HAP Opioid Learning Action Network (LAN)
South Eastern PA Regional In-Person Meeting
Wednesday, February 19, 2020
7:45 AM – 11:00 AM
Einstein Medical Center Montgomery / 559 W. Germantown Pike / East Norriton, PA

AGENDA

7:45 a.m.  Registration and Breakfast

8:00 a.m.  Welcome and Opening Remarks
- Jennifer Jordan, Vice President, Regulatory Advocacy, The Hospital and Healthsystem Association of Pennsylvania
- Beth Duffy, President and Chief Operating Officer, Einstein Medical Center Montgomery

8:15 a.m.  Single County Authority – Your Link to Resources
- Sheri L. Rubin, RN, Health Care Coordinator, Bucks County Drug & Alcohol Commission, Inc.

8:35 a.m.  OUD Screening Processes in the ED – Are you Missing Anything?
Panel Discussion
Moderator: Serge-Emile Simpson, MD, Director of Medical Toxicology Division, Einstein Medical Center Philadelphia
- Brad Bendesky, MD, FACEP, FAAEM, Medical Director-Mercy Fitzgerald Hospital, Trinity Health Mid-Atlantic Region
- Brenda Foley, MD, Assistant Medical Director, Emergency Department, Doylestown Hospital
- Marlissa Grasse, RN, Department of Emergency Medicine, Grand View Health

9:20 a.m.  Highlighting Harm Reduction Strategies throughout the Region
Presentation and Group Activity
Moderator: Liz Owens, MS, Clinical Project Manager, The Health Care Improvement Foundation
- Silvana Mazzella, Associate Executive Director, Prevention Point Philadelphia

10:05 a.m.  MAT Warm Handoff – What is your Method?
Case Studies
Moderator: Claudette Fonshee, RN, MSN, Director, Clinical Improvement, The Health Care Improvement Foundation
- Shannon Cogdell, Warm Handoff Program Director, Penn Foundation

10:50 a.m.  Wrap up and Next Steps
- Jennifer Jordan, Vice President, Regulatory Advocacy, The Hospital and Healthsystem Association of Pennsylvania
HAP Opioid Learning Action Network (LAN)
Southeastern Regional In-Person Meeting

Wednesday, February 19, 2020
7:45 AM - 11:00 AM

Einstein Medical Center Montgomery | Modular Building
Welcome and Opening Remarks

Jennifer Jordan
Vice President, Regulatory Advocacy,
The Hospital and Healthsystem Association of Pennsylvania

Beth Duffy, MBA
President & Chief Operating Officer
Einstein Medical Center Montgomery
Sheri L. Rubin, RN
Health Care Coordinator
Bucks County Drug & Alcohol Commission, Inc.
BUCKS COUNTY DRUG & ALCOHOL COMMISSION, INC.
WARM HANDBOFF - COLLABORATION WITH EMERGENCY DEPARTMENTS

Sheri Rubin, RN
Health Care Coordinator
Bucks County Drug & Alcohol Commission, Inc.
Single County Authority (SCA)

• Each county is required by the Department of Drug & Alcohol Programs (DDAP) to have a SCA.
• Bucks County Drug & Alcohol Commission, Inc. contracts with a network of providers to ensure the provision of a comprehensive and balanced continuum of quality prevention, intervention, recovery and treatment services for the county.
• Fund uninsured and underinsured individuals in Bucks County.
• Work closely with Bucks County Behavioral Health, which oversees HealthChoices (managed Medicaid) to coordinate services and care.
Single County Authority (SCA)

- BCDAC prioritizes those in the DDAP designated priority populations:
  - Opioid Overdose Survivors
  - Pregnant Women with Substance Use Disorder
  - Pregnant Women using IV Drugs
  - Individuals using IV Drugs
  - Veterans
- Bucks County also includes adolescents as a priority population.
- BCDAC will fund others based on available treatment dollars.
**Bucks County Connect Assess Refer Engage & Support (BCARES)**

- BCARES is Bucks County’s Warm Handoff (WHO) for opioid overdose survivors
- Purpose of the WHO is to provide a direct and seamless connection from the ED to D&A treatment
- DDAP mandates that each county have a WHO, but allows counties to choose their own model
- BCARES is a Certified Recovery Specialist (CRS) model in which people with lived experience provide support, education and resources to overdose survivors
Implementation – Developing Partnerships

• Director, BC Department of Health & Human Services

• Bucks County Health Improvement Partnership (BCHIP)
  – CEO/Exec. Director of each hospital
  – Bucks County Medical Director – Dr. David Damsker
  – Buy-in from each hospital

• Meetings with Individual Hospitals
  – Each identified a BCARES champion; typically either ED medical director or nurse manager
  – Champion was tasked with setting the stage and educating staff about BCARES and putting in place policies/procedures
  – MOUs developed between CRS providers and hospitals
Partnerships (Cont.)

