaine : 1900
- Tetramisole / Levamisole : 200
- Methylecgonidine : 100
- Fentanyl : 20
- Tropacocaine : 20
- 4-ANPP : 1

Test Date:	Nov 01, 2022
Pub. Date:	Nov 02, 2022
Src Location:	Lynn, MA
Submitter Loc:	Lynn, MA United States
Color:	White
Size:	5 mg
Data Source:	DrugsData
Tested by:	DDL
Lab's ID:	22100131

Sold as: Coke
Expected to be: Coke
Has Been Tried: Yes

Description
White powder ("white rock") in baggie.

MYTH: “FENTANYL IS PURPOSELY ADDED TO COCAINE TO GET PEOPLE ADDICTED

- Fentanyl is being found hyper locally in the cocaine, crack and meth supply
- This means that it is most likely happening towards the end of the dealing chain by accidental contamination
- We have no evidence that it is being maliciously added to get people “more addicted”

wbur LOCAL COVERAGE

Boston warns of surge in overdoses linked to cocaine laced with fentanyl

February 24, 2023 | By Martha Bebinger

Xylazine has emerged as another adulterant

- Xylazine is a **tranquilizer used in veterinary medicine**
- It is an alpha-2 adrenergic agonist – similar in structure to clonidine
- Is not new – has been used in Puerto Rico (early 2000s) and Philadelphia (2010s)
- It is being cut into fentanyl to prolong the high
- On the street it is referred to as **tranq** or sueño
- It can cause **extreme sedation**

Notable effects of xylazine

ACUTE EFFECTS:

- Profound sedation
- Blurred vision
- Super dry mouth
- Low blood pressure
- Bradycardia
- Weak reflexes
- Respiratory depression
- Disorientation
- Drowsiness
- Slurred speech
- Overdose

CHRONIC EFFECTS

- Severe skin wounds
- Incontinence
- Dysglycemia (high/low blood sugar)
- Anemia

Jawa R., Murray S.P. (2023, April). Zeroing in on Xylazine. Grayken Center for Training and Technical Assistance

Sedation Implications

- Complications from sedation can be broken into three categories – medical, overdose and environmental
  - Medical
    - Prolonged immobility increases risk for blood clots, rhabdomyolysis (which can cause acute kidney injury), muscle/nerve damage
  - Overdose
    - Sedation impacts ability to regulate breathing and muscle relaxant properties of xylazine may also cause restricted breathing
  - Environmental
    - Increased risk of theft, assault
    - Cold weather: hypothermia, frostbite
    - Hot weather: heat stroke, sunburn, dehydration

Xylazine skin wounds

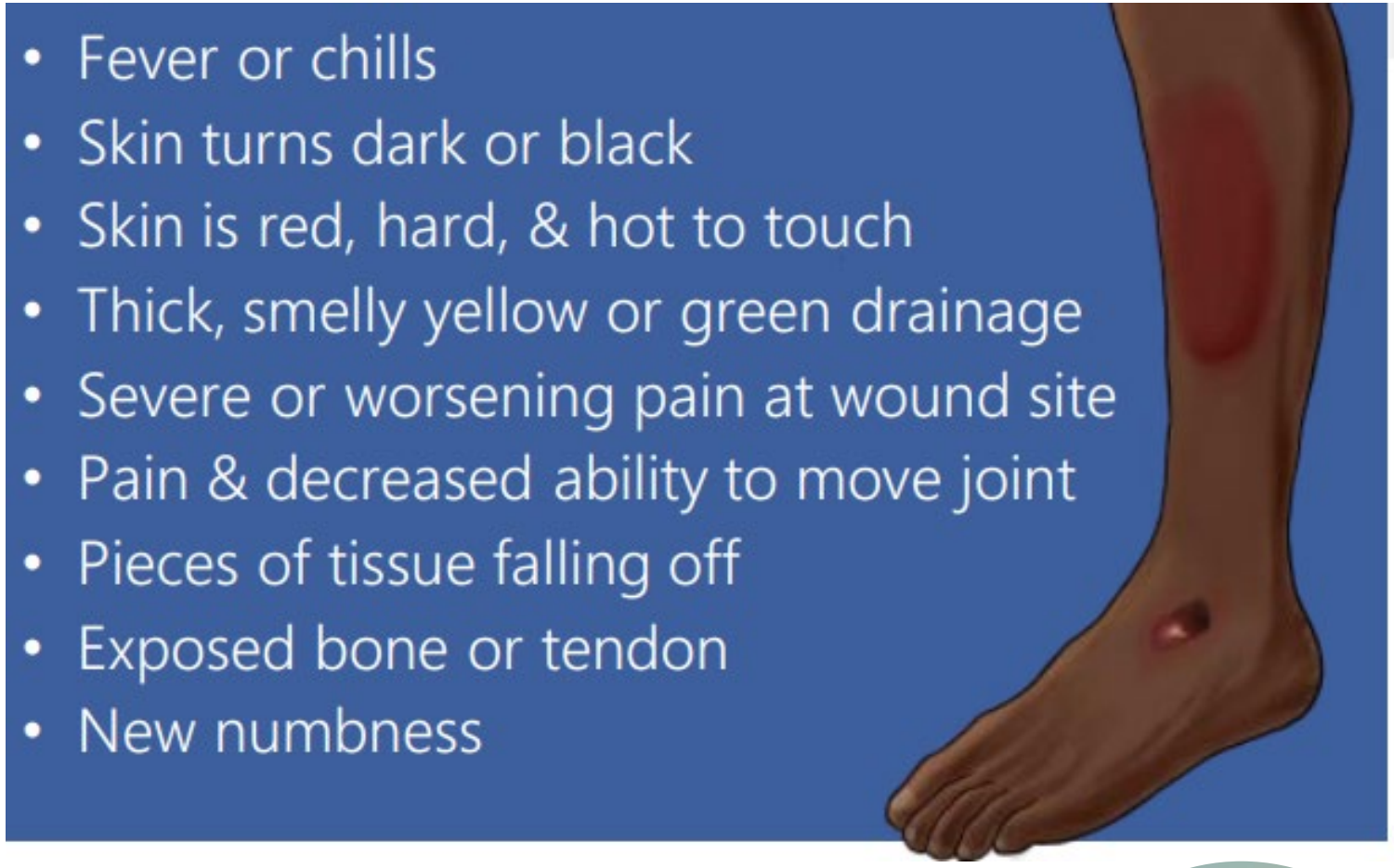
Ehrman-Dupre, R. et al. JAM. 2021

- Can start as purple/red blisters → may progress to areas of necrosis with thick eschar
- May be at injection site, missed injection site and non-injection (such as prior areas with scratches)
- **<u>Risk seems to be irrespective of route of administration</u>**
- Can appear as local vasculitis and range from small open sores to large ulcers, chronic osteomyelitis, gangrene resulting in limb loss

