Washington Drug &
Alcohol Commission, Inc.
One Day at a Time.

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To: Senator Gene Yaw, Chairman
The Center for Rural Pennsylvania

From: Cheryl D. Andrews, Executive Director
Washington Drug and Alcohol Commission,Inc.

Re: Confronting the Heroin/Opioid Epidemic in PA; specifically warm hand-off
The Fez, 2312 Broadhead Road, Aliquippa, PA 15001

On behalf of the Washington Drug and Alcohol Commission and the many faces of those afflicted with the disease of addiction, I thank you, Senator Yaw, and the other legislators present today, for your display of leadership and commitment to addressing this horrific epidemic that we are facing today. I thank you for holding these public hearings; it provides the opportunity to gain more information and education; which ultimately leads us to purposeful action. The Pennsylvania treatment infrastructure should not be viewed as a stand-alone system—it simply cannot solve all the problems in isolation—it requires all systems working together—including healthcare—in order to develop a seamless human services delivery system. Act 139, the funding of the state prescription monitoring system, and enacting Medicaid expansion are all exemplary of your commitment to this issue and again, I thank you for being able to testify today.

I am to speak specifically to warm hand-off policy today. I need to supply the panel with a little bit of background information. Overdose survivors are now considered a priority population by the PA Department of Drug and Alcohol Programs (DDAP). A priority population MUST be offered admission into the recommended level of care IMMEDIATELY. If the SCA chooses to restrict access to assessment and or admission to treatment, such restrictions shall not apply to priority populations. There are 5 priority populations:

1. Pregnant injection drug users
2. Pregnant substance abusers
3. Injection drug users
4. Overdose survivors and
5. Veterans

DDAP defines an overdose as a situation in which an individual is in a state of requiring emergency medical intervention as a result of the use of drugs or alcohol. In order to ensure expedient, appropriate and seamless care for an individual who has overdosed, SCA's (that's me) must develop, implement, and maintain a plan for screening, assessment, treatment and tracking individuals who have survived a recent overdose.

The SCA must:

1. **Have a process by which an overdose survivor will be offered a 24/7 direct referral from the ED to treatment. This is accomplished by using one of seven models that are provided by DDAP.**
    - Washington SCA utilizes several models: **"SCA Agency Model"** which designates one mobile Case manager for all three Emergency Departments within Washington County. The Second we use is the **"Certified Recovery Model":** This is where a CRS is deployed to the ED to provide a true intervention; a peer to peer engagement to begin the discussion of treatment and recovery. Finally, the Third type is the **"Direct Referral to Treatment by Hospital Staff"**: this is where the hospital staff will make a direct referral to a SUD treatment facility. This is the warm hand off concept: to seamlessly transfer the OD survivor from the ED to a treatment facility; this is a really great idea, but there are major challenges:
        - ✓ Ideally the OD survivor presents in the emergency department; ideally the ED staff have been trained and know how to make a referral to the SCA; ideally the OD occurs between 8:30AM-4:30PM Monday-Friday; Ideally there is a treatment bed available immediately and if the bed is available, the OD survivor has transportation to get there.
        - ✓ Washington County has had over 50 OD reversals by first responders other than EMS. By the time the ambulance arrives, the survivor is awake, alert, and beginning to show signs withdrawal. Many survivors refuse transport. If the OD survivor DOES get to the ED—it is VERY problematic orchestrating a bed to bed transfer—most often the survivor is discharged from the ED and sent home. They are given information and a phone number to call—and we all know that each one of these individuals picks up the phone the very next day at 8:30AM and schedules an assessment appointment.
        - ✓ What I discovered: there were far more obstacles than there were wide-open pathways. It was time to think outside of the box to try to accomplish the requirements that I must meet to help an overdose survivor. Please keep in mind that there are 47 single county authorities and we are all structured slightly different; however we are striving to meet the demand that is set before us. Also, think about all of the hospitals and their unique protocols related to OD survivors.

2. **Who are the parties involved and who does what?**
    - This seems relatively simple, but when it comes down to different shifts at any given hospital and staff covering shifts, etc, sometimes what is written down on paper doesn't always get carried out in the same fashion each time. There is a human element present; both on the part of the OD survivor AND the hospital staff and the realization that neither want to take it to the next level; whether the OD survivor is not ready for

treatment or the Hospital ED is overwhelmed with seemingly more emergent issues at that given time. The fact remains that it is not enough to write a protocol down and expect everyone to adhere to it.