• Working with 6 hospitals
  – BCARES serves any individual who overdosed on opiates and is one of the six Bucks County EDs, regardless of their county or state of residence, and regardless of their insurance status
  – Some part of larger hospital system; some not
  – Each hospital joined at their own pace
  – Respectful of each hospitals policies, preferences and culture
  – Worked with hospitals to determine hours of service
## CRS Provider & Hospital ED Partnerships

### CRS Providers
- Gaudenzia
- Council of SEPA (CSEPA)
- Penn Foundation

### Hospitals
- Lower Bucks Hospital
- Jefferson Bucks
- St. Mary Medical Center
- Doylestown Hospital
- Grandview Hospital
- St. Luke’s Upper Bucks
CRS Provider and Hospital ED Partnership

• Gaudenzia
  – On grounds of LBH
  – Only 24/7 assessment center in Bucks County
  – Have residential W/D management and rehab
  – Take admissions 24/7 & prioritize BCARES clients

• CSEPA
  – Runs a community recovery center and provides community based CRS services for Bucks County

• Penn Foundation
  – Across the street from Grandview Hospital
  – Have open access assessment hours on weekdays
  – Have residential W/D management and rehab & prioritize BCARES
  – Takes admissions 24/7 for BCARES clients throughout the County
How Does BCARES Work?

- CRS is 24/7 with a combination of on-site and on-call hours
- When a hospital notifies the CRS of a overdose survivor, they will meet with the individual and family face-to-face and provide:
  - Support, education, resources
  - Most importantly, motivate the individual to accept a seamless transition to treatment directly from the ED
  - CRS will arrange for transportation to treatment
- For overdose survivors, BCDAC will fund first 3 days of treatment, regardless of the person’s County of residence or insurance status.
- If the person does not choose to go directly to treatment, alternative pathways to recovery will be discussed, including MATs, and they are provided with materials and a “free assessment” card.
BCARES Expansion

• Independence Blue Cross Foundation Study
  – Recommended increase hours of service to 24/7
• Expanding to 24/7 (previously very few hours provided to each hospital)
  – Combination of on-site and on-call
• Expanded to see those with any substance use disorder; functions may be somewhat different
• Expanded out of ED to other hospital units
Stigma

- Was a significant factor at the start of the program
- CRS sometimes felt unwanted, not valued, that staff did not know who they were or their role
- Some staff did not want the CRS in the ED
- Increased hours made a positive impact
- Hospital staff value the role of the CRS and appreciate what they do
- Many staff have approached the CRS for support regarding a loved one’s SUD
BCARES Enhancements

- **BCARES Family Connect**
  - Original intent – Support in ED waiting room
  - Now – Expanding to include assessment centers and provider agencies
- **BCARES Healthcare Professionals Opposing Stigma**
  - Presented to over 460 professionals since April 2019 including presentations to ED staff
- Medication Disposal Boxes
Moving Forward

- Narcan Distribution
  - Started in one hospital
  - Narcan pilots have been offered to all EDs; awaiting policies and procedures
  - Offer to high risk individuals and families and providing education on administration

- Buprenorphine Induction in ED or Home Induction
  - Started in one hospital over a year ago
  - Provided education in BCHIP meeting
  - X-waiver for ED prescribers; incentive funding
  - Connections to community based providers for continued care
Bensalem Community Response Unit (BCRU)

- Collaboration with Bensalem PD, EMS, CSEPA CRS, Jefferson Torresdale
- Focused community response to overdose
- Includes a specially equipped SUV, a paramedic and a ride-along CRS
- Majority of Bensalem residents are taken to Jefferson Torresdale (Phila.)
- Able to cross county lines and provide service very similar to BCARES
Questions???

Contact Information:
Sheri Rubin, RN
slrubin@buckscounty.org
215-444-2729
# OUD Screening Processes - Are You Missing Anything?

