



How RU with an ARU?

1-Year Update on the Philadelphia Mayor's Opioid Crisis Task Force

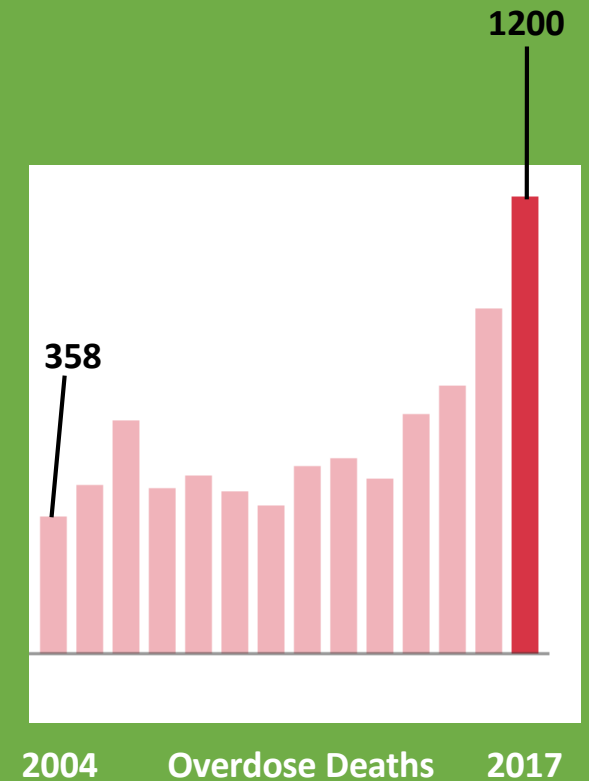


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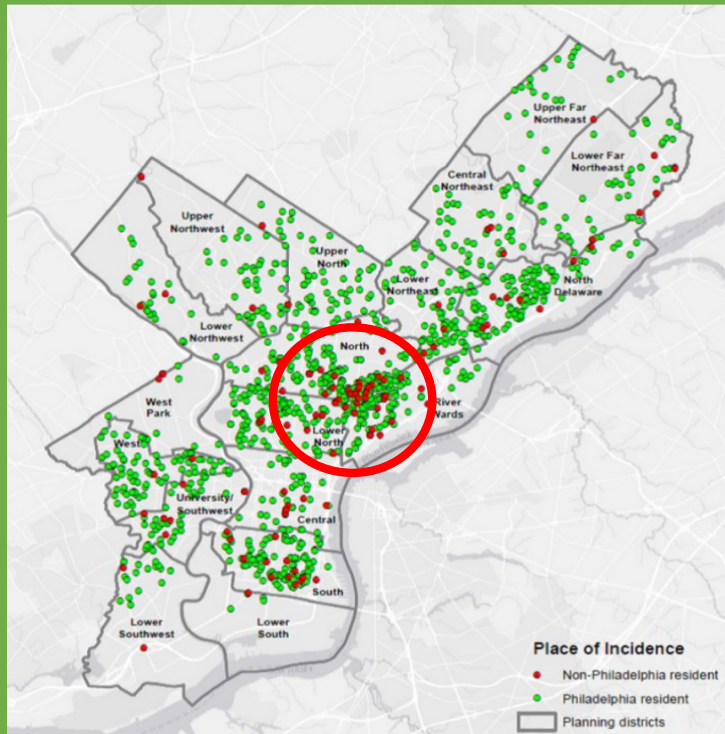
EMS Medical Director
Philadelphia Fire Department

Some Philadelphia Context

- Over 1,200 overdose deaths in 2017
- 4 times the homicide rate
- ~ 80% of ODs due to opioids
- Highest death rate of any major U.S. city
- Heroin purest, cheapest on East Coast



Overdose Deaths, 2014-2015



Medical Examiner's Office, Philadelphia Department of Public Health

- Kensington
 - Poorest neighborhood in America's poorest big city
 - Easily accessed by highway, public transportation
 - Destination for drug tourists
 - Largest open-air heroin market on East Coast



Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia, 2017

- Recommendations:
 - Media campaign re opioid risks, treatment
 - Better education of health care providers
 - Increased access to treatment
 - Making naloxone more available
 - Rapid response plan to identify outbreaks in real-time, quickly deploy to minimize harm



City's Response

- Cleaned up *El Campamento* and tracks
 - People moved to underpasses
- Increased shelter, drug treatment capacity
- Filed lawsuit against opioid manufacturers
- Investigating setting up Comprehensive User Engagement Sites (CUES)
 - Safe places for injecting, access to services



More Context – An Opportunity?