Jawa R., Murray S.P. (2023, April). Zeroing in on Xylazine. Grayken Center for Training and Technical Assistance

Red flag symptoms

- Fever or chills
- Skin turns dark or black
- Skin is red, hard, & hot to touch
- Thick, smelly yellow or green drainage
- Severe or worsening pain at wound site
- Pain & decreased ability to move joint
- Pieces of tissue falling off
- Exposed bone or tendon
- New numbness



Other adulterants on the radar

- Tinuvin (BTMPS)
  - Chemical additive used to protect plastics in medical and food industries
  - Calcium channel blocker which relaxes the heart and blood vessels, resulting in lower blood pressure
  - Users report a fishy or "shrimp ramen" smell, drugs feeling weak, drugs feeling weird or notably off, burning while injecting, a chemical smell when smoked, and nausea and vomiting
- Nitazenes
  - A family of synthetic opioids that vary in potency from less strong than fentanyl to more
  - No such drug called “nitazene”
  - Naloxone works on all of the derivatives
- Bromazolam
  - Benzo that is being increasingly found in the drug supply
  - Not new – developed in 1976 but not approved to be used in humans
  - All benzos increase fatal overdose risk when added to opioids
- Medetomidine is also an alpha-2 adrenergic agonist like xylazine
  - Approved for use in dogs in the United States
  - Reports of profound bradycardia
  - Management similar to xylazine – supportive care, consider medication for symptomatic bradycardia

Dope Code: AC2024B4284 Sold as: Dope	• Fentanyl • Metonitazene • Xylazine • 4-ANPP • Caffeine • Cocaine • Isotonitazene	• 30 • 20 • 20 • 10 • 10 • 1 • 1
Blue Powder Code: AC2024B4178 Sold as: M30 Percocet	• Fentanyl • Xylazine • Bromazolam • N-Pyrrolidino Protonitazene	• 70 • 30 • 10 • 1
Dope Code: AC2024B4381 Sold as: Dope	• Xylazine • Fentanyl • Metodesnitazene • 4-ANPP • Caffeine • Protonitazene	• 23 • 17 • 10 • 3 • 2 • 1

NEWS

Health Officials Warn about Sedative Medetomidine in Drugs; Local Authorities React

Thursday, May 30th 2024, 6:48 PM EDT

By **Caleb Yauger**

HARM REDUCTION IS ALL AROUND YOU!

HARM REDUCTION IS A SET OF PRACTICAL STRATEGIES AND IDEAS AIMED AT REDUCING NEGATIVE CONSEQUENCES ASSOCIATED WITH RISKY BEHAVIORS

PARACHUTES

BULLET PROOF VESTS

PERSONAL PROTECTIVE EQUIPMENT

NALOXONE (NARCAN)

SUNSCREEN

CONDOMS

HELMETS

SYRINGE ACCESS AND DISPOSAL

DESIGNATED DRIVERS

SEATBELTS

AIRBAGS

NICOTINE REPLACEMENT GUM OR PATCHES

LIFE JACKETS

NVHRC
NORTHERN VALLEY HARM REDUCTION COALITION

Syringe Service Programs hand out safer-use supplies to address specific harms of drug use