**Panel Discussion**

**Moderator:** Serge-Emile Simpson, MD, Director of Medical Toxicology Division, Einstein Medical Center Philadelphia

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<tr>
<th>Name</th>
<th>Title</th>
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<tr>
<td>Brad Bendesky, MD</td>
<td>Medical Director</td>
<td>Mercy Fitzgerald Hospital</td>
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<td>Trinity Health Mid-Atlantic Region</td>
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<td>Brenda Foley, MD</td>
<td>Assistant Medical Director</td>
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<td>Marlissa Grasse, RN</td>
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2/20/2020
Highlighting Harm Reduction Strategies Throughout the Region

Presentation

Moderator: Liz Owens, MS, Clinical Project Manager, The Health Care Improvement Foundation

Silvana Mazzella

Associate Executive Director
Prevention Point Philadelphia
INTEGRATING OVERDOSE PREVENTION & HARM REDUCTION IN THE DELIVERY OF HOSPITAL CARE

HAP LAN
2/20/20
HOSPITALS HAVE A UNIQUE OPPORTUNITY TO PREVENT OVERDOSE WITH PATIENTS, LARGER COMMUNITY

• Hospital admission and stay data tells us how many people have touch points
• Naloxone administration data tells us that increasingly reversals are happening in the community
• Pharmacy data tells us how few individuals are getting naloxone prescriptions
• Medicaid data tells us how easily and affordably we can scale up naloxone prescribing and distribution in hospital settings
PATIENTS NOT ACTIVELY AT RISK FOR OVERDOSE CAN BE TRAINED TO CARRY AND ADMINISTERNALOXONE

- Individuals at risk for overdose or having experienced overdose are more aware of overdose, and are interested in getting naloxone to save lives
- Individuals trained with medication for themselves will tell their family, partners, and peers how to use medication on themselves
- Individuals trained with medication for themselves can use medication on other victims
- Any individual living in a community with a disproportionate burden of overdose can be trained to be a first responder
Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain
Phillip O. Coffin, MD, MIA; Emily Behar, MA; Christopher Rowe, MPH; Glenn-Milo Santos, PhD, MPH; Diana Coffa, MD; Matthew Bald, MD; Eric Vittinghoff, PhD
Phillip O. Coffin, MD, MIA
From San Francisco Department of Public Health and University of California, San Francisco, San Francisco, California.

Results: 38.2% of 1985 patients receiving long-term opioids were prescribed naloxone. Patients prescribed higher doses of opioids and with an opioid-related ED visit in the past 12 months were independently more likely to be prescribed naloxone. Patients who received a naloxone prescription had 47% fewer opioid-related ED visits per month in the 6 months after receipt of the prescription (incidence rate ratio [IRR], 0.53 [95% CI, 0.34 to 0.83]; \( P = 0.005 \)) and 63% fewer visits after 1 year (IRR, 0.37 [CI, 0.22 to 0.64]; \( P < 0.001 \)) compared with patients who did not receive naloxone. There was no net change over time in opioid dose among those who received naloxone and those who did not (IRR, 1.03 [CI, 0.91 to 1.27]; \( P = 0.61 \)).
Brief overdose education is sufficient for naloxone distribution to opioid users

GM Santos, E Wheeler, C Rowe, PO Coffin

Results

Comfort with recognition of, response to, and administration of naloxone for an overdose event significantly increased after brief education among first-time recipients ($p < 0.05$). Knowledge of appropriate responses to opioid overdose was high across all assessments; 96% of participants could identify at least one acceptable action to assess and one acceptable action to care for an opioid overdose. Facility with naloxone administration was high across all assessments and significantly increased for intranasal administration after education for first-time recipients ($p < 0.001$). First-time recipients (before and after education) and refillers demonstrated a high level of knowledge on the Brief Overdose Recognition and Response Assessment, correctly identifying a mean of 13.7 out of 16 overdose scenarios.
Hospitalizations Attributable to Non-Fatal Opioid Poisoning

Number of Hospitalizations Attributable to Opioid Poisoning by Year

Age Category

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Sex

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INFORMAL, ROUTINIZED, BRIEF SCREENING FOR OVERDOSE RISK

“I ask every patient this, each visit, regardless of why they are here”:

• How many times have you overdosed in your lifetime?....How many times have you overdosed in the last year?
• How many bags/fentanyl/pain pills do you use a day?
• What do you mix with heroin or pain pills?.....What do you use before or after heroin or pain pills?
• How many times have you witnessed someone else overdose in your lifetime?.....How many overdoses have you witnessed in the last year?
• Have you ever overdosed after using something you did not think contained fentanyl or prescription opioids?
BRIEF OVERDOSE PREVENTION EDUCATION INTERVENTION

-I’m looking at your medical screening and I want to talk about your risk for overdose -or-

-I see you’ve witnessed some overdoses; you could save a life. Let’s talk about narcan

-You aren’t being singled out; we have made it a standard part of treatment to talk to anyone and everyone in recovery about overdose risk