- This is where it is important for the SCA (or whoever is providing the warm hand-off service to have a presence at the hospital (a real presence). The SCA staff should attend hospital trainings and early morning huddles to understand the flow of the ED as well as gain the trust of the Hospital staff. The SCA needs to help facilitate education and training opportunities for all hospital staff in order to reduce the stigma associated with substance use disorders.
- Ideally, the SCA should be involved with the hospital policy council in order to know hospital protocol and how best to interface when implementing new protocol related to OD survivors

3. Timelines for the process we have in place

- It is imperative to have some type of 24/7 access—same number; same response team; it becomes way too confusing when there is a normal business hour number to call and a separate afterhours number. Ideally, we want everything occurring in real time.

4. SCA must have a tracking mechanism for referrals and refusals to treatment

- Not all OD survivors are presenting in the ED. Those that do we can track; however there seems to be a reluctance on the part of the hospital to share this information. The SCA does not need any identifying information; just the stats. Again, this is not a true picture of the total number of overdoses
- Washington SCA has partnered with the Office of Public Safety to receive statistics on all 911 calls that have responded to an overdose; we are working to track how many OD survivors have been transported to an ED and how many refused
- Another barrier: some individuals are transported to a ED outside of Washington County. These SCA's and/or hospitals may not have the same protocols in place; therefore, the OD survivor may never be identified.

Many who know me know that I am solution focused—We all know about the problem; so let's change the conversation to solution. When it comes to warm hand off—it is the mission of Washington Drug and Alcohol to be present in the moment; we do not want to miss any opportunity to introduce an OD survivor to the world of treatment and recovery. Quite frankly this process began in July of 2015; however, the budget impasse put a stop to all efforts—including the warm hand-off. Once funding was restored, it has taken another 6 months to actually put some thoughts into action.

1. Effective June 8th the SCA will have an on-call service that will operate 24/7. This line is not for the general public—we want the general public to call 911. This line is for first responders; hospitals, and EMS workers who have reversed an overdose. Potentially, the on-call staff can respond to the scene of the OD and provide a true intervention, if the individual is refusing transport. If the OD survivor agrees to be transported to the hospital, we will dispatch a worker to the ED to begin the screening, assessment and referral process.

2. The SCA has now employed 1 full time Case manager and 1 full time Certified Recovery Specialist who will dedicate their workdays fully to the needs of the hospital
3. The SCA is working with a local residential treatment provider to expand bed capacity as well as having a bed available specifically for those who have survived an OD and who agree to enter into treatment. If a bed is not immediately accessed, the SCA staff will provide daily interim services for the client to minimize the chances for overdose until the bed becomes available.
4. The SCA is planning to conduct a root cause analysis on all overdoses over the past 3 years. The demographics are changing—we feel if we can better understand the make-up of those who have not survived an overdose, we may be able to better strategize to reduce this number. Outside of the regular factors: we want to know if these individuals have recently been in the drug and alcohol system and/or the mental system; have they recently been released from jail; geographic location of the incident; were there physical health issues; were they prescribed some form of MAT—methadone; suboxone, or vivitrol, etc.. This information is important in order to determine the best intercept points to start the conversation on overdose prevention and possible distribution of Narcan.

Addiction is a disease—Addiction is a public health crisis and we must address it as such. Our nation is a civilized society, we provide the best possible medical care to those who have other medical conditions such as cancer or heart disease; why is it then, as a civilized society, have we determined that coffins and cages are the best remedy to those with the disease of addiction. I personally don't think that BIG government is the answer to this crisis; however, as legislators, I respectfully request that when you enter into the conversation related to this issue; or think about proposing legislation; that you do so in a Bipartisan fashion. Together we are beginning to change the culture within our local communities, state and nation. It may be to our advantage to identify some best practices from other states related to warm hand-off; rather than each individual SCA trying to create a possible remedy from scratch. Perhaps some sort of structured template or definition that spans all the disciplines so everyone can be on the same page—Ultimately, if done correctly, there would be no wrong door when it comes to entering an Emergency Department as an OD survivor.