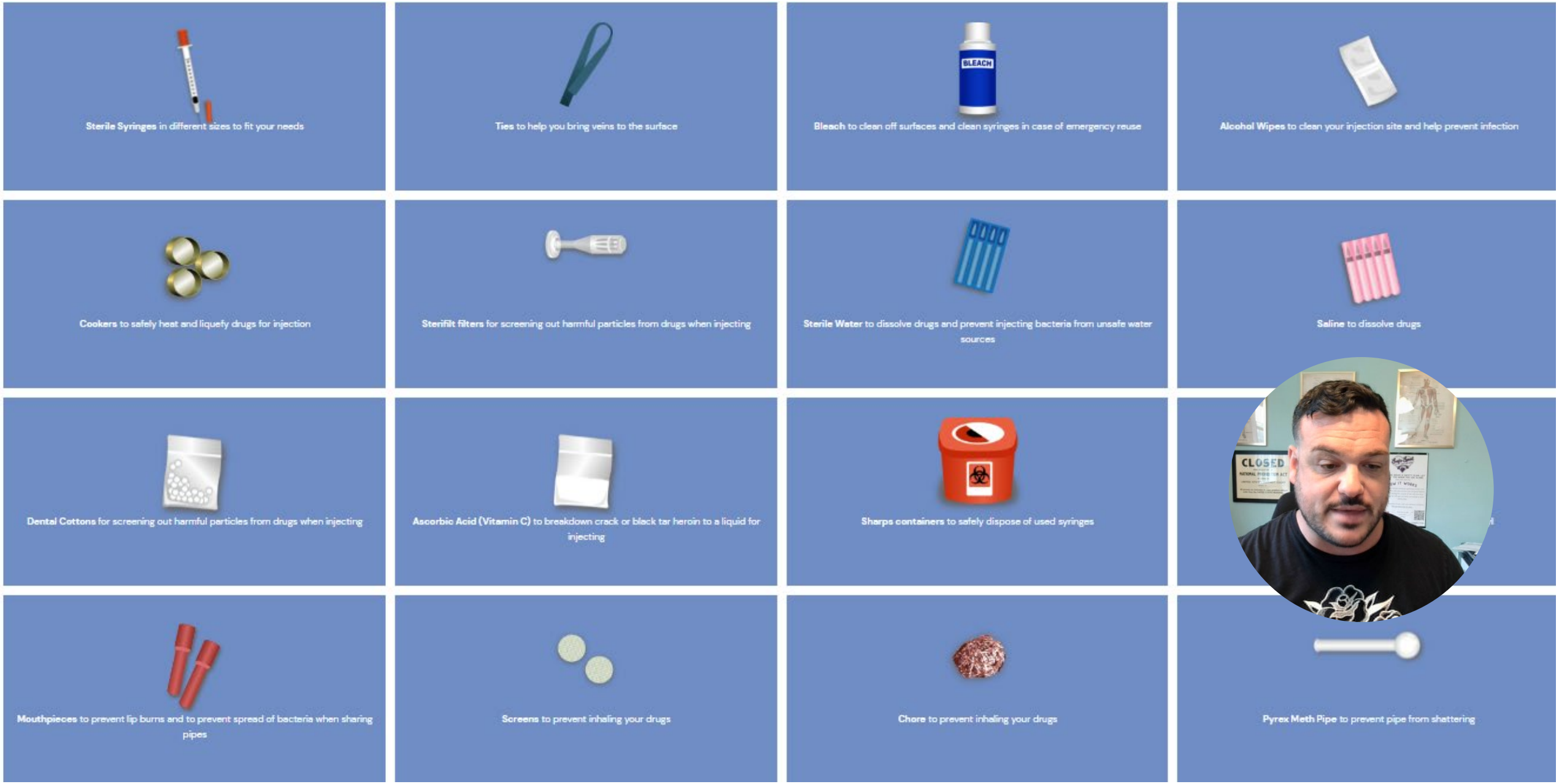


Image Source: Prevention Point Pittsburgh (PA) https://www.pppgh.org/

Why pipes?

There is a significant cost-saving benefit from preventative drug user health programs

- The lifetime treatment cost for one person with HIV is **$379,668**.
- This is equivalent to more than **5.4 million syringes** – enough for more than 1,500 people for a year.
- Preventative medicine is cheaper than emergency medicine or treating chronic illness and **we have a role to play** in spreading that message

	Estimated Impact in 2017
The Economy	
Lost Productivity from People Unable to Work	$5.9 Billion
Foregone Incomes due to Fatalities	$1.1 Billion
Businesses	
Lost Business Productivity due to Absenteeism	$1.9 Billion
Lost Business Productivity due to Presenteeism	$775 Million
Additional Health Care Costs	$2.1 Billion
Health Care Providers	
ED Visits	$122 Million
Inpatient Stays	$538 Million
ICU Stays	$271 Million
Neonatal Abstinence Syndrome	$48 Million
Early Intervention and Support for Families Affected by OUD	?
Medical Complications from OUD*	?
State Budget	
MassHealth	$860 Million
Dept. of Public Health	$136 Million
Dept. of Mental Health	$17 Million
Dept. of Children and Families	$370 Million
Criminal Justice System	$500 Million
Communities	
First Responders	$43 Million
Opioid-Related Police Costs	$510 Million

Source: Massachusetts Taxpayer Foundation / RIZE

The overdose timeline has altered significantly

Respiratory Depression → Respiratory Arrest → Cardiac Arrest

Respiratory Arrest → Cardiac Arrest

This begins a countdown timer which is highly variable…

- Age
- Overall state of health
- Acute illness (flu/pneumonia/COVID)
- Chronic health (COPD)
- Recent infection with endocarditis/myocarditis

Reduce the total amount of naloxone given by slowly titrating it for ventilatory status

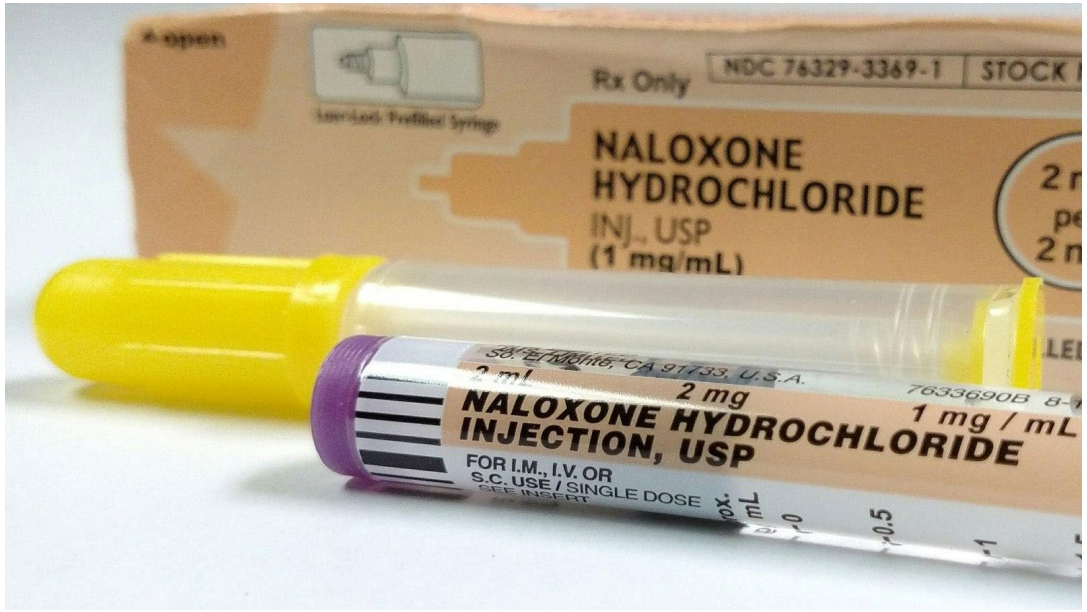
- **Assess the level of respiratory depression and hypoxia** – not all overdoses should be managed identically
- Naloxone should be **titrated for patient's breathing**, not their level of responsiveness
- 0.5mg IM has always been my go-to first dose
- If the patient is breathing spontaneously, assist ventilations using a bag valve mask (BVM) and **assess oxygenation before giving naloxone**

Consider using an airway adjunct

- When taking a ventilation-focused approach to overdose, use an airway adjunct to increase efficacy
- This will reduce the amount of air pushed into the stomach that can cause nausea/vomiting when patient becomes responsive
- OPAs seem to be the go-to, but can cause trauma in the mouth if used incorrectly and may increase likelihood of vomiting when the person becomes responsive (gag reflex)
- NPAs work great for short-term ventilating and are less uncomfortable when the patient regains consciousness (please use lube)