-We are choosing to do it right after ___________ so that you are prepared for yourself, or to save others in the community

-I’m sure you know a lot about this so I don’t tell you what you already know

-Tell me what you know about overdose, what puts someone at risk, and what to do when you see one, and I’ll fill in the blanks

-This isn’t going to take more than a few minutes
TRAINING IN OVERDOSE PREVENTION:
Overdose Prevention Education Components

Aim of training is to help individuals learn to:

- Understand what is different between opioid and stimulant overdose
- Understand that training and medication only for opioid overdose
- Understand what puts someone at risk for overdose
- Understand how to recognize an overdose
- Understand importance of calling 911
- Understand how to respond to an overdose
- Understand how to re-evaluate post reversal, stay with person, ensure that person does not use again

For individuals receiving prescriptions or medication for themselves, provider needs to stress importance or patient informing parent, peer, partner they carry medication
BASIC POINTS TO COVER WHEN CONDUCTING OVERDOSE PREVENTION TRAINING

- Risk factors for overdose: Pharmacological effects of opioids, of benzodiazepines and other substances used with opioids, poly-drug use and synergistic effect of side effects, reduced tolerance, fluctuation in tolerance, fluctuation in drug purity levels, using alone, injecting entire shot at once, having been recently discharged from prison, hospital, or a residential treatment program because your tolerance is low, having such high tolerance that you are using an amount that shuts down your respiratory system, having apnea, severe COPD, asthma, or other breathing issues, having HIV, HCV, kidney issues, or any immune or drug metabolizing issue, or aging and having reduced respiratory capacity and ability to metabolize drugs. Finally, fentanyl is everywhere

- Recognizing the signs and symptoms of an overdose: Turning blue, turning cold, does not wake up, cannot stand on own, no movement during sleep or wake response

- Calling 911: Calling 911 is a way to save someone who did not overdose on opioids. The person may need more than the dose given safely by a lay person. Or something else may be going on. In Philadelphia people will not be arrested

- Performing rescue breathing (no chest compressions ever). People should be encouraged to do rescue breathing before a reversal, and then after. Staff in the building should always use the best practice of an ambubag.

- Administering naloxone by intra muscular injection, or through nasal narcan: Use 1 dose at a time due to withdrawal. If someone is using a syringe, you can let them know that the tip can be removed if they have a concern about unsteady hands or to avoid a needle-stick. This will not work as quickly. Nasal narcan might take 8 minutes to work for someone to be up and moving. As long as they start breathing, they are no longer blue, grey, or purple, and their temperature changes, just keep doing rescue breathing unless you really think they need another dose

- Aftercare: Make sure people know that naloxone does not remove opioids. Make sure they know they will withdraw and naloxone only lasts up to 1 ½ hours. For some people, it will only last 10-20 minutes. People reversed are at greater risk of overdose after reversal. If they use again they have what they overdosed on in their system, plus what they add on top. They might overdose again, but do it alone with no one to help
Patient Name: John Doe  Date of Birth:  

Address:  Date Prescribed: November 18, 2016

Rx

Narcan Nasal Spray 4mg  
#1 (Two Pack)
Administer as directed PRN for suspected overdose

DAW / No Substitution

Refills: 2

Prescriber: Sue Smith, MD

Signature:  

they are us.  PREVENTION POINT
WHAT IS IN THE OVERDOSE PREVENTION SUPPLY BAG

• 1-3 doses of 4mg nasal Narcan
• 1 pair of gloves
• 1 rescue breathing shield
• 1 set of overdose reversal instructions in English & Spanish
How to Reverse an Overdose

1. Identify the Overdose
   Look for signs like inability to stand, slow or irregular breathing, and gagging or snoring without catching breath.
   The person may turn pale, blue, or ashy.

2. Clear the Area
   Remove any hazardous materials, put on gloves if you have them, and ask anyone not helping to stand to the side.
   Lay the person down if you can do it safely.

3. Try to Wake Them Up
   Gently shake them. Ask loudly if they’re okay. Firmly rub their sternum or pinch their nail bed.

4. Call 911
   Describe the symptoms: “My friend is unresponsive and not breathing.”
   Tell the dispatcher your location and give directions if necessary. Stay on the line.
How to Reverse an Overdose

Give NARCAN®
Put the dispenser in the person’s nose and push the plunger to release.
NARCAN® acts in two to five minutes
Some people may require a second dose if they aren’t waking after five minutes.

Help their Breathing
Check that nothing is in their mouth.
Tilt their head back and hold their chin up.
Use a Barrier if you have one.
Pinch their nose and give one rescue breath every five seconds.

