HAP Opioid Learning Action Network (LAN)
Philadelphia Regional In-Person Meeting

Thursday, December 5, 2019
7:45 AM - 10:30 AM

Thomas Jefferson University Hospital| Jefferson Alumni Hall
Welcome and Opening Remarks

Kate Slatt
Vice President, Innovative Payment and Care Delivery
The Hospital and Healthsystem Association of Pennsylvania

Brian G. Swift, PharmD., MBA
Enterprise Vice President & Chief Pharmacy Officer, Associate Dean of Professional Affairs
Jefferson College of Pharmacy
OUD Screening Processes - Are You Missing Anything?

Group Activity

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

Refer to handout and list action steps your organization includes during screening process.

- What tools are used during screening process?
- When does screening process take place?
- Who is part of the screening process?
OUD Screening Processes – Are You Missing Anything? Panel Discussion

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

**Sarah Weiss, MD**
Toxicology Fellow & ED Physician,
Einstein Medical Center Philadelphia

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

**Priya E. Mammen, MD, MPH**
Emergency Physician,
Public Health Consultant

**Jeanette Trella, PharmD, BCPPS**
Managing Director,
The Poison Control Center

12/5/2019
ED Screening for OUD
Are we missing anything?

Serge-Emile Simpson, MD
Einstein Healthcare Network
HAP Opioid LAN
December 5, 2019
OUD Screening in the ED

• Where will the screening take place:
  • Triage
  • In the ED

• Who will perform the screen?
  • Patient
  • Nurse
  • Physician
  • Peer
  • Other substance abuse professional (LCSW, LSW,
OUD Screening in the ED

• Who will you screen?
  • Every man, woman and child?
  • Subgroup of chief complaints?
    • Intoxication
    • Overdose/withdrawal
    • Chronic pain
    • Soft tissue infections
  • PDMP?

• Hours of operation

• What will you do with the results of the screen?
  • Do you have a plan for management of all SUDs?
OUD Screening Tools

• Screening tools to consider:
  • [https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools](https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools)
  • Develop your own

• Become familiar with the DSM V definition of OUD
Create a non-judgemental environment in your ED/Triage area
Naloxone distribution/prescribing
Brief intervention (SBIRT)
Buprenorphine induction
Linkage to outpatient treatment (Warm Hand-off)
Bridge prescribing of buprenorphine/naltrexone (X waiver)
Inpatient treatment bed
Follow through

- Essentially case management and troubleshooting
- Who performs follow through?
  - Peer
  - Social work
  - Physician/nurse
- Metrics
  - WHO completion
  - Return visits to ED
  - PDMP
- Do you form an ongoing relationship with the patient?
- Do you have a plan for return visits?
Hospital Variation in Approaches to Opioid Use Disorder

Priya E. Mammen, MD, MPH, FAAEM
Emergency Physician
Public Health Consultant
Lindy Institute of Urban Innovation
Rate of ED Visits for Overdose by Opioid, Heroin, or Unspecified Substances per 1,000 Visits by Month
(January 1, 2007 - September 30, 2019)

- In addition to people who died from opioid overdoses, many more were treated in hospital emergency departments.
- The percentage of Philadelphia hospital emergency department visits related to opioid overdoses increased from approximately 0.4% in 2007 to nearly 0.7% in 2015.
- In 2015, there were over 6,500 emergency department visits for opioid overdoses.
- For each opioid-related death, there were approximately 12 hospital emergency department visits.

(Source: Philadelphia Department of Public Health, Division of Disease Control)
Views from the ED

• We evaluate and treat acute and chronic pain
• We evaluate and resuscitate all ACLS transports
• EDs offer unfettered access to medical evaluation
  • Often where patients and families turn for access to treatment
• EDs function at the nexus of multiple systems
3 Waves of the Rise in Opioid Overdose Deaths

- **Other Synthetic Opioids**: e.g., Tramadol and Fentanyl, prescribed or illicitly manufactured
- **Commonly Prescribed Opioids**: Natural & Semi-Synthetic Opioids and Methadone
- **Heroin**:

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<th>Year</th>
<th>Wave 1: Rise in Prescription Opioid Overdose Deaths</th>
<th>Wave 2: Rise in Heroin Overdose Deaths</th>
<th>Wave 3: Rise in Synthetic Opioid Overdose Deaths</th>
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Deaths per 100,000 population
Emergency Physicians Respond

