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

Monday, November 25, 2019
7:45 AM - 10:30 AM

UPMC Shadyside | Herberman Conference Center
Welcome and Opening Remarks

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

Michael Lynch, MD
Emergency Department Physician and Medical Director for Substance Use Disorder at UPMC
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

Rachel Shuster, BSN, RN, CARN, CAAP
Center for Opioid Recovery, OUD-COE, UPMC Presbyterian, Montefiore Hospital

Stephanie Klipp, RN, CARN
Addiction Consult Service, UPMC Presbyterian Hospital

Kyle Harder
Director, Business Development, Gateway Rehab
OUD Screening Processes: Are You Missing Anything?

Rachel Shuster, BSN, RN, CARN, CAAP
Kyle Harder
Stephanie Klipp, RN
Screening Tools for Substance Use Disorders (SUDs)

• Multitude of **validated** tools:
  
  • [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)

  • Variations in screening for:
    • Alcohol versus other substances
    • Adults versus adolescents
    • Self-administered screens versus clinician-administered
SUD Screening/ Assessment Tools for Adults

• Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
  • 14 items

• CAGE-AID (CAGE questionnaire expanded to include other drugs in addition to alcohol)
  • 4 items

• NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)
  • If using the following link, the tool will automatically tally at the conclusion of the questionnaire
    • [https://www.drugabuse.gov/nmassist/](https://www.drugabuse.gov/nmassist/)
SUD Screening/ Assessment Tools for Adolescents

- Screening to Brief Intervention (S2BI)
- Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
- NIDA Drug Use Screening Tool: Quick Screen (NMASSIST) – *adapted version for adolescents*
- CRAFFT
SBIRT: Screening, Brief Intervention, and Referral to Treatment

- Recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA) for those with SUDs and those at risk
- Early intervention helps
- But … don’t forget:
  - Meet people where they’re at
  - Harm Reduction
- Reimbursable for billing: [https://www.samhsa.gov/sbirt/coding-reimbursement](https://www.samhsa.gov/sbirt/coding-reimbursement)
Important Takeaways

• Understand the implications of misdiagnosis
  • Patients with acute/chronic pain
  • Patients with risky use
  • Mild/moderate/severe SUDs
• Patients with OUD are no less deserving of adequate pain management
  • Opioid analgesics should be considered when appropriate
• Ensure non-stigmatizing, person-first language both in verbal communication and in written documentation
  • Because words matter!
• DISCLAIMER: Despite these recommendations, ask people about their preferred terminology (if appropriate) – this is especially important for other non-SUD labels and diagnoses
## Words Matter: Let’s Change the Narrative

<table>
<thead>
<tr>
<th>STIGMATIZING LANGUAGE 😞😞</th>
<th>Non-Stigmatizing Language 😊😊</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict/Alcoholic</td>
<td>Person with a Substance Use Disorder</td>
</tr>
<tr>
<td>Substance/Drug Abuser</td>
<td></td>
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<tr>
<td>Abuser/User</td>
<td></td>
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<tr>
<td>Drunk/Junkie/Tweaker/Bum/etc.</td>
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<tr>
<td>Drug Habit</td>
<td>Substance Use Disorder / Addiction</td>
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<tr>
<td>Abuse</td>
<td>Use/Misuse</td>
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<tr>
<td>Drug Problem</td>
<td>Risky, Unhealthy, or Heavy Use</td>
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<tr>
<td>Clean</td>
<td>Person in Recovery</td>
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<td></td>
<td>Abstinent</td>
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<tr>
<td></td>
<td>Not Drinking or Using Drugs</td>
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<tr>
<td>Addicted Babies/Born Addicted</td>
<td>Babies Born with an Opioid Dependency</td>
</tr>
<tr>
<td>Clean/Dirty (re: toxicology screen results)</td>
<td>Negative/Positive</td>
</tr>
<tr>
<td>Substitution or Replacement Therapy</td>
<td>Pharmacotherapy</td>
</tr>
<tr>
<td>Medication-Assisted Treatment</td>
<td>Treatment or Medication for Addiction</td>
</tr>
<tr>
<td></td>
<td>Medication for [SUD/OUD/AUD/etc.]</td>
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</tbody>
</table>
OUD Screening Processes: Are You Missing Anything?