Wait With Them
Try to stay until medical help arrives.
Put them on their side if they are Breathing but not fully awake.
If they wake up, tell them they overdosed and were given NARCAN®.
If they use more, it could be fatal.
Try to keep them calm.
BILLING MEDICAID FOR NALOXONE

• Straight Medicaid pays for almost all formulations
• All public benefits MCOs pay for at least one formulation
• Nasal Narcan is the preferred product for nearly all Medicaid MCOs
• Private insurance pays in some instances
• Hospitals billing Medicaid can offset costs of naloxone for uninsured patients through Medicaid receipts
• Roughly 82% of individuals accessing syringe exchange approached by co-located pharmacy are insured
• Medication can be e-prescribed and billed bedside
• 340b pricing eligible based on clinical care and patient
INCORPORATING AND ROUTINIZING A HARM REDUCTION APPROACH
HOW INJECTION BEHAVIORS AFFECT HEALTH

• Lack of sterile equipment of all types, safe places to use
• Lack of information on safest injection practices
• Lack of access to safer injection equipment
• Skin popping, muscling, missed shots, rushed injections
• Re-use of previously used equipment, self and others’
• Broken equipment, lodged needle points, inhalation of cotton, choy
• Irregular vein rotation, repeated use of same injection sites
• Repeated use of injection sites with active wounds and infections
• Injecting in lower extremities, arteries, more hidden parts of the body
• Utilizing others to perform injections in arteries
• Stigma of disclosing wounds, admitting to unsafe practices
WHY WE NEED TO HAVE ROUTINE HR DISCUSSIONS

While many people got taught early on to inject safely, need no help, and will get offended if you try to teach anything:

- Some people do some things very safely but use un-sterile supplies, miss some steps, do things differently depending on time of day, who they are with, where they are
- Some people get taught really unsafe practices and you can teach new things
- Many women never learned to take care of themselves and rely on others
- Even people who have been doing this a long time don’t always know how to be safe
WAYS TO BRING UP SAFER INJECTING

1. In context of discussion regarding risk, you can ask where people get their supplies, if they are familiar with the syringe exchange and other harm reduction services, and what types of supplies they use or need more of right now. You can also ask if someone has enough of a few particular items. This lets someone know you are not judging them.

2. You can also ask what someone is using and/or injecting, and this can open up a discussion about if that is different than before, etc.

3. Another opening for a discussion can come from noticing a wound and asking if the person wants to be seen, but also asking about it or if they have been doing anything differently, etc. Or, you can ask if they have any active wounds or issues.

4. After any discussion, validate what person is doing to be safe, and/or fill in blanks, or talk through safest way to inject for those who don’t know what they are doing or are being unsafe.
MORE HONEST AND EXPLICIT CONVERSATIONS ABOUT MANAGING DRUG USE

• You can ask how much person uses daily, today, usually
• If more than one drug, injected together? is that a change from before, are there any new wounds, etc.
• Don’t make drug use a big deal, normalize it and how much person is using
• You can ask if that is a good amount or if it is less or more than usual
• You can ask “when you do this much how do you feel? When you do more/less, how do you feel?”
VEIN CHOICES: Try to shoot below the shoulder and above the thighs. Arms and hands On any vein start higher, then go lower. Legs and feet not ideal because of clots, dvt, cvd. Least ideal neck and groin, breasts, penis.
1: Remove the plungers from two syringes.
2. Using a third syringe, carefully replace both plungers syringe, draw up the hit and empty half into each of the syringes.
3: Carefully replace both plungers.
SAFER INJECTING: HOW, WHERE, WHEN, & WHO

Affirm that you know the person knows what they are doing but that you want them to walk through their process because you may be able to help them feel better or be safer or have access to more tools

ASKING ABOUT PROCESS IS NECESSARY

• Process: Where and how do you usually do it, what kind of equipment do you always use, do you have a safe place to do it, do you have the right supplies, do you have enough supplies? Can you plan how much you are using and do you know what you are using? Do you know someone else who has done that mark?

ASKING ABOUT SURROUNDINGS IS NECESSARY

• Surroundings: Is there enough light, is it a safe place, is there a chance you will be rushed or interrupted, can you plan what you are doing, where, and how, is there an opportunity to be sterile, do you have your supplies with you? Safety of a place with amenities or privacy can include benefit of water, less stress, and greater chance of hitting all steps, but can come with increased risk of overdose of no-one else around
ASKING WHAT IS DIFFERENT WHEN USING WITH OTHER PEOPLE IS NECESSARY
• You can ask: Is there anything you do differently when you are with someone else, is there anything you do differently with someone you don’t know or don’t know well? If you have to share do you know person sharing with? Is there someone else around to make sure you don’t go out for too long or check out? Who is going first? Are there enough supplies for everyone or can you divide stuff first?