A Grassroots Effort Led by Emergency Physicians to Mitigate the Escalating Opioid Epidemic

Case Study • April 25, 2018

Priya E. Mammen, MD, MPH, Peter Sanaman, MD & Joanmarie Perrone, MD, FACMT
Thomas Jefferson University Hospital
Penn Presbyterian Medical Center
Hospital of the University of Pennsylvania

Number of opioid prescriptions by select EDs, 2011-2016

Source: The Authors
Overdose Prevention

• Emergency Departments (used to) see the majority of near fatal overdoses

• Increased access to naloxone by police and fire and community has improved overall outcomes

• EDs were recognized as the first in the city to routinize naloxone prescribing/distribution and patient and family education prior to discharge.
Increased Access to treatment

- Multiple Barriers to direct referral
- Identification
- Residence
- Insurance
- Timing of presentation
- Treatment options and availability
- Coordination
- Patient engagement
Variation Between EDS
Learning from Variation

Project Engage – Christiana Care
• Innovative program utilizing Engagement Specialists to identify, engage and link patients with OUD/SUD into treatment
• Inpatient consult for OUD/SUD treatment
• Started in 2008
• Dr Terry Horton
  • Internal Medicine, Addiction Specialist
• Client Satisfaction model

Center for Healing
Cooper University Hospital
• Multipronged Program started in 2015
• Low barrier access to care
• ED initiated buprenorphine for withdrawal
  • Home induction
• Collaboration with EMS for outreach, leave behind naloxone, bupe in field
• Inpatient consult
• Dr Rachel Heroz & Dr Matt Salzman
  • Emergency Med, Toxicologists
  • Partner with Internal Medicine, Psychiatry Addiction Specialists
PRINCIPLES OF HARM REDUCTION

**Designs** public health interventions that minimize the harmful affects of drug use

**Understands** drug use as a complex, multi-faceted issue that encompasses behaviors from severe abuse to total abstinence

**Meets people where they are** in the course of their drug use

**Ensures** that people who use drugs have a real voice in the creation of programs

**Affirms** people who use drugs are the primary agents of change

**Empowers** communities to share information and support each other
PRINCIPLES FOR HOSPITALS

**Designs** clinical interventions that minimize the harmful affects of drug use and decrease barriers to care for patients and providers

**Understands** drug use as a complex, multi-faceted issue that encompasses physical, mental and behavioral health and is confounded by Social Determinants of Health

**Meets EDs where they are** in the course of their patient needs, service development and in line with their resources

**Ensures** that Emergency Departments have a real voice in the creation of programs

**Affirms** people who need services are the primary agents of change

**Empowers** all clinicians involved in care for PWUD to collaborate, share information and support each other for the benefit of patients first and providers as a result
Health Systems have a duty to serve

- Requires paradigm shift, innovation, and redesign
- Requires true interdisciplinary collaboration and partnership
- Once size does not fit all
- Time wasted is life lost
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
12/3/19
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 ADMINISTER NALOXONE

- 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
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

Sex

Race/Ethnicity

Insurance Status

The number of hospitalizations attributable to non-fatal opioid poisoning of Philadelphia residents has increased since 2002. In 2019, there were 651 non-fatal opioid related overdoses that required admission to an acute care hospital. Select a year to see the demographic breakdown for that year.
Naloxone Prescriptions Dispensed to Medicaid Beneficiaries in Pharmacies

PDPH
Health
Information
Portal
Opioid Page
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

Address: ____________________________ Date Prescribed: November 18, 2014

RX

Narcan Nasal Spray 4mg

#1 (Two Pack)

Administer as directed PRN for suspected overdose

DRAW 1 No Substitution

Refills: 2

Prescriber: Sue Smith, MD

Signature: ____________________________
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.

Contact:
Prevention Point Philadelphia
2913 15 Kensington Ave.
Philadelphia, PA 19134
(215) 334-5272
www.pppphiladelphia.org
How to Reverse an Overdose

1. 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.

2. 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.

3. 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.