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Stephanie Klipp, RN
Highlighting Harm Reduction Strategies Throughout the Region

Presentation

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

Alice Bell

Overdose Prevention Project Coordinator

Prevention Point Pittsburgh
Harm Reduction Strategies for a Public Health Crisis

Alice Bell, L.C.S.W.
Overdose Prevention Project
Prevention Point Pittsburgh
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Harm Reduction Services

- **Providing Sterile Injection Equipment to prevent HIV & Hep C since 1995.**
- Testing for HIV and Hepatitis C
- Case Management, assistance to treatment
- Crisis Intervention & Counseling
- Overdose Prevention & Response Training
- **Naloxone Distribution since 2005.**
- Wound Care Consultation Clinic
- Education on safer injection.
- Fentanyl test strips for drug checking
- All Services Free of Charge
- Anonymous/Confidential
- Low Threshold
Allegheny County Accidental Drug Overdose Deaths
2000-2017*

85% of cases include more than one drug

PPP implemented naloxone program
OxyContin Reformulation

*Data from Allegheny County Medical Examiners Annual Reports. Includes all overdose deaths where these drugs were present at time of death, alone or in combination with other substances.
People who are dependent on prescription opioids and can’t get them anymore — whether because their physician, afraid of consequences, has stopped writing prescriptions or because the street supply has dried up — have three choices, said Clark. They can quit, they can go to treatment or they can turn to heroin... in many states there is no coordination between the enforcement against overprescribing of opioids and the need for treatment for people who are dependent and can’t quit... And there is still a pervasive attitude against agonist medications like methadone and buprenorphine, even among many in the substance abuse treatment community. The unintended consequence of the successes in reducing prescription drug abuse may well be an increase in heroin use, said Clark, noting that medication-assisted treatment has resulted in reducing HIV and hepatitis by reducing needle sharing.”

“Of course, the consequences are "unintended," but that doesn’t mean they couldn’t have been foreseen. “It was never the intention to force people to take heroin,” said Clark. “But if you shut down treatment, and there is an increase in heroin, there will be an increase in HIV, increase in hepatitis, increase in crime, increase in complications associated with using and an increase in international criminal activity.” There will also be an increase in overdoses, which is painfully ironic given that the main reason prescription opioids have had so much attention is the overdoses. “You can predict the dosages that will cause overdoses with prescription medication,” said Clark. “But with heroin, you’re moving to a market where not only can you not predict the dosage, but you can’t predict the quality — you can’t predict anything — and the risks really start to climb.”

- Quoting H. Westley Clark, M.D., director of SAMHSA’s Center for Substance Abuse Treatment (CSAT) in 2012
Supply Reduction Without Increased Access to Treatment and to Naloxone Had Devastating Consequences.

- Since 2010 Prescription Opioid Overdose deaths plateaued, but overall opioid overdose deaths more than doubled, primarily driven by illicit fentanyl overdose deaths.
- In addition to overdose deaths, Hepatitis C infections have increased 250% since 2010. Rural states have seen Hep C increase of 364%.
- HIV Outbreaks: Over 200 injection-related HIV cases rural, Scott County, Indiana, from 2015 outbreak.
- Lowell/Lawrence, MA – 129 cases of HIV; CDC concerned about possible outbreaks in small towns/rural areas without access to SEP.
- Huntington WV - 80 injection-related HIV cases, up from 8 or 9 annually.
- Restricting access to sterile injection equipment is not effective strategy.
EFFECTIVE NALOXONE DISTRIBUTION
Prevention Point Pittsburgh
Cumulative Data - July 2005- June 2019

97% of Naloxone Rescues Performed By Individual Who Use Opioids

Total Number of Individuals Who Received Naloxone
Total Number of Overdose Reversals

Third Party Implemented
NUMBER ONE priority: Put naloxone in the hands of those most likely on the scene and first to respond, individuals who use opioids, themselves. Reached through SSP’s, Jails, Hospitals, SUD Tx Programs, Homeless Service Programs, Medical Clinics.

Make naloxone EASILY available and plentiful enough to saturate communities of people who use drugs. Pharmacy dispensing has had minimal impact as PWUD’s are not likely to access. Hospital dispensing is essential component of effective strategy.
An almost 2000% increase in naloxone distributed through SSP, jail, hospital ED's, SUD Tx Providers, Pharmacies, ACHD.

