PENNSYLVANIA COLLEGE
of EMERGENCY PHYSICIANS
ADVANCING EMERGENCY CARE

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820

(877) ER-DOC-PA
info@pacep.net
www.pacep.net

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House Human Services Committee
Warm Hand Off Legislation
March 12, 2019

Testimony Provided by:
Charles F. Barbera, MD, MBA, FACEP
Chair, Department of Emergency Medicine
Reading Hospital / Tower Health

Dear Ladies and Gentlemen of the Human Services Committee:

On behalf of the Pennsylvania College of Emergency Physicians (PACEP) and the over 1,700 emergency physicians across the Commonwealth that we represent, we thank you for allowing us to give testimony regarding HB 2727.

Emergency Physicians are on the front-lines of the opioid epidemic and we see the devastating consequences of this crisis on a daily basis. This has inspired Emergency Physicians across the Commonwealth to take a leadership role in addressing the opioid epidemic. PACEP members are developing warm handoff programs, lending experience and expertise to Department of Drug and Alcohol Programs' Regional Warm Handoff Summits, creating non-opioid pain management algorithms, expanding access to naloxone, and instituting innovative programs to initiate Medical Assistance Treatment (such as the initiation of buprenorphine) in Emergency Departments (EDs) throughout the Commonwealth. PACEP is eager to work with you to improve warm handoff programs.

With this background, we would like to address specific concerns with HB 2727:

First, for a warm handoff to be optimally achieved, substance use disorder treatment programs and personnel who are capable of assessing and accepting patients need to be available 24 hours a day, 7 days a week, 365 days a year. Warm handoffs are coordinated between Emergency Departments and the Single County Authorities (SCAs), however all SCAs do not have the personnel or funding to provide 24/7 warm handoff services for every hospital in Pennsylvania. Currently, there are not enough case managers and peer recovery specialists to meet with patients in the ED and arrange treatment. Mandatory warm handoff programs would only be as good as the community resources available to receive these patients. Until those resources are fully funded and available, placing the responsibility to provide this service solely on hospitals and EDs would result in undue burden

to a system that is already functioning at capacity. Additional funding to county agencies as well as coordination with Pennsylvania's public and commercial insurers to incentivize substance use disorder treatment program patient engagement from the Emergency Department is needed to ensure that EDs have a place to send these patients.

As an example, during a recent shift I had a patient present after a heroin overdose reversed with naloxone at 2:00am. After medical stabilization, he was agreeable to seek opioid use disorder treatment. Despite the best efforts of myself, our dedicated nurses and case manager, we could not find a substance use treatment bed available to accept him that evening for a warm handoff. Our hospital has invested considerable time and personnel into a warm handoff program, but we could not get this patient to treatment due to lack of available treatment resources. Unfortunately, HB 2727, despite best intentions, would not have helped this patient.

Second, Section 3 proposes to develop a network where emergency medical services can directly transport overdose survivors to treatment and recovery centers, bypassing the ED. Although we agree with the concern that Emergency Departments are overburdened, patients who suffer an overdose often have multiple medical complications, as well as co-occurring illness such as blood infections or poorly regulated chronic disease. Therefore, we believe that all patients suffering from an overdose should be evaluated in an acute medical facility. Even patients who initially appear to be stable after reversal with naloxone can develop delayed respiratory, cardiac and neurological complications. It is difficult to determine which patients will suffer these adverse and potentially life-threatening events at the time of initial evaluation. Although HB 2727 proposes the creation of 24/7 facilities to provide initial assessments and treatment of patients with substance use disorder, these do not yet exist, and creation could be costly and delayed. Licensed detoxification facilities are designed to treat medical complications of withdrawal and chronic substance use, but they are not equipped to manage acute medical complications of overdose and intoxication. Directly transporting patients to such facilities without an evaluation in an Emergency Department could put them at significant risk of life-threatening sequelae. Additionally, this could be a source of significant liability for prehospital providers, who may be asked to make a determination of medical appropriateness in a matter of minutes.

Third, HB 2727 also adds additional unfunded administrative burdens to Emergency Departments and our staff. PACEP certainly supports the expansion of available educational materials related to stigma, substance use disorder treatment, and warm handoff programs. However, mandating all Emergency Department personnel participate in warm handoff Continuous Medical Education (CME) will be ineffective because warm handoff protocols are unique to each county, hospital, and community. A one-size-fits all CME curriculum by the Department of Health will not address the nuances of each program. Education regarding opioid use disorder will be more effective if the curriculum is developed and instituted at the hospital or health system level. Additionally, the reporting requirements mandating that Emergency Departments track every patient treated, screened, transferred and refusing treatment is another unfunded administrative cost that would detract our limited resources away from patient care.

Next, in order for a program of this magnitude to be successful, it needs to have the financial support to be self-sustaining. Pubic grants are temporary measures that do not cover the cost of the program and eventually expire. True sustainability requires public and private payer reimbursement for all warm handoff measures. Each warm handoff is very resource and labor intensive, involving case managers, social workers, and peer recovery specialists evaluating patients to determine their individual treatment plan, performing bed searches for available treatment facilities, and conducting follow-up communication to those being treated as outpatients. There are additional expenses associated with transporting patients to their treatment destination. Despite all of the time our Emergency Department personnel dedicate to this process, we commonly do not receive reimbursement for these services. We appreciate that HB 2727 has language calling for "reasonable and fair

reimbursement" from insurers. However, many smaller Emergency Departments may have at most one patient qualifying for a warm handoff per day, and reimbursement on an individual patient level will not compensate for the resources needed to operate a 24/7 warm handoff program.

Mandating warm handoffs does not ensure that each patient will receive the desired treatment. Emergency Departments medically manage the patient and when clinically stable initiate the warm handoff process. From that point forward, the SCA's manage the program. Currently, the SCAs have inconsistently available resources and are not capable of accepting patients into treatment facilities 24/7/365. Imposing mandates on Emergency Departments will not change this reality unless coupled with sufficient resources for our SCAs to execute warm handoffs. Therefore, PACEP believes Section 5 of HB2727 requires revision to state that the SCAs should have to certify to the Departments of Drug and Alcohol Programs and Health that their warm handoff programs have engaged with the Emergency Departments in their area of responsibility. This certification should place specific emphasis on the feasibility of rapid, 24/7/365 acceptance of patients willing to engage in a warm handoff regardless of insurance status and that reimbursement is in place from all relevant payers for these Emergency Department provided services. This is the opposite of what is outlined in the draft legislation that instead calls for Emergency Department certification to SCAs.

Improving efficiency will help to defray some of the labor associated with finding a treatment bed. PACEP believes that any warm handoff legislation should establish a substance use/detox bed tracking system including real-time updates for the capacity available at each treatment facility in order to streamline the process of finding a site available to accept the patient. This database should list the facility capabilities, treatment available, insurance accepted and be updated in real-time to obviate the need for a case manager to call each facility in search of an available bed.

Finally, Section 8 outlines the creation of an Opioid Recovery Taskforce. If an Opioid Recovery Task Force is created, we request that it include a member from PACEP given the fact that we are the only physicians routinely treating patients immediately after an overdose. This task force should have the necessary ground level expertise to make recommendations that are both feasible and effective in addressing the opioid crisis in our state that can then be proposed for legislative execution.

PACEP stands ready to continue our leadership in implementing warm handoff protocols across the state. We look forward to working with you to modify HB 2727 so that it provides the resources necessary for Emergency Departments and SCAs to improve our current warm handoff programs.