Support our work: bit.ly/PPPgive
Prevention Point Philadelphia
2103-15 Nnamdi Azikiwe Ave.
Philadelphia, PA 19134
(215) 834-5272
www.ppponline.org
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—20 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

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

Sosunmolu Shoyinka, MD,

Chief Medical Officer

Department of Behavioral Health and Intellectual Disability Services (DBHI DS)
Philadelphia Opioid LAN Regional Meeting

Dr. Sosunmolu Shoyinka
Chief Medical Officer
Thursday, December 5, 2019
Philadelphia DBHIDS

$1.6B single-payer system operated by the City of Philadelphia

Within DBHIDS there are six divisions, that oversee services for children, adults, and families:

- Intellectual disAbility Services (IDS) division served 15,487 in FY 2018
- Division of Behavioral Health managed services for 35,815 uninsured individuals in FY 2018
- Community Behavioral Health (CBH) managed mental health and substance use services for Medicaid and had 718,023 members in CY 2018 and served 117,531 members in FY18.
Community Behavioral Health

The only county in Pennsylvania that opted to create its own Behavioral Health Managed Care Organization

501(c)3 organization with a Board of Directors controlled by Philadelphia County

Keeps administrative costs very low - **approximately 7.6%**

Does not retain any assets or benefits; all monies saved are available for City of Philadelphia reinvestment opportunities

Reinvestment opportunities advance the system in priority areas, e.g. Adult Substance Use Partial Hospitalization Program and Children's Mobile Crisis Services
Substance Use Disorder Treatment Continuum

Within DBHIDS, Community Behavioral Health (CBH) manages the behavioral health services for Medicaid beneficiaries while the Division of Behavioral Health (DBH) manages care for uninsured individuals and various recovery support services.

*Coordinated Response to Addiction by Facilitating Treatment (CRAFT)*
Treatment & Services
Mayor’s Task Force to Combat the Opioid Epidemic

- 4 Strategies
- 18 Recommendations
Reducing the Effects of Opioid Misuse and Overdose

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<td>▪ Expand treatment programs</td>
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<td>▪ Health care provider education</td>
<td>▪ &quot;Warm handoffs&quot;</td>
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<th>Criminal Justice System</th>
<th>Harm Reduction</th>
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<td>▪ Treat addiction in jail</td>
<td>▪ Naloxone distribution</td>
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<td>▪ Overdose education and naloxone distribution</td>
<td>▪ Overdose Prevention Services</td>
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Highlights for Treatment Recommendations

**NET 24/7 Access Point** was created to accept individuals with a full range of substance use disorders and withdrawal symptoms for assessment, stabilization, and referral to appropriate level of care with warm hand-off.
Residential Drug and Alcohol Levels of Care (PCPC 4B, 3B, 3C, 2B/ASAM 4, 3, 2) required to provide Medication-Assisted Treatment (MAT)-compatible services by January 1, 2020 through direct capacity to prescribe or connection with a community provider.

CRCs and D&A Providers Offering Detox can elect to provide buprenorphine stabilization.

All D&A Providers incorporate medication-assisted treatment (MAT) options into treatment planning for members.

Discussing OUD treatment options including MAT

Informed consent—risks, benefits and alternatives

Formal agreements where necessary
Increasing Access

**Removed Prior Authorizations** – *Residential Rehab (3B/3.5 or 3.7) and Drug and Alcohol Partial (2A or 2.5)*

**Outpatient levels of care** – *Time to induction*

**Residential levels of care** – *Night and weekend hours*

**Crisis Response Centers (CRCs)** – *Aftercare linkage for members with substance use disorders who are not authorized for residential level of care*
Rate of MAT Prescribing per 1,000 MA Beneficiaries with a Primary OUD Diagnosis, Philadelphia, Q1 2015 - Q2 2019

Number and Rate of Medication Assisted Treatment (Any Medication) for Distinct Medicaid Beneficiaries with a Primary OUD Diagnosis
Number and Rate of Buprenorphine Prescribing for Distinct Medicaid Beneficiaries with a Primary Diagnosis OUD, Philadelphia, Q1 2015 – Q2 2019
Philadelphia DBHIDS In-Network Medication Assisted Treatment Capacity

DBHIDS In-Network MAT Program Capacity (any medication) = 12,386 slots. 3,106 MAT slots are available.
Medication-Assisted Treatment Capacity