The U.S. Drug Enforcement Administration reports that the number of people in Pennsylvania who died of drug overdoses decreased by 18 percent between 2017 (5,456 deaths) and 2018 (4,492 deaths).

Allegheny County was responsible for 32% (305 out of 964) of the decrease in deaths seen 2017-2018 statewide.
Allegheny County, Pennsylvania
Accidental Drug Overdose Deaths 2000-2018

2018: 41% Decrease in Deaths

2018: 77% of deaths involve Fentanyl and/or analogues
87% of cases include more than one drug

*Data from Allegheny County Medical Examiners Annual Reports. Includes all overdose deaths where these drugs were present at time of death, alone or in combination with other substances.*
“If you believe that the opioid epidemic is in fact iatrogenic, as you do, if you believe we must restrict prescribing to reverse it, then we have the highest ethical standard to not further harm people as we try to fix this problem.

Akin to a surgeon removing an instrument left in an abdomen, we would not rip out what we left behind and tell you to get out of our office.

We would very carefully repair the problem and serve you with the utmost care and caution until that issue and any complications were managed. “

Phillip Coffin, MD, MIA
San Francisco Department of Public Health
Plenary Session Harm Reduction Conference, Baltimore, MD
October 23, 2014
The Medication IS the Treatment rather than “assisting.”

Research shows people do just as well on bup or methadone alone as methadone plus counseling.

Counseling, therapy, support groups can undoubtedly be beneficial for some, BUT the benefits of medication are not contingent on auxiliary treatment.

In the age of fentanyl, refusing medication to someone because they don’t go to counseling may be a death sentence! Opioids Replacement medication should be more easily available than illicit fentanyl in order to reduce deaths.

MA Retention in OUD Treatment
An emergency response to the opioid overdose crisis in Canada: a regulated opioid distribution program

Mark Tyndall

Simply warning people to avoid fentanyl or the plethora of new synthetic analogs is both naive and ineffective.

Although it is widely accepted that liberal prescribing practices have contributed to the current crisis, encouraging physicians to reduce their opioid prescriptions in an environment where the illegal alternatives are lethal is harmful. Abruptly cutting people off their prescription will likely lead to withdrawal. A reduction in the overall number of prescriptions creates a shrinking supply of diverted drugs, the unintended consequence of which may be to push people, many of whom were not even known to be chronic opioid users, into much more unstable and dangerous drug markets. People who once had consistent access to either prescribed or diverted pharmaceutical opioids are suddenly in grave danger of being poisoned by a single lethal purchase.

Although a number of important “upstream” interventions are critical to our response, including a functioning system for treating addiction, supportive housing programs, screening programs for at-risk youth, a cultural shift in how we view drug users and a reduced reliance on the criminal justice system, these will come too late for the families who will lose a loved one this year or the next. We cannot simply give up on the current group of chronic opioid users who are playing a form of “Russian roulette” with every injection or inhalation.

The public health response to any poisoning epidemic should be to provide safer alternatives for people at risk. In the case of the overdose crisis, this would mean providing a regulated supply of pharmaceutical-grade opioids to people at highest risk of overdose. Any options to expand access to pharmaceutical-grade opioids runs counter to prevailing narratives regarding the origins of the current overdose crisis. However, it is now clear that the rapid rise of overdose deaths across the country is a result of illegal, unregulated and lethal synthetic compounds that have largely replaced the regular street supply.
Hepatitis C, increased by more than eight-fold in the 10-county Southwestern Pennsylvania region — climbing from 335 cases in 2003 to 2,818 in 2014, driven by the spike in injection drug use and shared needles, creating an explosion of hepatitis C among younger injection drug users.

Sterile syringes cost about 7 to 10 cents each (about $185/year average) when purchased in bulk, compared to the cost of treating hepatitis C — which can range from $50,000 to $80,000.

New data from West Virginia DOH revealed 1,114 newly reported chronic hepatitis C cases in 2018.
Provide Access to Sterile Injection

- Prescribing syringes should be one element of a comprehensive relationship between the physician and the patient and should be done within the context of the patient's overall medical and health needs, as part of a non-judgmental, culturally sensitive interaction that includes an openness to discussing injection-related activities and a willingness to provide links to other needed programs and services.