ASKING ABOUT VEIN ROTATION IS NECESSARY
• Where do they inject most often? How often and how is that site doing? Do they rotate veins to give them a break and avoid abscesses and other infections?

ASKING ABOUT DIFFERENT DRUGS AND DIFFERENT PROCESSES AND BEHAVIORS WITH DIFFERENT DRUGS IS CRITICAL
• Do they use the same equipment for different drugs? How does that work for them? Have they experimented with different gauges when they mix it up to avoid abscesses and infections?
WHAT’S IN THE STANDARD PPP SUPPLY BAG

• BZKS: to clean hands, under nail beds
• Alcohol wipes: to disinfect injection site before using
• Tourniquet: to help hit vein and not miss
• Cookers: a sterile place to mix, sterile cooker used to divide and not share
• Cotton: to filter drugs, reduce chances of clumps being injected (PPP cotton is sterile)
• Water: sterile water has no microbes, and helps clean everything and reduces infection. Saline water has the same salt content as the blood, so it helps reduce collapsed veins and chances of blown veins and missed shots down, for cleaning wounds
• Antibiotic ointment: for cuts, small wounds
• Wound care kits: to clean, treat, and cover wounds
HARM REDUCTION SERVICES IN PHILADELPHIA

- PREVENTION POINT PHILADELPHIA
- PROJECT SAFE
- SOL COLLECTIVE
- ANGELS IN MOTION
- IN MY BACK YARD
- GOODS AND SERVICES
HOSPITALS CAN MAKE A HUGE IMPACT BY INCORPORATING HARM REDUCTION AND A NO WRONG DOOR MODEL

• Screen for and, where possible, treat for sequelae of substance use
• Briefly screen everyone for opioid use and overdose risk
• Routinely provide narcan to individuals who have not only overdosed but have other indicators of substance use
• Routinely provide narcan to anyone living in a geography where overdose fatality rates are high
• Discuss harm reduction techniques; distribute or prescribe supplies to reduce infection and inject more safely
• Incorporate induction protocols in ED and inpatient units
Silvana Mazzella
Associate Executive Director
Prevention Point Philadelphia
215-634-5272, 267-975-5419
Silvana@ppponline.org
Highlighting Harm Reduction Strategies Throughout the Region
Group Activity

Moderator: Liz Owens, MS, Clinical Project Manager, The Health Care Improvement Foundation

Group Activity—15 minutes:
1. Break up into groups
2. Assign roles
3. Share/discuss different harm reduction strategies
   - What is working well?
   - Where is there opportunity?
   - What are the next steps?
   - What is your organization’s role in making this region safer?

Report Out—10 minutes:
- Each group reports out
MAT Warm Handoff - What is your Method?

*Presentation & Case Study*

**Moderator:** Claudette Fonshell, RN, MSN, Director, Clinical Improvement, The Health Care Improvement Foundation

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**Shannon Cogdell**

Warm Handoff Program Director

Penn Foundation
Penn Foundation’s Warm Handoff Program

Shannon Cogdell, BA
# Impact of the Opioid Crisis

## On our State

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<th>Year</th>
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**PA Coroner’s Association**

## On our Community

### Yearly Loss of Life
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<th>Year</th>
<th>Bucks</th>
<th>Montgomery</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>205</td>
<td>158</td>
</tr>
<tr>
<td>2015</td>
<td>123</td>
<td>152</td>
</tr>
<tr>
<td>2016</td>
<td>168</td>
<td>231</td>
</tr>
<tr>
<td>2017</td>
<td>225</td>
<td>245</td>
</tr>
<tr>
<td>2018</td>
<td>217</td>
<td>210</td>
</tr>
<tr>
<td>2019</td>
<td>Not yet available</td>
<td>97</td>
</tr>
</tbody>
</table>

**University of Pittsburg Data**

## Nationally

### Top 5 States

<table>
<thead>
<tr>
<th>State</th>
<th>Death Rate in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Virginia</td>
<td>52.0 per 100,000</td>
</tr>
<tr>
<td>Ohio</td>
<td>39.1 per 100,000</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>39.0 per 100,000</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td><strong>37.9 per 100,000</strong></td>
</tr>
<tr>
<td>Kentucky</td>
<td>33.5 per 100,000</td>
</tr>
<tr>
<td>National Rate</td>
<td>13.0 per 100,000</td>
</tr>
<tr>
<td>National Total</td>
<td>42,249 total deaths</td>
</tr>
</tbody>
</table>

**Centers for Disease Control**
More than Just Opioids

Heroin, Fentanyl, Cocaine were the most frequently identified substances in decedents (76% of deaths)
Public Health Impacts

OVERDOSE RATES

CONTINUE TO INCREASE
Overdose death rates have increased every year since 1999. In 2016, there was a loss of life of over 42,000 attributed to overdose.