- Between 2014-2017, number of pts given naloxone rose from 2,102 to ~5000
- Over past year refusal rate after naloxone rose from 8-15%
- Is there a way to help those who refuse transport?
 - *One of the busiest EMS systems in the country*
 - *Nearly 297,000 annual ambulance runs*
 - *On routine basis run out of ambulances to send to calls*

PFD Alternative Response Unit (ARU)

- ODs constitute only ~ 5% of call volume
- Must preserve resources for other 95% of calls
- City to fund Alternative Response Unit (ARU)
 - Staffed by EMS officer, social worker, recovery specialist
 - Operate in Kensington, respond with ambulances to OD pts
 - Warm handoff to those refusing transport, coordinate f/u
- ARUs may be way to preserve resources, get pts to f/u care
 - *Will report back next year...*

2018 EMS STATE OF THE SCIENCE Gathering of Eagles

Columbus Discovers a New World: An Addiction Stabilization Center as an SOP



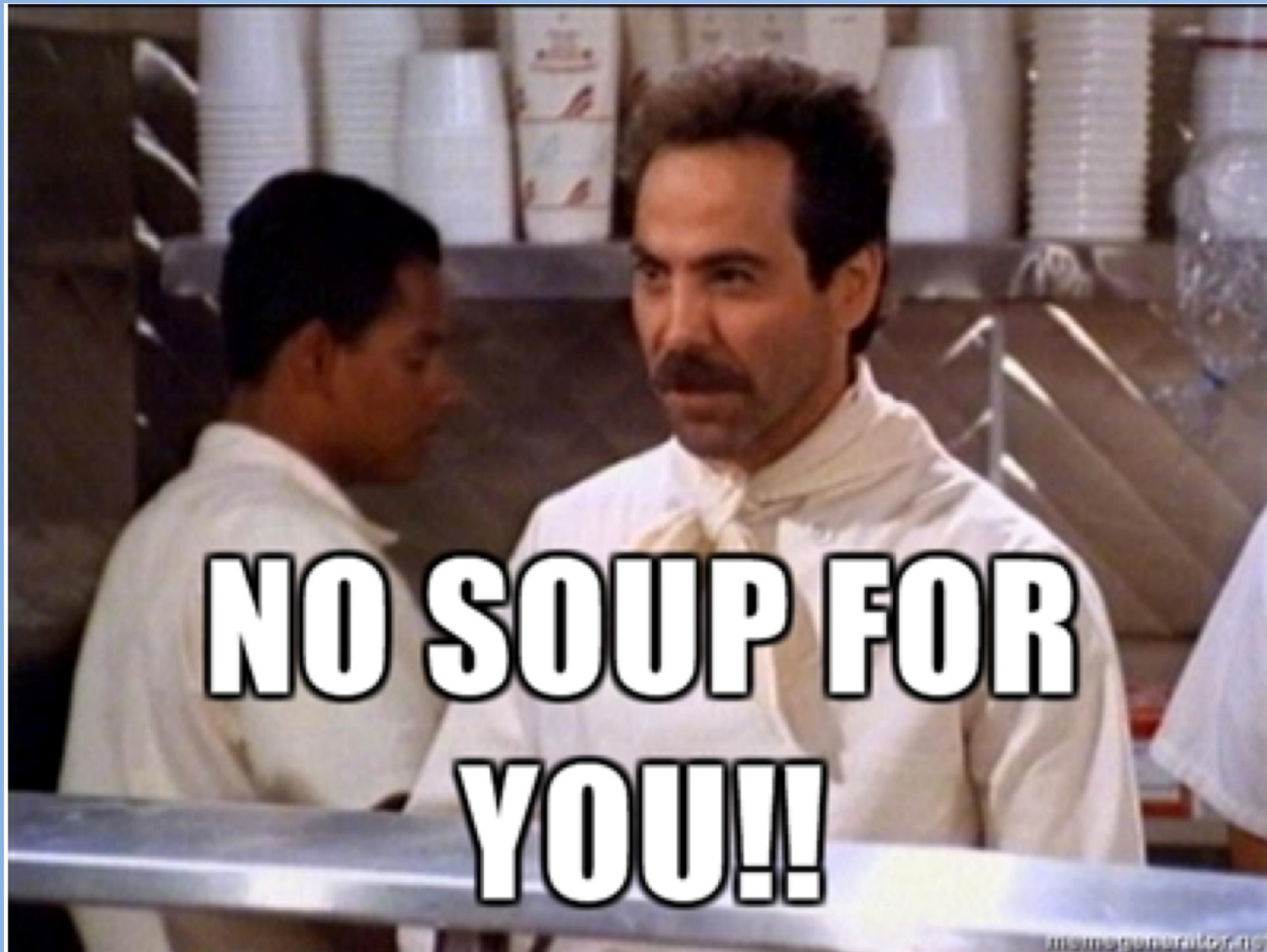
Dr. David P. Keseg M.D. FACEP

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Disclosures



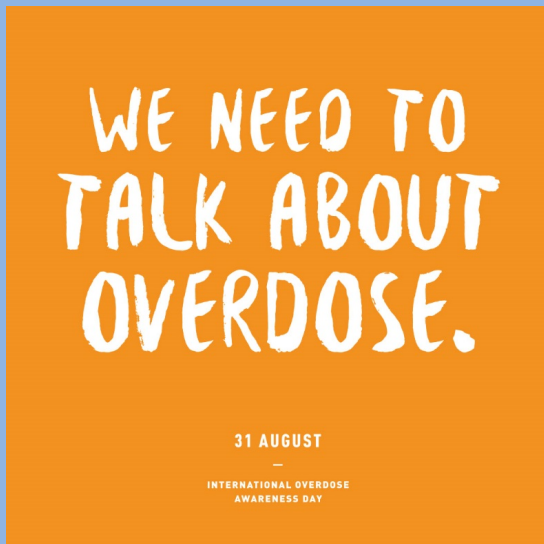
***Is there a better way
to break the cycle of
opiate abuse besides
routine transport to
the Emergency
Department?***