- Physician prescription of injection equipment is legal in 48 jurisdictions to legality.

- Physicians generally have broad discretion to prescribe drugs and devices that they believe are medically beneficial for their patients. Several major medical and legal societies, including the American Medical Association, the Infectious Diseases Society of America, and the American Bar Association all support efforts to improve IDUs' access to sterile syringes, including physician prescription.
Key Findings
Evidence from randomized controlled trials of HAT in Canada and Europe indicates that supervised injectable HAT — with optional oral methadone — can offer benefits over oral methadone alone for treating OUD among individuals who have tried traditional treatment modalities, including methadone, multiple times but are still injecting heroin.

Although heroin cannot be prescribed in the United States because it is a Schedule I drug, it would be legal to conduct a human research trial on HAT. The literature on treating OUD with hydromorphone (e.g., Dilaudid) is less extensive than the literature on HAT; however, the existing results are encouraging. Hydromorphone trials in the United States would face fewer barriers than HAT trials.
Safe drug-use rooms are typically designed to help keep people who use drugs out of the hospital, but they could work within hospitals. A safe place to inject for patients in the hospital could reduce conflict with staff, protect patients and providers from needle sticks and other hazards, and enable patients to receive respectful, high-quality care in their hospital beds. Safe drug-use rooms could also offer treatment for addiction, a step often neglected in hospitals.

Alternatively, if patients are prescribed medications they need of the type needed, in adequate doses and with sufficient regularity to ensure they remain comfortable and do not experience withdrawal symptom, patients may not need to provide their own medications in the hospital and reduce conflicts, leaving AMA, and the need for staff to adopt a police role.
Of 73 visits to PPP’s wound care consultation program, when people were asked the question “If you hadn’t come here for this problem, where would you have gone?”

- 9 people reported they would have gone to ED.
- 19 stated they would have gone to a “clinic,” “urgent care,” or their PCP.
- 50 stated they would have done “nothing” or treated the problem themselves.
Harm Reduction Practices in Hospitals

- **Reduce Overdose Deaths:**
  - Provide naloxone in hospital ED’s and other outpatient settings. People should leave with naloxone!
  - Dispense buprenorphine and insure additional doses available.

- **HIV, Hep C, Endocarditis, soft tissue infections.**
  - Offer testing for HIV, Hep C.
  - Prescribe/Dispense sterile injection equipment.

- **Foster effective, compassionate, provider relationship with patients. End “policing” role, prevent patients leaving AMA.**
  - Provide medication to prevent withdrawal symptoms and keep patient comfortable.
  - Treat whatever health issues people present with.
“Harm reduction is the radical notion that drug users are people.”

– [Iowa Harm Reduction Coalition](#)
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 & Case Studies

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

Ashley Potts, LCSW
Senior Project Manager Highmark Inc.

Skyler Hoyle, RN
Nurse Navigator, Addiction Medicine, Center for Inclusion Health, Allegheny Health Network
Addiction Medicine

• Addiction Medicine (AM) at Allegheny Health Network was developed to assist individuals with substance use disorder gain access to appropriate treatment.
• The AM team develops care pathways and warm handoffs for individuals into evidenced based care
• Sees patients in the emergency room, inpatient hospital floors and outpatient clinics
• Works directly with other hospital disciplines to ensure quality of care
• Robust multidisciplinary team consisting of physicians, nurse practitioners, physician assistances, registered nurses, social workers and certified recovery specialists
Case Study

• 26 y/o female with a history of OUD presented to the ED at 12pm on a Tuesday.

• Patient was given Narcan and stabilized. She was interested in treatment options.

• AM was consulted: pt reports she was doing well until a relapse a two days ago. She was on buprenorphine in the past and was interested in resuming this treatment.

• Patient was alert and oriented. She was provided with Clonidine, Vistaril and Zofran to manage her withdrawal through the night at home.

• She was provided a prescription of buprenorphine and educated on dosing to reduce/prevent precipitated withdrawal. Pt also received a prescription of Narcan.

• The patient was provided a follow up appointment with AM clinic that Friday to continue her treatment
Barriers
Questions

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Wrap Up and Next Steps

Jennifer Jordan
Vice President, Regulatory Advocacy,
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 2nd

https://www.surveymonkey.com/r/lan-112519