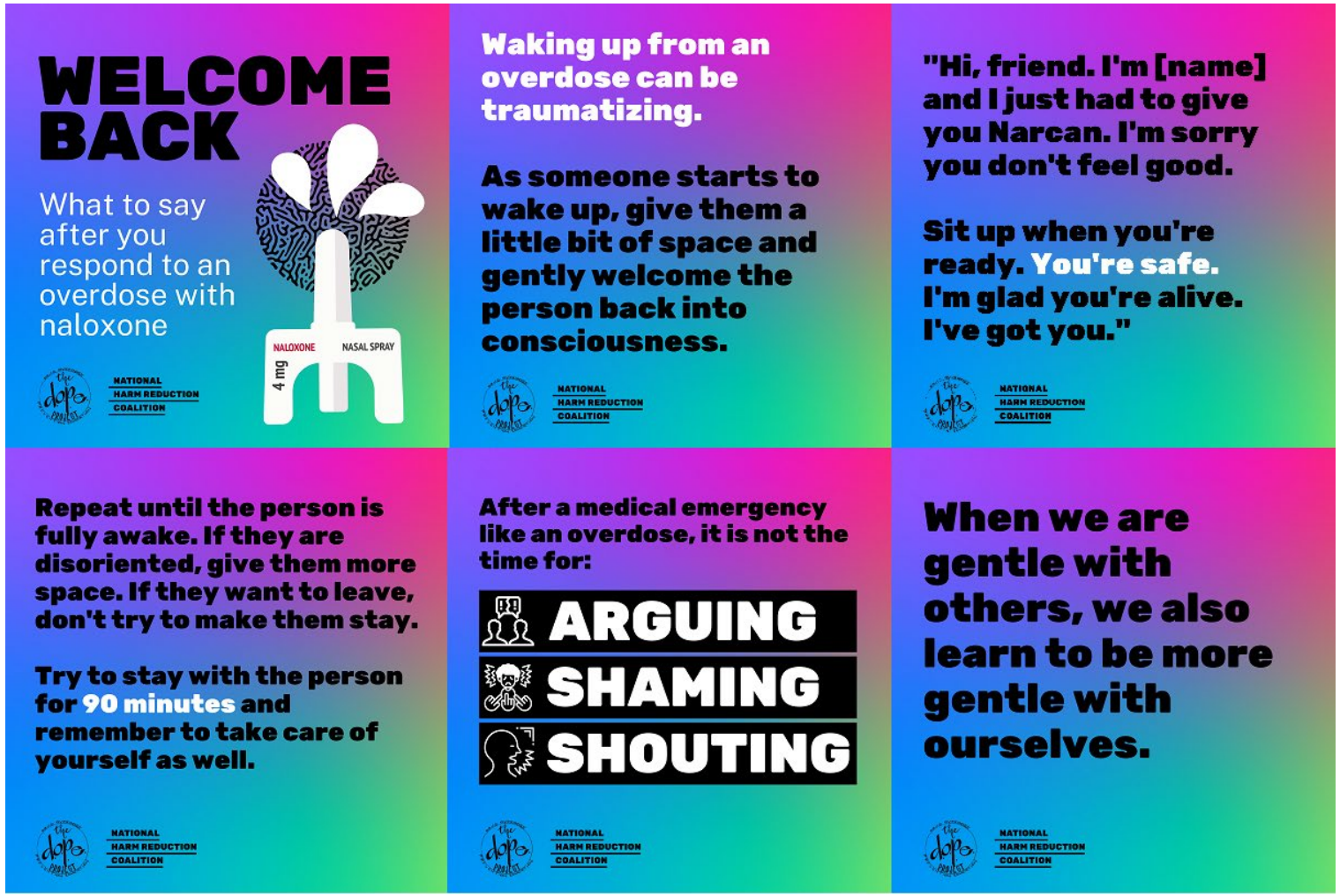
Focus on fixing hypoxia and restoring respiratory drive during an overdose

- Be mindful of the time in between naloxone doses – **intranasal or intramuscular routes will need more time to work**; support with BVM while waiting
- **Naloxone will not fix acute hypoxia**, and BVM support must be priority treatment
- Fixing hypoxia will **lessen chances of confusion or agitation** when the patient regains consciousness



LO-2

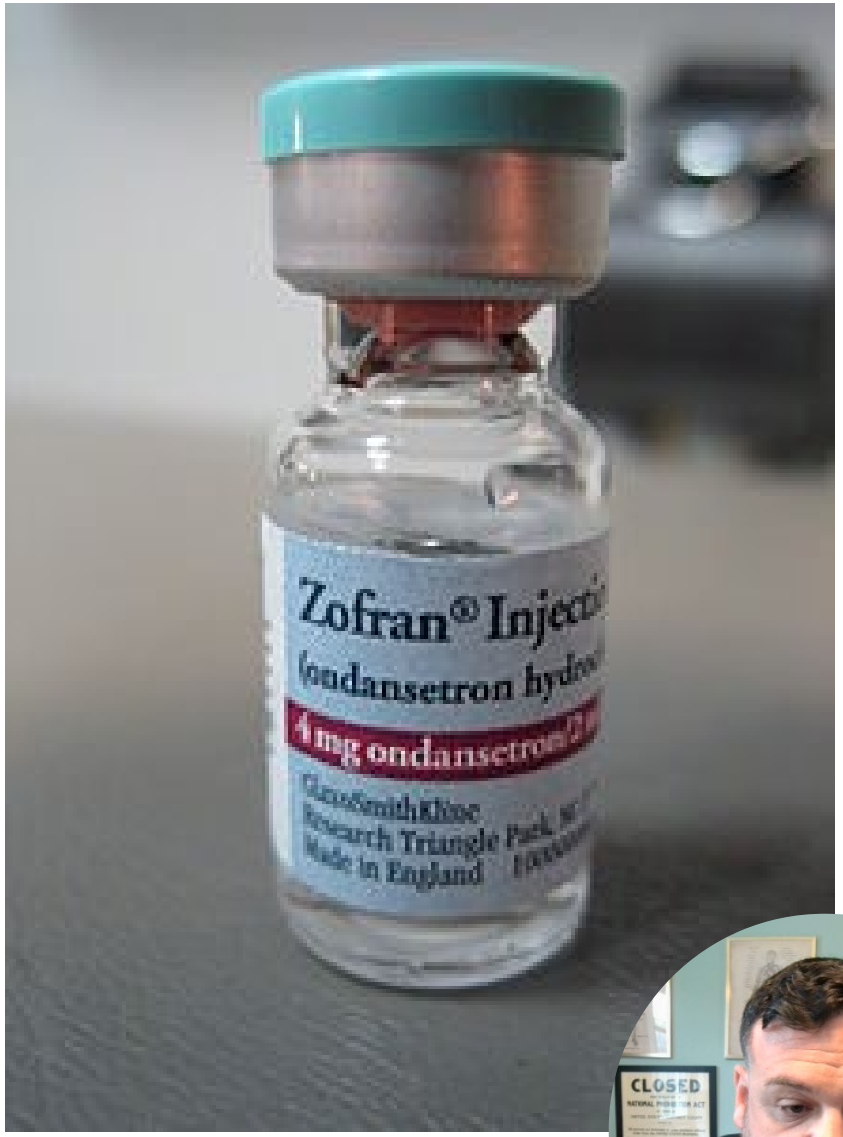
How we speak to patients after they wake up from an overdose matters



