Geisinger

Testimony on Confronting the Heroin/Opioid Epidemic in Pennsylvania
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Good morning. Thank you for inviting me to discuss confronting the heroin/opioid epidemic in Pennsylvania. My name is Christopher J. Wilson, MD. I am an Assistant Residency Director and Associate Staff Physician in the Department of Emergency Medicine – Geisinger Medical Center. I am speaking before you on behalf of the Geisinger Health System which is the nation's largest rural health services organization and a vertically integrated delivery system.

Emergency Medicine Perspective

1. Providing and training Police and BLS services in PA with naloxone will undoubtedly save lives and is a huge step in an effort to prevent deaths from overdose of Heroin/Opioids.
    a. This, however, is an acute treatment of an emergency and is not a cure for the addiction
2. There are the immediate life threatening effects of Opioids in the acute overdose whether it be unintentional or in a suicide attempt but there is also very significant and possibly fatal risks of chronic heroin/opioid abuse and injection. Which include but not limited to:
    a. The risk and transmission of Hepatitis C and HIV
    b. Cirrhosis of the liver
    c. Subcutaneous abscess, cellulitis, compartment syndromes, and necrotizing fasciitis
    d. Deep vein thrombosis, venous insufficiency, and thrombophlebitis
    e. Bacterial endocarditis
    f. Septic emboli
    g. Septic arthritis, osteomyelitis, and spinal epidural abscess
    h. Acute ischemia of the limbs
3. It also has to be mentioned the enormous toll that chronic drug abuse/addiction takes on the family members of loved ones who are addicted. I believe others will/have speak to this issue today.
4. The patient may present to the Emergency Department in acute withdrawal from opioid addiction. Symptoms that present as such:
    a. Agitation and anxiety
    b. Nausea, vomiting, diarrhea, and abdominal cramping
    c. Rhinorrhea, yawning, piloerection, sweating and lacrimation
    d. Diffuse muscle pain and cramping
    e. Mydriasis
5. These symptoms are so incredibly uncomfortable this can be a major contributor to why opioid addicted patients, even those who wish to quit, go back to abusing narcotics.
    a. As we can attempt to manage these symptoms medically to the best of our ability with non-narcotic medication, often there is no substitute for opioid replacement therapy like methadone and suboxone.
6. In terms of referral via the Emergency Department for presentations of opioid related complaint this is really a divergent issue.
    a. There are the acute overdoses which necessitate medical treatment and often hospital admission prior to being medically stable for transfer/referral to an opioid treatment facility. There is obviously more time for appropriate social work/case management referrals to take place.

i. There are also those patients who are admitted for psychiatric treatment in which drug abuse significantly contributes to and complicates their treatment, and after psychiatric care need appropriately be referred to a drug/alcohol treatment facility.

b. The second presentation are those who walk in stating they want treatment for his/her addiction or those presenting in acute opioid withdrawal who want medical treatment without resumption of IV drug use or illegal purchase of oral/transdermal narcotics.

7. For the purpose of the emergency department this is what the state has termed the "warm hand-off" the acute referral of those wishing/needing drug rehabilitation.
    a. Particular issues with acute referral include that there is quite often a "dual diagnosis" of psychiatric illness as well.
        i. This can become particularly problematic as there are few facilities equipped with relatively limited # of beds to appropriately treat these "dual diagnosis patients".
    b. At the facility which I practice now, we have luxury and privilege to work with an ED social worker who is incredibly helpful in the management and disposition of patients seeking rehabilitation "warm hand-off" scenario.
        i. Although this is not a 24/7/365 service, as this is just not realistic, certainly we see some of the difficulties facilities without these resources face in the "warm hand-off".
        ii. The reality is I have been asked to provide testimony to the Center for Rural Pennsylvania and most hospital emergency departments which fall into the locals of PA you represent do not have this very valuable resource so this referral process is left to the providers and often emergency nurses which can be daunting as they are caring for often multiple acutely ill patients while trying to accomplish this task.
    c. Another complication is that rarely ever is it a solitary drug addiction. Many patients abuse multiple drugs and alcohol at the same time. While opioid withdrawal can be quite uncomfortable, acute alcohol and benzodiazepine withdrawal may be life threatening so facilities that treat such must consider all substances being abused.
    d. In speaking with social workers and nurses these referrals for acute treatment can be problematic as facilities often employ call services so a referral is made to often out of state service that then contacts the facilities and can often be a significant delay in knowing if patient will even be considered for admission and if there are treatment beds available. One person termed it more of a "lukewarm hand-off".
    e. The reality of it is there are not always beds available for acute inpatient treatment so often patients are discharged or decide they no longer want to wait and go home from the emergency department with a referral to an inpatient treatment facility or ambulatory/county based referral to facilities for the outpatient opioid replacement therapy.
        i. Or simply pamphlets with the numbers to provide call for treatment themselves.
    f. The trouble with this is when a patient with addiction arrives home to this environment they likely will relapse and abuse the longer time goes by before attempted rehabilitation can take place.
        i. Even after treatment, when returning to the previous environment, relapse often occurs.

8. In terms of emergency medicine as providing testimony for all emergency medicine providers whether, working at a small community hospital or a large tertiary referral center, no matter what resources are available if a one-call system whether statewide or regional could be

instituted. I truly believe it would make a dramatic impact on referral for treatment of both opioid and all addictions.

a. I know other states have attempted to do this and I do not know for what degree of success they have achieved.
    i. This specifically for Emergency Medicine could be dramatic. If providers knew there was a uniform procedure to establish a "warm hand-off", I believe there would be a dramatic increase in utilization and referral.
    ii. This would not be limited to EM both Primary Care providers and inpatient caregivers could establish referral through this same process.
    iii. If this one call could allow a decision tree for both ambulatory and inpatient referral it would ease the burden to the emergency providers.
    iv. I truly believe physicians uniformly want what is best for their patient and if an avenue is made for this an impact may be made on the opioid problems in Rural PA.

Geisinger is proud to have "proven" that you can reduce cost while improving quality and outcomes, thereby enhancing the overall "value" for patients, employers, and the government.

We look forward to continuing to work with the various state agencies, the state legislature, and the Administration on developing smart healthcare policy that supports improving the experience of healthcare, improving the health of populations, and reducing per capita costs of healthcare.

Thank you.