Background

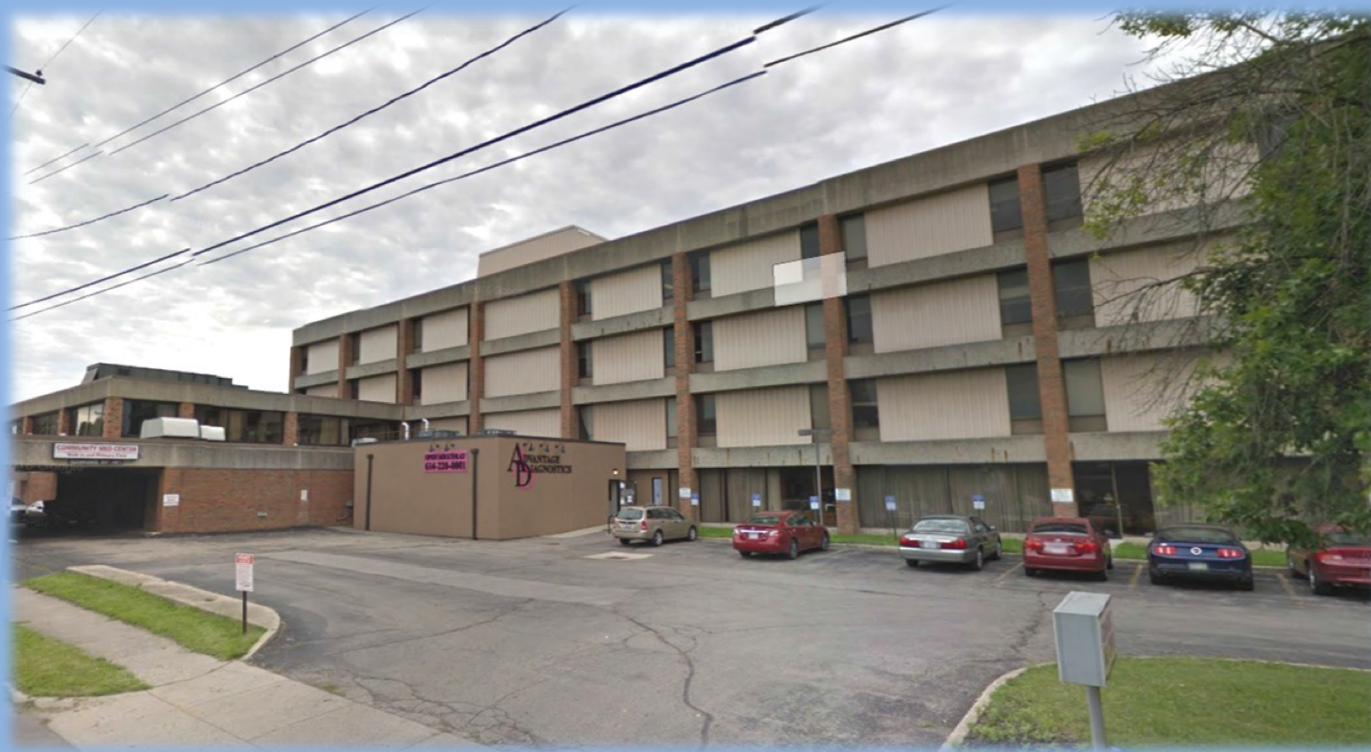
- **Notable increase in opiate-related overdoses in Franklin County**
- **10-15 naloxone (Narcan) administrations daily in Franklin County**
- **2017 Franklin County Opiate Action Plan**
- **Usual path:**
 - **Overdose → Narcan → ER (medically treated, referred for drug treatment) → Community → Overdose**

Change the Path

- Overdose → Narcan →
- EMS decides if person needs hospitalization or direct transport to the Addiction Stabilization Center