Source: National Harm Reduction Coalition and The Dope Project

Managing acute withdrawal symptoms after an overdose

- When naloxone is given to a patient, it sends them into opioid withdrawal
- Symptoms of withdrawal are very painful and can be severe – **vomiting, diarrhea, sweating, restlessness, tachycardia**
- Treat acute nausea/vomiting:
  - Ondansetron 4 mg IV/IM/,
  - **If an IV is unable to be established, administer it via IM injection**



Opioid withdrawal is incredibly painful

"You want to know what hell is? I think dope sick is that. That's hell. Hell on earth. **I would rather have somebody saw my leg off at the knee** than go through that."

Source: Understanding why patients with substance use disorders leave the hospital against medical advice: A qualitative study (Rachel Simon, Rachel Snow & Sarah Wakeman, 2019)

Why EMS bupe?

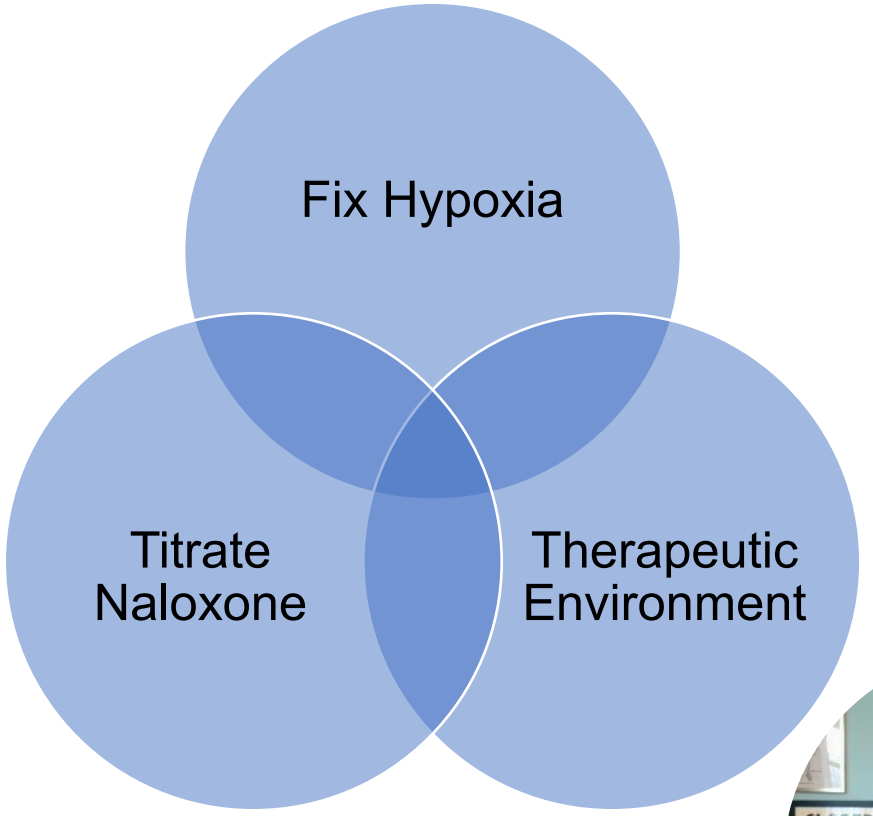
- EMS agencies around the country are starting bupe programs
- It is very challenging for us to get people transitioned to bupe in the fentanyl era
- The best time to do so is directly after receiving naloxone – a unique opportunity for EMS to make a difference

Buprenorphine Initiation Methods

	Microdose	Low Dose	High Dose	QuickStart
Time since last use	None	1-2 days	12 hours	None
Initiation period	One week +	2 days +	2-3 hours	30 minutes
Is tapering required?	Yes	No	No	No
Expected withdrawal	None, but withdrawal can still occur	Must be in moderately severe withdrawal to start	Must be in moderate withdrawal to start	Short, but moderately severe once the process has begun (<30min)
Total transition time	On average, 8–14 days	2 days +	~15 hours	1 hour

A NOTE ON AGITATION AFTER OVERDOSE

- Pervasive myth that is perpetuated by improper care
- 3 major things to reduce the likelihood of an agitated patient:
  - **Fix hypoxia** first through rescue breathing before the person wakes up
  - **Reduce** the total amount of **naloxone** you give
  - **Reduce** the number of **people** in the room when they wake up, especially those in uniform



Thoughts on high-dose naloxone and nalmefene

- There has been persistent misinformation about the need for higher-dose naloxone products in the face of fentanyl
- Naloxone is a highly competitive opioid antagonist and there are a finite number of receptors
- Narcan 4mg is already a very high dose (compared t 0.4mg) – **8 mg is way too high**
- Nalmefene has a very long duration of action and worsens the impact of withdrawal

MYTH: “YOU WILL RE-OVERDOSE WHEN NARCAN WEARS OFF”

- The literature is unclear when it comes to the likelihood of re-overdosing after naloxone administration
- Fentanyl has a relatively short duration of action (15-30 minutes) and naloxone has a duration of action of 1-2 hours
- In the era of long-acting pharmaceutical opioids like morphine and dilaudid, there was a more plausible mismatch in duration of action
- One possible explanation with fentanyl is that naloxone causes withdrawal which will increase the likelihood that the overdose survivor will need to re-dose their opioid to get out of withdrawal
- This could be misinterpreted as the survivor re-overdosing from the initial dose because the naloxone had “worn off”

What if that person is going to use again?