DISEASE Prevalence

COMMUNICABLE DISEASES INCREASE
Rates of Hepatitis C, HIV/AIDS and STDs have increased, following parallels of number of injection drug users.

RISK TAKING BEHAVIOR

RISKY SEXUAL BEHAVIORS
• HIV & STD Prevalence
• Unintended Pregnancy
• Infants Born Addicted
From 2015 to 2016 there was an increase from 5.6 to 19.5 per 100,00 people substance related neonatal and maternal hospitalizations.
A clinical pathways tool was created to help those with a range of opioid related issues get connected to treatment services.

Emergency departments are critical partners in the commonwealth’s response to the opioid epidemic.

A provider’s office in the community is embedded with the hospital to ensure that there are resources for the specialty care that is required for drug and alcohol treatment.
Warm handoff is an approach where a health provider does a face-to-face introduction to a substance abuse specialist and makes a direct referral into substance abuse treatment. Similar to a heart attack patient, who once stable in the emergency department, would receive a facilitated referral to a cardiologist, opioid use disorder patients should receive similar treatment.
THE MOST CRITICAL TIME

- Naloxone has a shorter half-life than synthetic opioids such as Fentanyl. Individuals who are overdose and receive Narcan still may have adverse reaction if not monitored by medical professionals.
- Drug use following a Naloxone administration can lead to death due to the way the opioids are bound to the receptors.
- The jarring experience of having an overdose may encourage somebody to seek treatment.
In support of the DDAP protocol and local single county authorities Penn Foundation has partnered with 5 hospitals to provide the Warm Handoff Program.

The Warm Handoff Program targets anyone with a potential drug and alcohol issue, as well as their families following a hospitalization.

Program utilizes Certified Recovery Specialists and engagement specialists, who are themselves in recovery to connect with survivors from a place of empathy and compassion.
INGREDIENTS for success

Several elements have come together to make the Warm Handoff Process successful.

- **Whole Hospital Coverage**
  - The Warm Handoff is provided to anyone seen in the hospital; blind of payer, coverage, or residency.

- **Specialty Funding to Secure Treatment**
  - Specialty county funding is available for residents who need financial assistance for treatment.

- **Finding Champions**
  - Building strong relationships with hospital staff; relationships with social work and trainings to ensure implementation.

- **Rapid Access**
  - Answering service available 24/7 to triage calls and ensure that referrals aren’t missed after hours.
How to Capture Referrals

- **E-HR Triggers for Consult**
  CRS Consult is put in the E-HR by provider, which sends directly to the printer in the Warm Handoff Staff Office

- **24/7 Phone Access**
  24/7 Rapid Access phone line, to take referrals from providers when a consult is needed
POST INCARCERATION

Overdose is common after a period of sobriety such as release from incarceration or following discharge from treatment.

CHRONIC PAIN PATIENTS

Individuals who are not familiar with substance abuse treatment are met with a professional who can help them navigate the system.

Elderly POPULATION

We have navigated several cases of elderly persons who have accidentally overdosed.

Range of Ages Served: 16 years to 92 years

Catching the Whole Community.
Mutual Benefits

Our program has several mutual benefits for all parties involved: the hospital system, treatment providers and individuals.

Uninsured Hospital Patients cause financial strain on hospital systems. Our access to special funding streams for overdose survivors allows us to take this burden off the hospitals.

It is common practice that individuals utilize hospitals as a means to access treatment. Connecting individuals to treatment and case management gives them other avenues to treatment and allows the emergency departments to be used for other medical emergencies.

Addiction treatment is a medical specialty, connecting individuals to the most appropriate care increases the chances of positive outcomes.
Emergency Department Outcomes

Hospital Project Implementations
- August 2017 Lansdale Abington Hospital
- October 2017 Sellersville Grandview Hospital
- February 2018 Quakertown St. Luke’s Hospital
- March 2018 Doylestown Hospital
- June 2018 Abington Main Campus

Overdose Referrals
Over 1000 referrals total since program inception in 2017

74% D&A
26% OD

Education and Relationship Building
Building relationships with nursing staff and other medical professionals to educate on addiction and remove stigma. Penn Foundation has recently started training medical providers on Empathy as it relates to substance use disorder patients, as well as motivational interviewing to help make patients receptive for consent to treatment.
For Those Who Refuse Treatment: Toolkit

OVERDOSE PREVENTION
Detailed educational information about how to identify, respond and reverse and overdose.