Maryhaven Addiction Stabilization Center

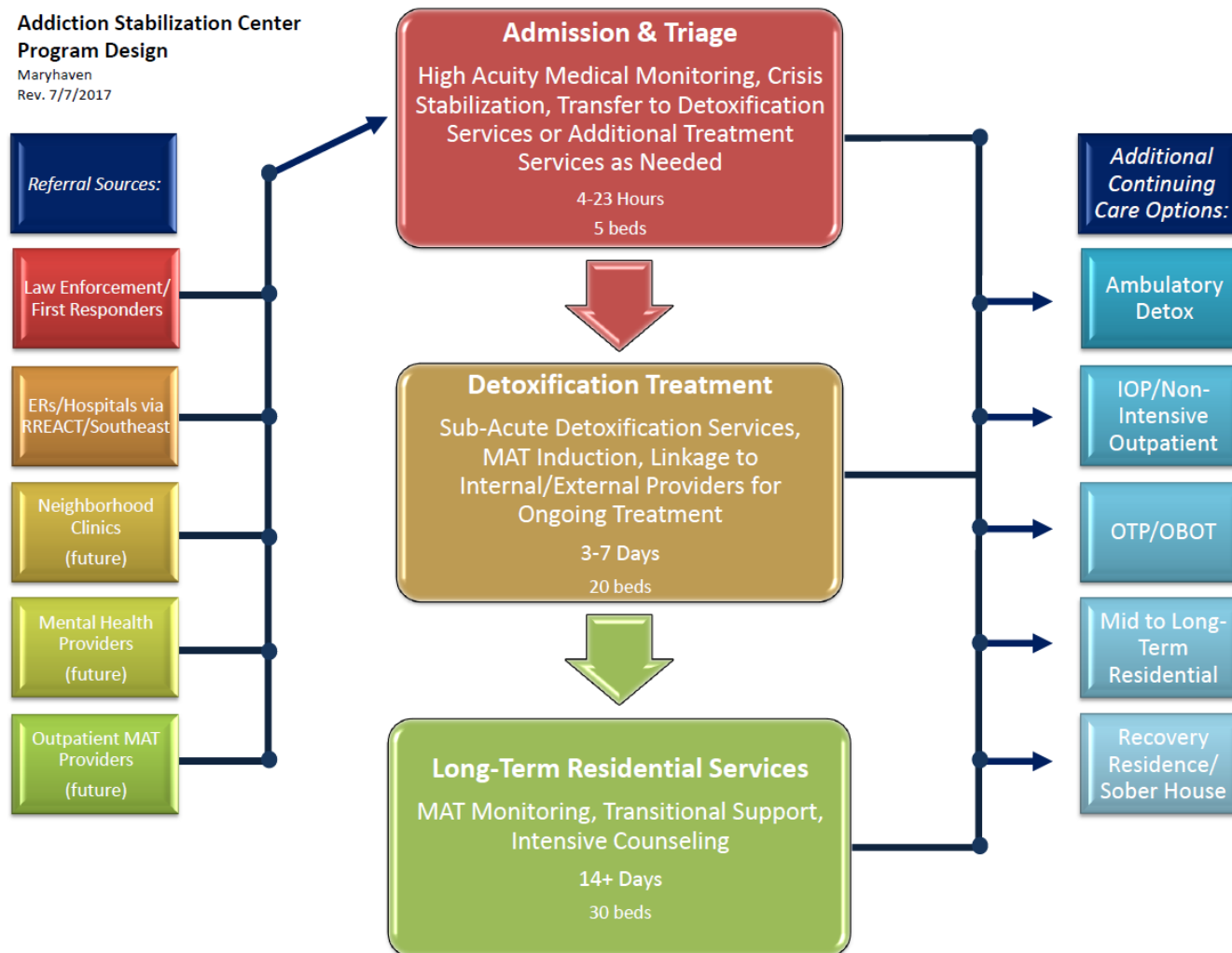


The Maryhaven Addiction Stabilization Center

- **Developed with ADAMH Board, City of Columbus**
- **55 bed facility**
 - Admission & Triage (5 beds)
 - Detoxification (20 beds)
 - Non-Medical Residential (30 beds)
- **100+ Maryhaven employees**
 - Interdisciplinary teams
 - physicians, nurses/nurse practitioners, counselors, paramedics, patient care assistants, admission specialist, peer recovery supporters
 - Contracting with CPD for Special Duty security

**Addiction Stabilization Center
Program Design**

Maryhaven
Rev. 7/7/2017





The ideal patient includes:

- Known or suspected overdose from an opiate, responds appropriately to Naloxone and ventilation
- Non-complex medical care needs associated with addiction stabilization
- Non-infectious contamination risk to others from airborne transmission
- Not an immediate threat of harm to self or others
- Voluntarily seeking assistance, meets clinical criteria

The patient would not be admitted if:

1. The patient does not meet clinical criteria for addiction treatment (e.g., lack of substance use history)
2. The patient is experiencing command hallucinations, psychosis (or has taken Ketamine?)
3. The patient has a blood glucose greater than ____ or has evidence of DKA
4. The patient has an uncontrolled seizure disorder or has active seizure activity
5. The patient has a BAC higher than 0.30
6. The patient requires supplemental airway ventilation and/or pulse oximetry less than 92%
7. The patient has been diagnosed with Pericarditis/Endocarditis within the last 6 months
8. The patient has head lice, scabies, MRSA or TB
9. The patient is unable to swallow
10. Glasgow Coma Scale (GCS) >13, not responding to Naloxone
11. The patient has incontinence and cannot manage independently
12. The patient has been homicidal or suicidal within the last 24 hours
13. The patient has more complex medical conditions (e.g., cellulitis, abscesses) that require hospitalization or ED evaluation