- Ask the cops not to take their stuff – we already know how potent it is!
- Offer to stay with them through their next use event if they are alone
- Put them on the phone with SafeSpot and we will hang out with them!
- If they have a friend, make sure they have naloxone leave behind kit
- Make clear that the risk of overdose is high

MYTH: “OVERDOSE IS OVERWHELMING EMS SYSTEMS MORE THAN ANYTHING ELSE”

Fatal overdoses occur in a private residence over 85% of the time in Rhode Island, 75% in New Jersey, 63% in Connecticut and 60% in Massachusetts

Virtual Spotting via Hotline as a tool

How to Use Safe Spot 1-800-912-0590 ?

WHEN USING ALONE, CALL 1-800-972-0590. (TOLL FREE)

Connect with a trained peer operator.

Make a safety plan.

99%

1%

If caller stops responding, operator calls for help.

If caller remains responsive during safety window, they disconnect. Call back next time!

The safety plan designates a local responder, such as a friend, family member, or EMS to respond and help.

https://safe-spot.me

SafeSpot is available in all 50 states

Our hold time last month was 13 seconds

<u>Naloxone is only effective if someone is there to push the plunger; we are there when no one else can be</u>

Washington callers accounted for 21.1% of total call volume from 2023-2025

Substandard prehospital care impacts patient outcomes

- Hand-off: “This is a 35 y/o female heroin addict who is here because of how she injects. Her arms are pretty beat up. I told her she should stop using so this doesn’t happen. There wasn’t anything for me to do on the way so I turfed it to my BLS partner”

<u>Treatment en route:</u>

-None

<u>Room assignment / Outcome</u>:

-Waiting room

-Patient feels neglected and leaves before being seen

-*OR*-

-Express room

-Significant delay of sepsis diagnosis/treatment

LO-2

Assessment and Treatment Plan

- "The patient is a 35 y/o **woman with a history of injection drug use**. She recently had her car stolen and has not been able to get to the syringe program and **has been reusing the few syringes she had left**. This has caused **significant wounds** to her forearms, and **I bandaged them up** for the ride. I also noted in my assessment that **she has a fever**, so I did a full work-up and **she meets sepsis criteria**. One of her arms is bright red and she rates **her pain as 10/10**. I gave her **0.5 mg/kg Ketamine IM** which has made her much more comfortable. I also **started an IV and I'm giving her some fluids** because she hasn't had anything to drink today."

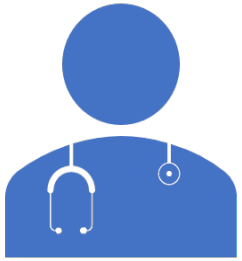
Treatment en route:
-Bandage open wounds
-0.5 mg/kg IM Ketamine for 10/10 pain
-Full Vitals, including EKG & capnography
- **Infection Source: Wounds on arm**
- **Temperature (101.5 °F)**
- **Heart Rate: 130bpm, Sinus Tach**
- **RR: 28**
- **ETCO2: 18 mmHG**
- **BP: 92/60**

-IV access obtained, normal saline initiated
-Sepsis Alert

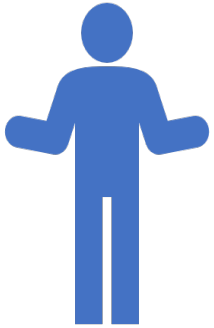
Room assignment / Outcome:
-Main pod
-Instant physician care for Sepsis Alert
-Rapid IV antibiotics administered
-Continued Pain Management (you set the tone)
-Admission to ICU
-Initiation on Suboxone or Methadone
-Discharge to Continued Care for OUD

LO-3

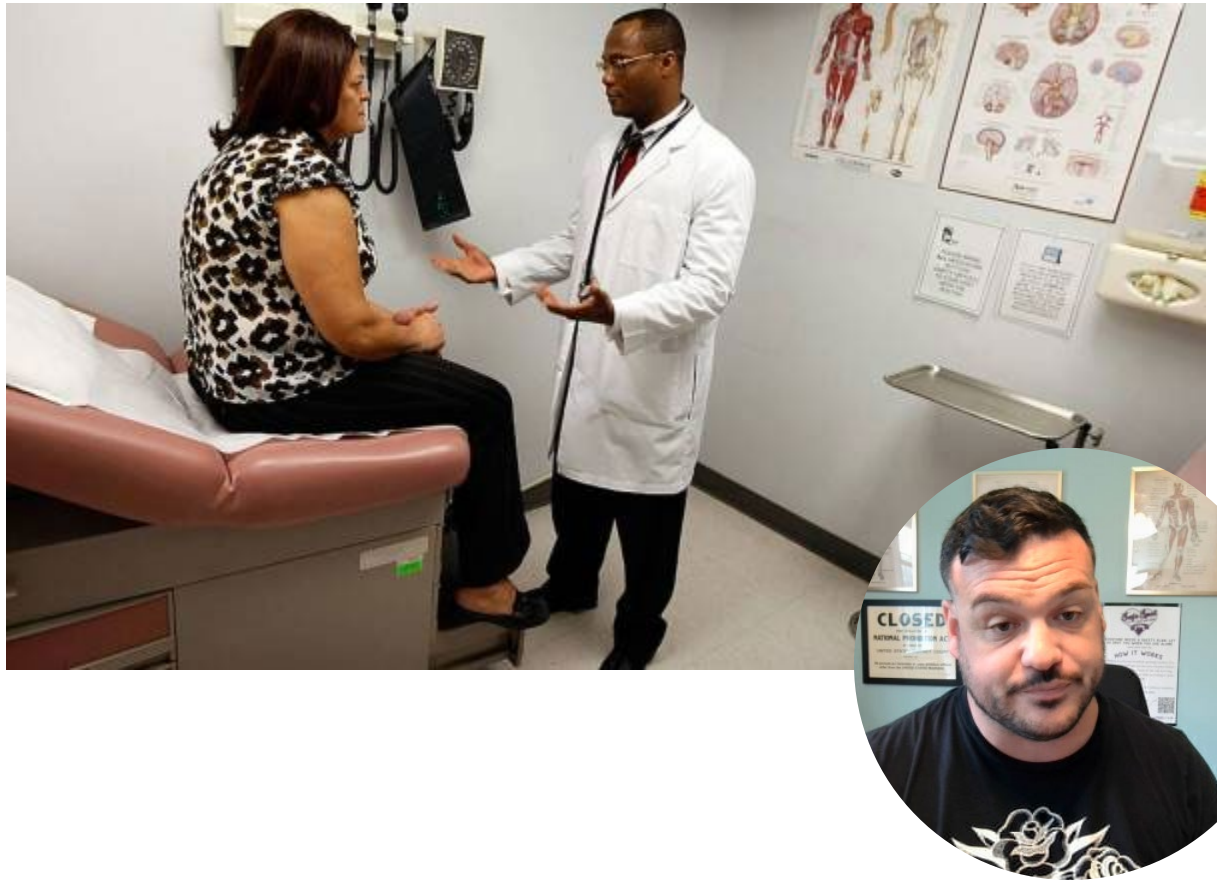
Using stigmatizing language has a direct correlation to patient outcomes



In a 2018 study, physicians were given the same patient twice: described once using stigmatizing and then using neutral language



Researchers found that the patient with stigmatizing language was associated with more negative attitudes and given less aggressive management of pain.

