Community Paramedicine and the Opiate Crisis

Innovative Stratiges Producing Positive Outcomes

Lt. Mike Campbell | Stanly County EMS | Community Paramedic Division

Learning Objectives

At the end of this presentation, the attendee will gain more information on the following subjects:

- Background of Stanly County EMS Community Paramedic Division
- Key concepts and ideals of the Agency and CP Division
- Introduction of team members
- Utilizing community resources and building partnerships
- Community Paramedic capabilities
- Common misconceptions associated with harm reduction
- Important data points to collect
- The importance of stigma change in public service

ABOUT STANLY COUNTY, NC

- Located in the south piedmont area of North Carolina
- Population ≈ 62,000 residents
- Area: 405 square miles
- Rural community with a large farming presence
- Median household income is ≈ $50,000/year
- Poverty rate is 13.2%
- Unemployment rate is 3.5%
- Uninsured rate is 12.9%

Stanly County, North Carolina

Stanly County EMS

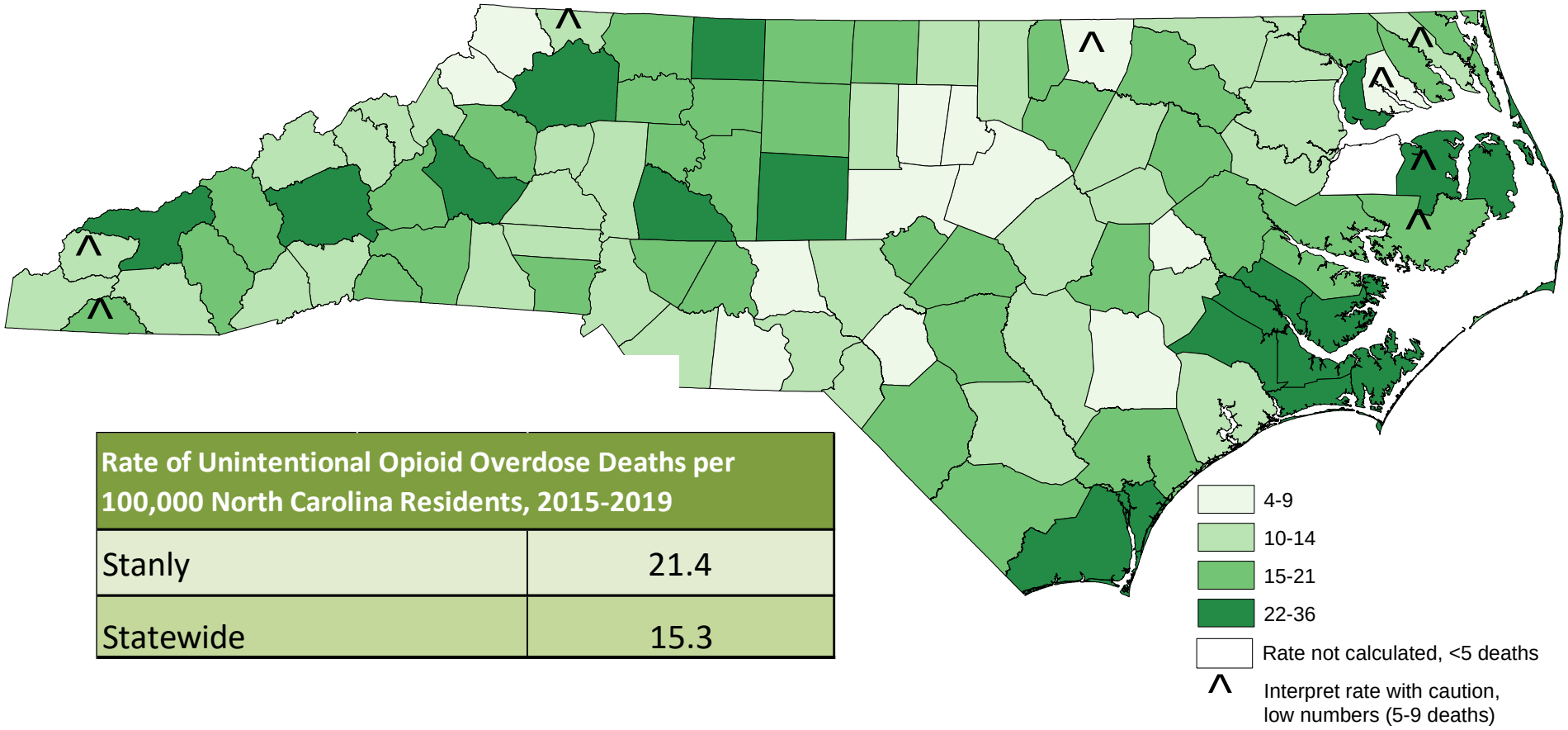
- Operates 6 fully staffed EMT-Paramedic level ambulances, 1 Paramedic supervisor, and 1 Community Paramedic
- CP is currently staffed 12 hours every day all year. 24-hour staffing to begin Oct 1, 2021
- Approximate call volume is 12,000 calls annually which includes IFT and non-emergency transports
  - 207% increase in Covid-19 calls since June 2021
  - 40% vaccination rate across the County
- Multiple paid and volunteer fire departments functioning at the EMT-Basic and Advanced EMT levels
- 1 local hospital with cardiac and trauma centers nearby