EMS Protocol for Transporting Patients to the Addiction Stabilization Center

Known or suspected overdose from an opiate and had responded appropriately to Narcan with spontaneous respirations over 6/min

NO

Transport to appropriate ED

YES

No complex medical care needs

- Blood glucose < 300
- pO2 > 92%
- No supplemental ventilations required
- Able to swallow
- Glasgow Coma Scale >13
- Can manage independently
- No seizure activity
- No confirmed pregnancy
- Systolic Blood Pressure < 180 or > 80
- Diastolic Blood Pressure < 120
- Pulse < 120

NO

Transport to appropriate ED

YES

No infectious contamination risk

- No head lice
- No scabies
- No MRSA
- No active TB

NO

Transport to appropriate ED

YES

No significant psychological issues

- Not homicidal/suicidal
- No excited delirium
- No command hallucinations

NO

Transport to appropriate ED

YES

TRANSFER TO ADDICTION STABILIZATION CENTER

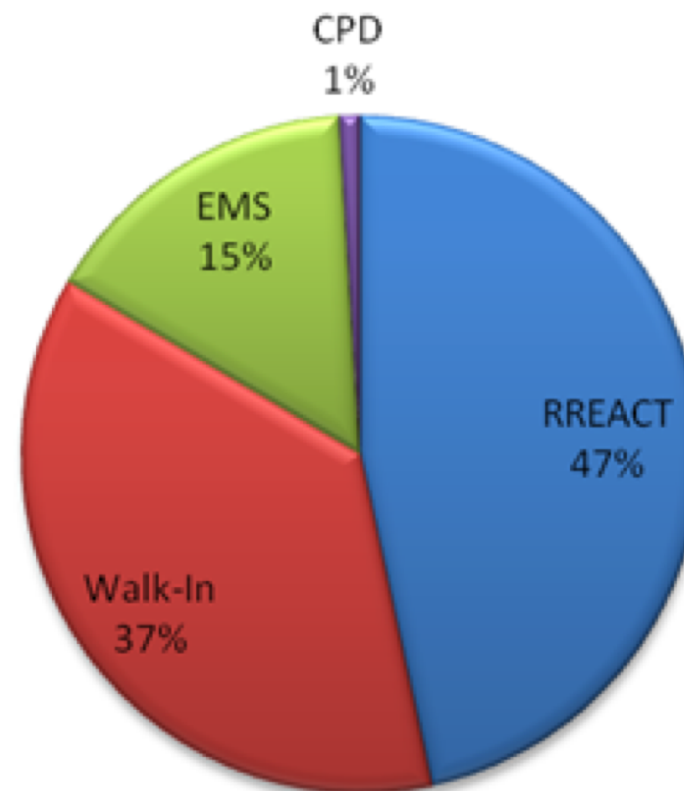




MASC Admissions by Referral Source

1/19/18-2/18/18

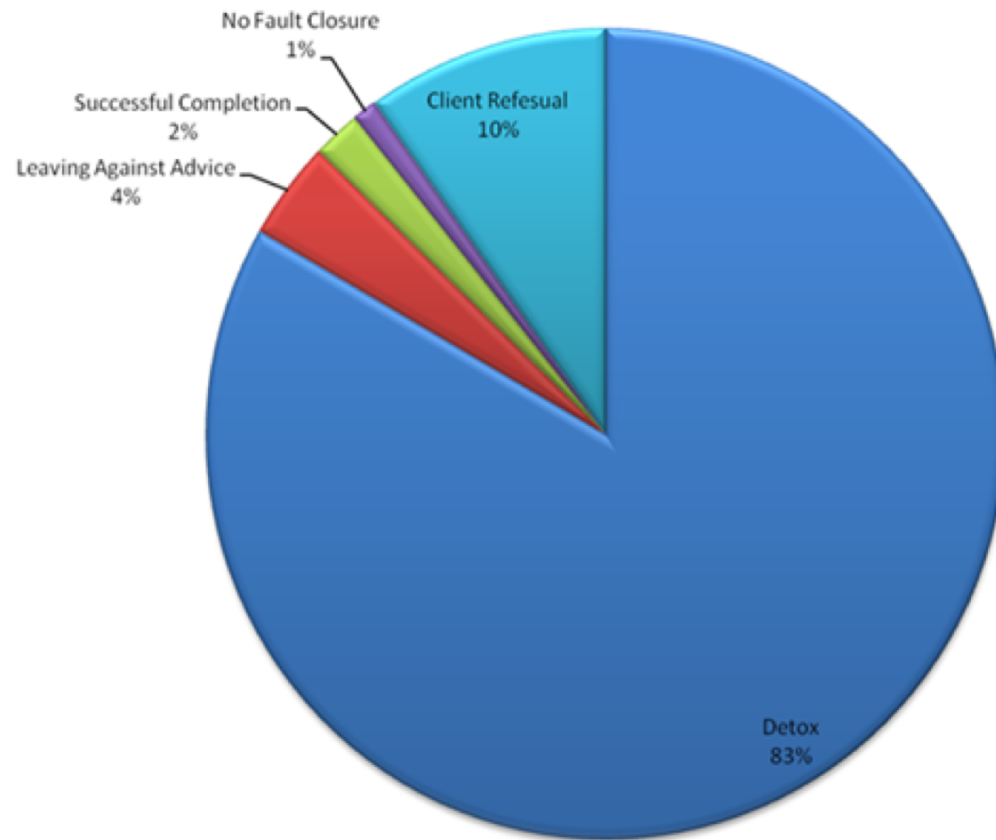
n=103



Client Outcomes after Arriving in Admission and Triage at MASC

1/19/18-2/18/18

n=103

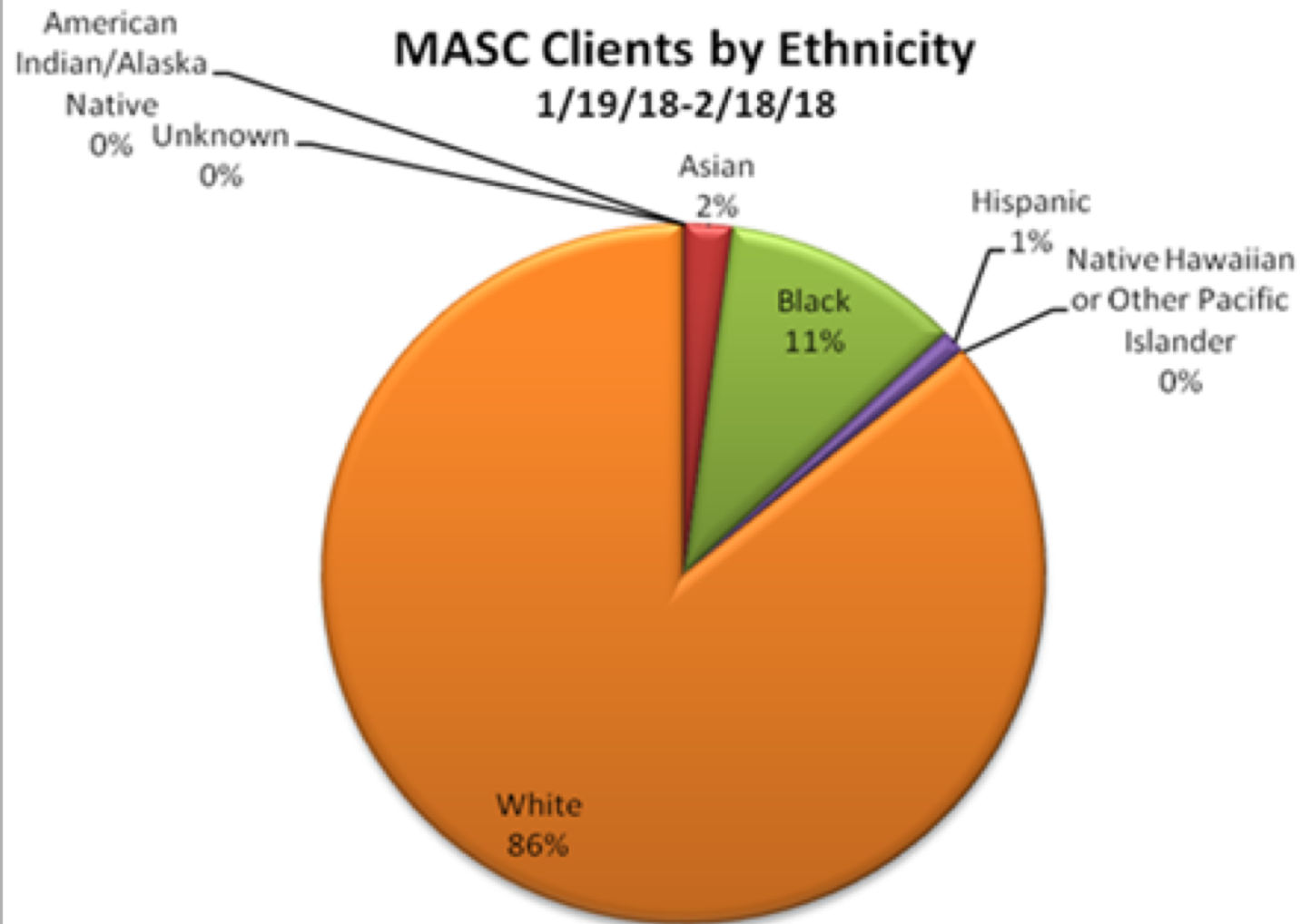


Status after Admission and Triage

After the first 23 hours of care:

- **80%** of clients have agreed to go on to Detoxification treatment on the 3rd floor.
- **10%** decided to leave against advice
- **7%** decided to decline admission.
- **1%** of clients left directly from Admission and Triage to an outside provider