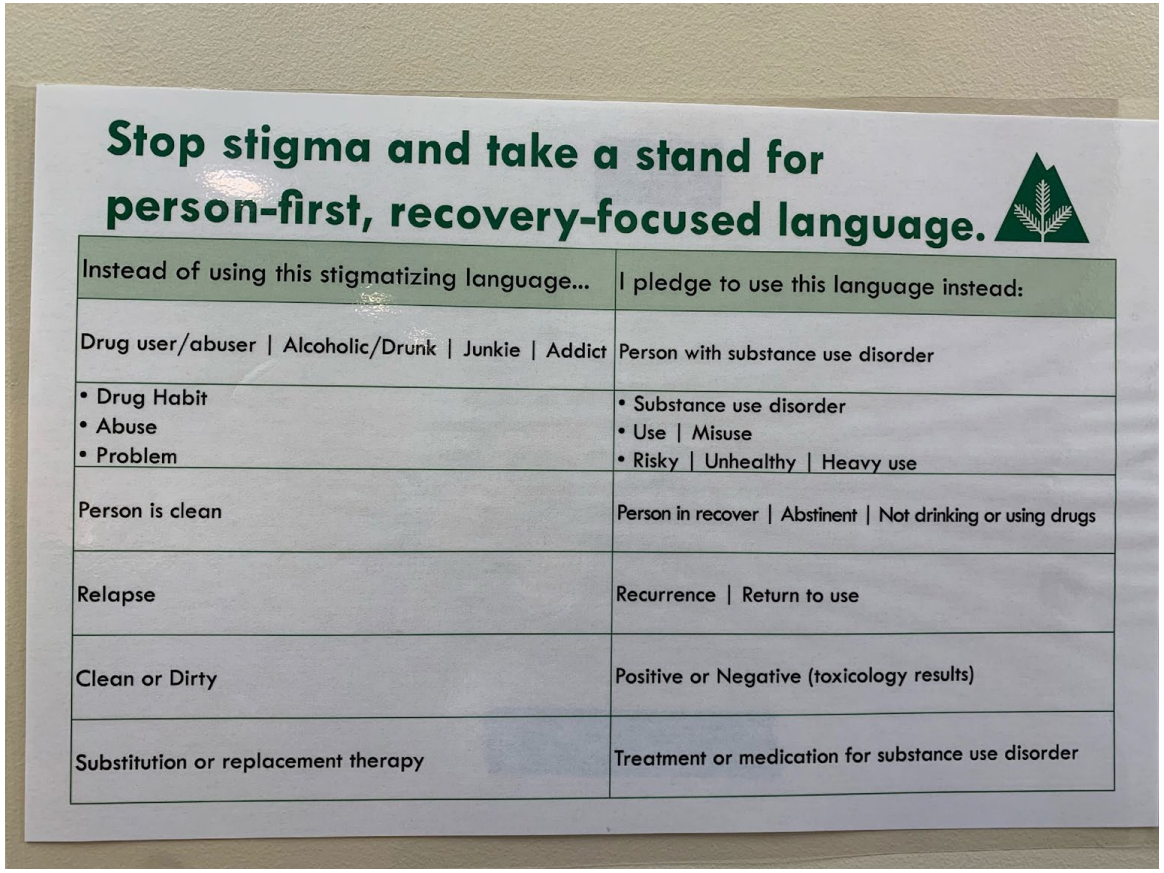


Source: *Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical* Record (Goddu et al, 2018)

LO-3

Take a stand and use person-first language

- Providers at all levels are changing their use of language
- Using outdated, stigmatizing language **impacts your communication with doctors and nurses**



Stop stigma and take a stand for person-first, recovery-focused language.

Instead of using this stigmatizing language...	I pledge to use this language instead:
Drug user/abuser | Alcoholic/Drunk | Junkie | Addict	Person with substance use disorder
• Drug Habit • Abuse • Problem	• Substance use disorder • Use | Misuse • Risky | Unhealthy | Heavy use
Person is clean	Person in recover | Abstinent | Not drinking or using drugs
Relapse	Recurrence | Return to use
Clean or Dirty	Positive or Negative (toxicology results)
Substitution or replacement therapy	Treatment or medication for substance use disorder

Sign located at Berkshire Medical Center in Pittsfield, MA

LO-3

Provide objective patient hand-off reports

- EMS provider hand-off reports have the potential to bias receiving providers (doctors and nurses) against patients
- Using **patient-centered language**, **objective findings** and **communicating treatments** will improve patient outcomes

Our data matters! EMS data are used by researchers to develop public health policy

- The accuracy in how you document your calls **has a direct impact on public health policy** and funding for programs like community EMS

MYTH: “YOU CAN BE EXPOSED TO FENTANYL BY CASUAL CONTACT”