<table>
<thead>
<tr>
<th>37 Provider Agencies</th>
<th>Operating 75 Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MAT Capacity – 12,386 slots</td>
<td></td>
</tr>
<tr>
<td>a. Total Occupied MAT Capacity – 9,280 slots</td>
<td></td>
</tr>
<tr>
<td>b. Total Available MAT Capacity – 3,106 slots</td>
<td></td>
</tr>
<tr>
<td>c. Available MMT Capacity – 1,553 slots</td>
<td></td>
</tr>
<tr>
<td>d. Available Non-MMT Capacity (Buprenorphine, Vivitrol) – 1,789 slots</td>
<td></td>
</tr>
</tbody>
</table>

Program Types: Outpatient, Intensive Outpatient, Residential, Partial Hospitalization, Withdrawal Management, and Centers of Excellence

Total MAT Capacity:
- 75% occupied
- 25% available
Thank You

Dr. Sosunmolu Shoyinka
Sosunmolu.shoyinka@phila.gov
MAT Warm Handoff - What is your Method?
Presentation & Case Study

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

Nedson Campbell, MD
Medical Director
Onward Behavioral Health
Case Presentation

Nedson Campbell, MD
Onward Behavioral Health
Medical Director
crisis. So we have created an unprecedented response. We work directly with communities to provide the resources, knowledge and training required to turn the tide.

All 50 states and 9 territories have a designated team in prevention, treatment and recovery under the States Targeted Response Technical Assistance (STR-TA) federal grant. And if that’s not enough, additional consultants are on call.

Please reach out to us today. There is no cost—we are here to help.

OpioidResponseNetwork.org

Every challenge you face (opioid prevention, treatment, recovery) can be addressed. We work closely with you to determine what training and education you need to overcome the identified challenges.

Ask.

Contact us at OpioidResponseNetwork.org to submit a request and a designated Technology Transfer Specialist for your region will get back to you within one business day.

Get Help.

A few examples:

- Build coalitions
- Provide training and technical assistance
- Connect you with clinical mentoring
- Develop educational resources
- Identify local resources
- Create systems of care
- Provide expertise on integrating use of medications for treating addictions into your clinical practices

TREATMENT

Treating opioid use disorder with medications and counseling is effective. Our work includes the following treatment topics:

- Psychosocial interventions
- Pharmacotherapy: buprenorphine, naltrexone, and methadone
- Telepsychiatry/telemedicine
- Pain management
- Buprenorphine induction in the ER
- Implementing medications for treating addictions into primary care

RECOVERY

Patients benefit from recovery support throughout the continuum of care. We provide educational resources and training on:

- Medication-assisted recovery
- Recovery support services
Case 1

- 17yo SBM Drexel Freshman from Egg Harbor, lives in W. Phila dorms, unemployed, no children, and no legal issues.

- Presents via EMS after recent car accident in Fishtown as restrained passenger with no-LOC. 1st degree burn on face from airbag deployment complaining of diffuse pain.

- CT scan negative.
Case 1

- UDS positive for Opiates and asked nurse if he could take his personal “herbal supplement” Kratom to help with pain.

- Experiencing w/d symptoms that include irritability (yelling at nurse), N/V, and chills.

- Admits to regular Percocet use, w/d symptoms, and open to treatment options.
Treatment Cycle I.

- Hospital Bed
- OD
- OutPt Tx
- Mild OUD
- BBC
- Naltrexone
Treatment Cycle II.
Treatment Cycle III.
Plans Converge
Case 2

- 32yo MWM, NE Philly resident, currently homeless (former union plumber), HS grad, 2 children, and felony possession charge pending.

- Found down in front of Wawa on Broad Street

- Naloxone x2 by EMS
Case 2

- UDS positive – Opiates, Cocaine, Bup, and MJ
- Cellulitis on L hand with prominent track marks on L lower arm and neck.
- PMH – asthma with no recent attacks.
Case 2

- Reports h/o 2-3 bundles daily depending on finances

- Tx Hx - detox x6 since 2003 and h/o OD x3
  - Discharged from Eagleville one week ago

- Meds- Gabapentin 300mg PO TID from PCP
Thank You!
Wrap Up and Next Steps

Kate Slatt
Vice President, Innovative Payment and Care Delivery
The Hospital and Healthsystem Association of Pennsylvania
Upcoming Key Dates

• December 12, 2019 Webinar
• December 19, 2019 Webinar
• January 9, 2019 Webinar
• January 16, 2019 Office Hour Call
• Ongoing Collection of Tools/Resources

Submit to mkenyon@haponline.org
Thank You!

Please fill out the following evaluation by December 12th

https://www.surveymonkey.com/r/lan-120519