- **1%** had to be transferred to Detoxification at main campus for health reasons.

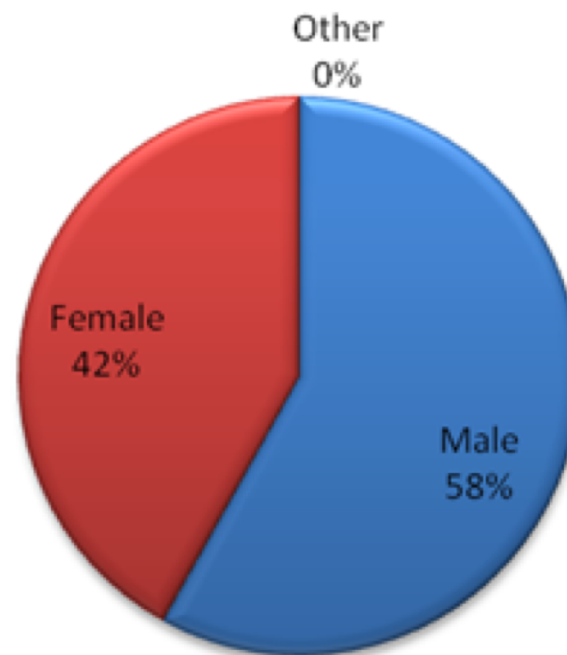
MASC Clients by Ethnicity 1/19/18-2/18/18



Total Clients Admitted to MASC by Gender

1/19/18-2/18/18

n=93



If You Build It...





Addiction Stabilization Center Florida Style

Kenneth A Scheppke, MD
Chief Medical Officer
Palm Beach County Fire Rescue



Centralized Free Standing Addiction Stabilization Facility

- Regionalization model
- Concentration of expertise and resources
- EMS Bypass to this facility
- 24/7 EM and Psych
- Attached to 6 day per week outpatient substance use disorder clinic
- Supported by taxpayers
- Community paramedicine care of patients during clinic off hours