The Opiate Crisis in Stanly County

- Since before 2017, Stanly County has been the leader in the state in opiate related ER visits, deaths, and lost wages per capita
- 2015-2019 Stanly County experienced 21.4 deaths per 100,000 residents with a North Carolina average of 15.3
- In 2019, the opiate crisis cost Stanly County over $29M between hospital costs, lost wages, and people who are no longer able to work due to dying from an opiate overdose.
- Fentanyl, Carfentanyl, and other synthetic opioid overdoses have been consistently on the rise. Mixing these potent opiates with stimulants such as methamphetamines have caused a significant increase in negative outcomes for patients, and an increase in 911 calls
- Very few treatment centers which are underfunded and understaffed make it difficult for people to get into recovery.
- Enough Rx opiate pills were distributed to allow every resident of Stanly County 33 pills each totaling over 2 million dispensed opiates in 2019
  - Only 15.9% of Stanly County residents received an opiate Rx

Rate of Unintentional Opioid Overdose Deaths

Per 100,000 North Carolina Residents, 2015-2019



Rate of Unintentional Opioid Overdose Deaths per 100,000 North Carolina Residents, 2015-2019	
Stanly	21.4
Statewide	15.3

Technical Notes: Rates are per 100,000 N.C. residents, Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone),T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics)
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics; Population-NCHS
Analysis by Injury Epidemiology and Surveillance Unit

One Year's Estimated Total Lifetime Costs

Medical and Work Loss from Medication & Drug Fatalities, All Intents, 2019

Total Medical Costs in Stanly County, 2019	$129,492
Total Work Loss Costs in Stanly County, 2019	$29,234,524
Combined Costs, 2019	**$29,364,016**

Cost per capita in Stanly County, 2019	**$468**

Technical Note: These estimates only include fatalities and do not include additional costs associated with non-fatal overdoses, treatment, recovery, and other costs associated with this epidemic.

Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, Unintentional medication and drug overdose: X40-X44/Population-National Center for Health Statistics/Economic impact-CDC WISQARS, Cost of Injury Reports, National Center for Injury Prevention and Control, CDC for all medication and drug deaths (any intent), Base year (2010) costs indexed to state 2017 prices.
Analysis by Injury Epidemiology and Surveillance Unit

Program Implementation

- SCEMS received grant funding in 2018 to form a Community Paramedic Division focused solely on opiate crisis
- Study is to determine if Peer Support and field Suboxone inductions were an effective means of harm reduction.
- Program implementation January 2019 with go live date of May 2019
  - Needed time to develop protocols and SOGs and hire and train staff

SCEMS Community Paramedic Division Team Members

- EMS Medical Director
- EMS Training Officer
- 4 Full Time CPs
- 4 Reserve CPs
- Peer Support Specialist
  - Undoubtedly the most important position in this part of the Division
- MSW Social Work Intern
  - UNCC student who is focusing on a mental health/substance use track