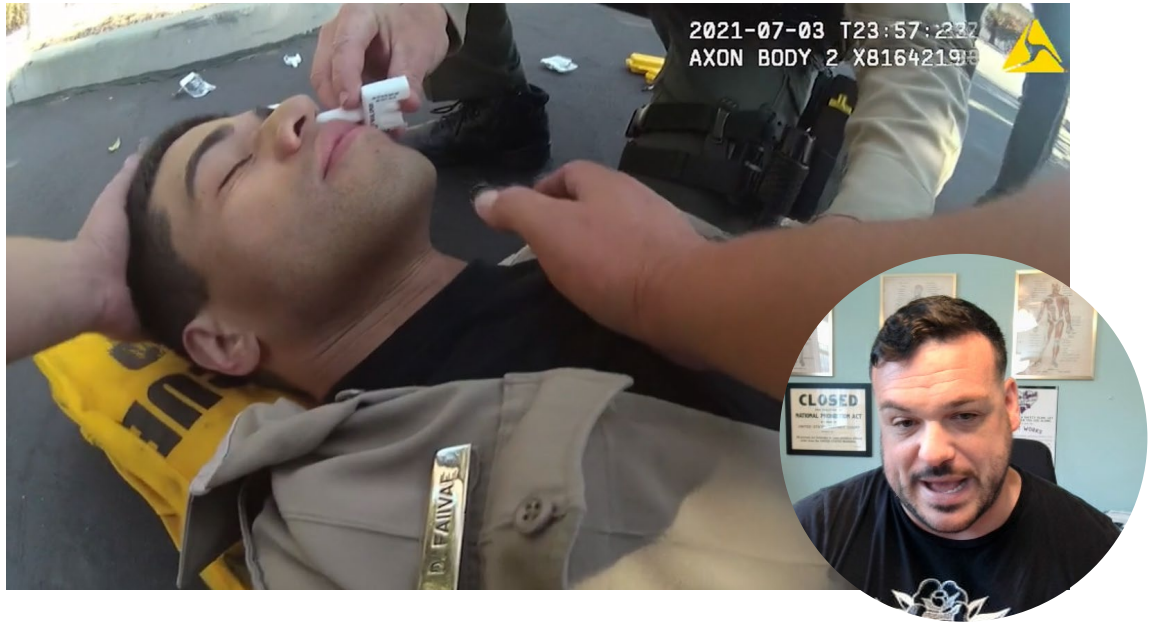
It is our job to challenge fentanyl exposure myths

- There is significant misinformation about fentanyl and its risk to responders
- Fentanyl **cannot be absorbed by the skin in powder form, nor can it be effectively aerosolized to present an inhalation danger**
- Responders often display **symptoms of panic attack** – hyperventilation, nervousness, sweating, syncope; these are the exact opposite symptoms of opioid overdose
- Universal precautions are more than sufficient to protect you
- HazMat teams **are not needed** to decontaminate ambulances or cruisers that may have powder fentanyl in them

MASS LIVE

A Cape Cod ER was shut down, Narcan given to staff after opioid exposure, but experts say airborne overdose is 'impossible'

Updated: Jan. 21, 2022, 12:58 p.m. | Published: Jan. 21, 2022, 5:32 a.m.



It is our job to challenge fentanyl exposure myths

- We have a duty **as medical providers** to correct this misinformation, as bystander or police fear of fentanyl can mean someone not responding to help in an overdose
- If it was this easy to consume opioids, people who use drugs would not be injecting

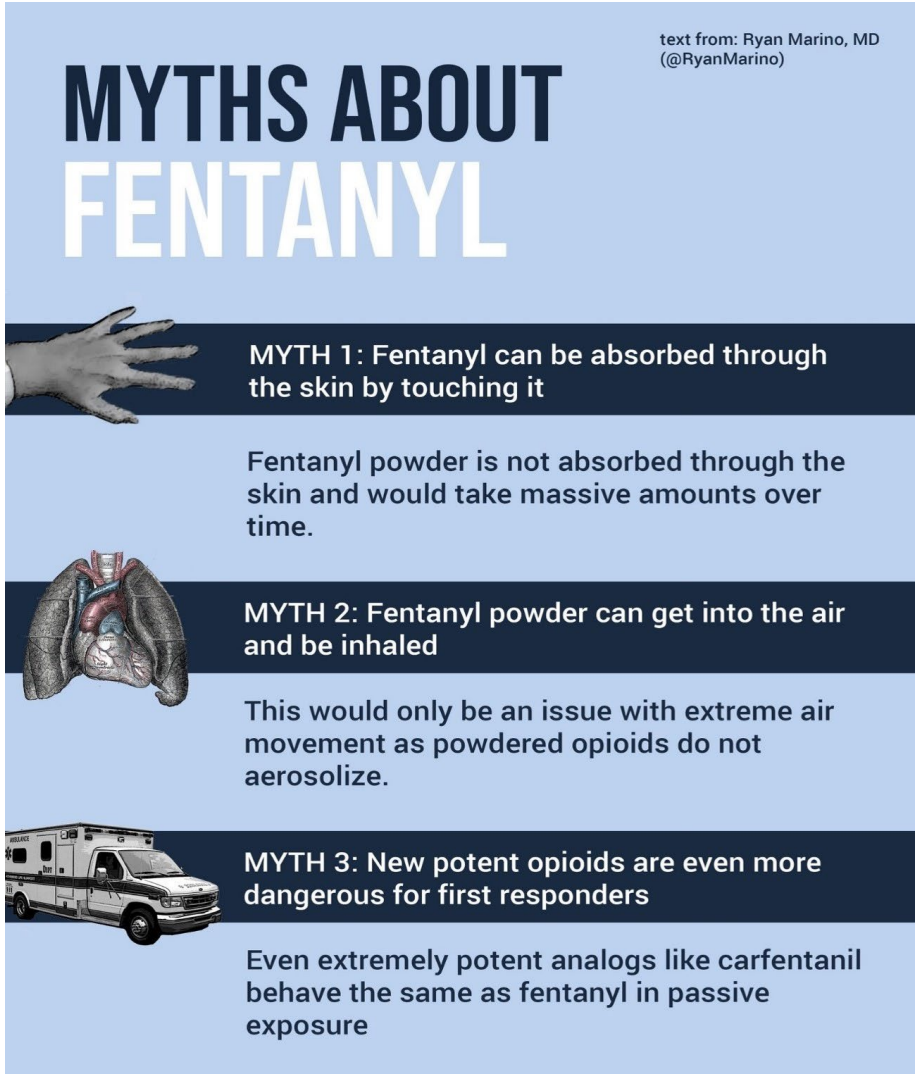


Image by Abdullah Shihipar, MPH / Text by Ryan Marino, MD

EMS sees what public health doesn't: people in their homes, in the moments that matter most

- Many public health programs focused on drug user health (harm reduction) mostly access people who use drugs that are unstably housed
- **EMS have the incredibly rare opportunity to be inside people's homes with high-risk overdose survivors and their social networks**
- You may be that person's only touchpoint to overdose prevention education and resources

Please don’t hesitate to reach out:

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DOH 530-332 October 2025

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