ACT 139
Act 139 – Good Samaritan Protectionism Laws are explained in details to encourage others to assist in time of opioid emergency.

NARCAN
Standing Order Narcan Prescription as well as list of pharmacies in the area that carry Narcan for ease of access.

TREATMENT OPTIONS
Explanation of treatment options for those unsure about treatment.

FUNDING
Funding sources are explained for those who do not have the means to afford treatment.

ADVOCATE
Contact information to a peer specialist assigned to their case. If the individual is not ready for treatment now, they have a point of contact when they decide they are ready.
Innovation

Using technology to remove barriers
When time is critical, minutes matter… Penn Foundation and Abington Jefferson Health are piloting a telehealth assessment program to provide assessments.

Telehealth Assessments
Patient’s level of care will be determined via a face to face online video call that will allow for clinical determination to be made.
19 year old female patient presented to the hospital due to having severe abdominal pain. Client is 25 weeks pregnant and became concerned about the fetus so she presented to ED.

Client was admitted into the L&D unit at the hospital. Ct reported the pregnant was a surprise to her and her fiancé and an added stressor to their already strained relationship. Client reports she has an OBGYN, and has had two ultrasounds. Client reports is not on prenatal vitamins d/t stomach issues when taken.

Client reported she has not use methamphetamine in 10 months, and has not used heroin or Percocet in about 1 year. She reported that she has been using Subutex or Suboxone off and on for the last year that she has bought off the street. Typical use is 8mgs daily. Ct reported she was buying Suboxone or Subutex as a way to not use heroin or Percocet. Client reports that the Suboxone was used at a therapeutic dose and that she doesn’t experience intoxication at this dose.

Client lives with grandparents and there is no use in the home.

Client reported history of trauma and did not want to talk about the details. She reports history of anxiety, PTSD and depression. One past psychiatric inpatient stay in her teens.

Client was seen by Penn Foundation Warm Handoff, who coordinated immediate MAT for her due to pregnancy. Client was inducted on a MAT program and connected with individual therapy. The client stated that she feels good about her choices to be honest and engage in appropriate treatment.

During the course of her treatment, client’s baby has a birth defect and she eventually would be connected to a children’s hospital for this. The pregnancy is considered compromised, and requires weekly stress testing. Client has maintained abstinent from her substance of choice.

Client has stayed active in treatment, and has been supported by the Center of Excellence, for continued case management support through her pregnancy.
37 year old female was brought to Abington due to her water breaking at 16 weeks. During the course of her treatment it was found that there were fetal abnormalities, and her pregnancy was ectopic, and D&C was preformed due to pregnancy not being viable.

Client was using heroin, fentanyl and marijuana and client was medicated with Methadone in the hospital for withdrawal symptoms.

Client was referred to Penn Foundation staff, to work on a care plan for drug and alcohol treatment.

Client was offered inpatient treatment and declined immediate placement due to wanting to get her affairs in order.

Client was called every day to ensure her safety and support her getting into inpatient treatment.

Client was placed into detox, then left AMA due to her feeling that her detox needs weren’t being met.

Client was connected to outpatient methadone center.

Client’s significant other was offered treatment as well, which he declined.

Client was followed for 30 days to ensure that her safety and healthcare needs were being met.
In the patient’s own words

Thank you SO MUCH!!!! Abington staff (you in particular) have really gone above and beyond on my behalf and that means the world to me!!! I don’t often have a lot of support in my corner and it’s nice to feel like someone other than my bf and a select few others make a point to show their concern. So thank you again!!❤️
THANK YOU!

We are glad to answer any questions during the question and answer session.

Shannon Cogdell, BA
scogdell@pennfoundation.org
267-404-5754
Wrap Up and Next Steps

Jennifer Jordan
Vice President, Regulatory Advocacy
The Hospital and Healthsystem Association of Pennsylvania
Upcoming Key Dates

- March 5, 2020 Webinar
- March 19, 2020 Office Hour Call
- March 26, 2020 Webinar
- Ongoing Collection of Tools/Resources
  Submit to mkenyon@haponline.org
- Save the Date! July 23, 2020 Annual In-Person Event
Thank You!

Please fill out the following evaluation *by February 26th*

[https://www.surveymonkey.com/r/lan-021920](https://www.surveymonkey.com/r/lan-021920)