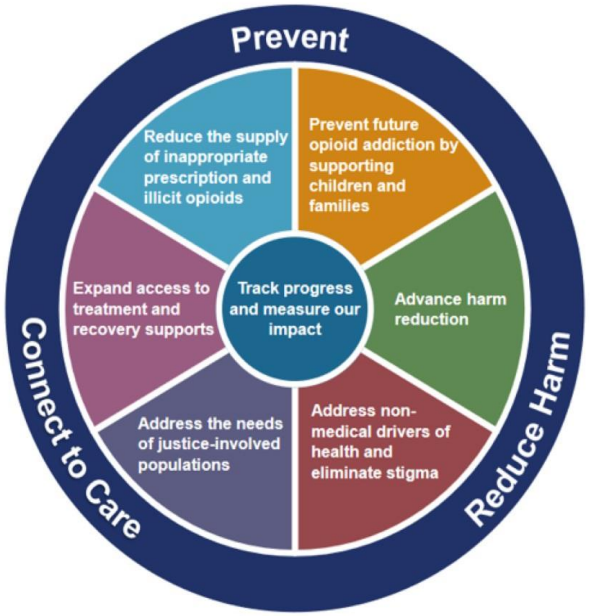
Additional Training

- All Community Paramedics, whether full time or reserve must go through the following training:
  - Take and pass an approved Community Paramedic course
  - 16-hour PORT Training
    - Now being taught in house due to limited in person trainings across the state
  - 40-hour CIT training
  - 8-hour MAT Waiver training
  - Motivational interviewing training
  - Advanced patient assessment training
    - Blood draws, Covid-19 testing, vaccine administration, wound care, etc.
    - Ultrasound, advanced mental health assessment, clinical withdraw assessment, POC lab testing coming soon
- This training is in addition to required yearly continuing education

Key Concepts

- Community Paramedics focus on the key concepts of the NC DHHS Opioid Action Plan:
  - Prevention
  - Connection to Care
  - Harm Reduction
  - Statewide initiative to reduce deaths and negative outcomes caused by the opiate crisis
- Most PORT Teams and Harm Reduction Coalitions operate under this plan
  - NC DHHS distributes grant funding to many organizations across the state
- Key Concepts include Prevention, Connection to care, and Harm Reduction
- Stigma change was added in Stanly County

The N.C. Opioid Action Plan (N.C. OAP) has seven focus areas to reduce addiction and overdose death:



https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/north-carolinas-opioid-action-plan

Prevention

- Community engagement and awareness
  - Educate the public on the harms of using illicit opiates
  - Work with public school systems to enhance D.A.R.E. education
  - Peer Support acts similarly to an AA/NA sponsor
  - Assist with transportation to appointments
  - Telehealth/Telepsych visits
  - Medical clearance and ER diversion allows patients admission into treatment centers, preventing them from leaving ER AMA and suffering a secondary overdose
  - Connect those with mental health disorder to MHD providers quickly

Connection to Care

- MOU's in place with 2 local MAT providers
- Both facilities also grant funded
  - Provide low cost to no cost treatment options
- Same day referrals
  - The faster a patient enters long term recovery, the better
- Connect patients to healthcare resources
  - PCPs, Specialists, Dental care, etc
- ER Diversion and medical clearance allows patients to go where they need to go and not the Emergency Room

Monarch

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Harm Reduction

- Easily the most controversial part of our program
- Harm reduction efforts directly correlate to an individual's success in recovery
  - Maslow's hierarchy of needs
- Community Naloxone distribution, field Buprenorphine induction, partnership with local SSP (syringe service program)
- HIV/Hepatitis C testing
- Resource acquisition
  - Social worker can connect individuals to other resources such as housing, food, social insurance, etc.
- Project Lazarus:
  - Local Harm Reduction coalition made up of resources across the County
    - SCEMS, Stanly County Health Department, Atrium Health, Law Enforcement, Syringe Exchange, Sober living facilities, PCP offices, religious groups, soup kitchens, etc.
    - With so many players on the team, it is easier to connect the individual with the resource they need, when they need it

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Stanly County Sheriff's Office
Jeffrey A. Crisco, Sheriff
223 S. Second Street Albemarle, NC 28001 Phone (704)986-3714 Fax (704)986-3733

SCEMS Community Paramedic Responsibilities and Capabilities
We're pretty busy

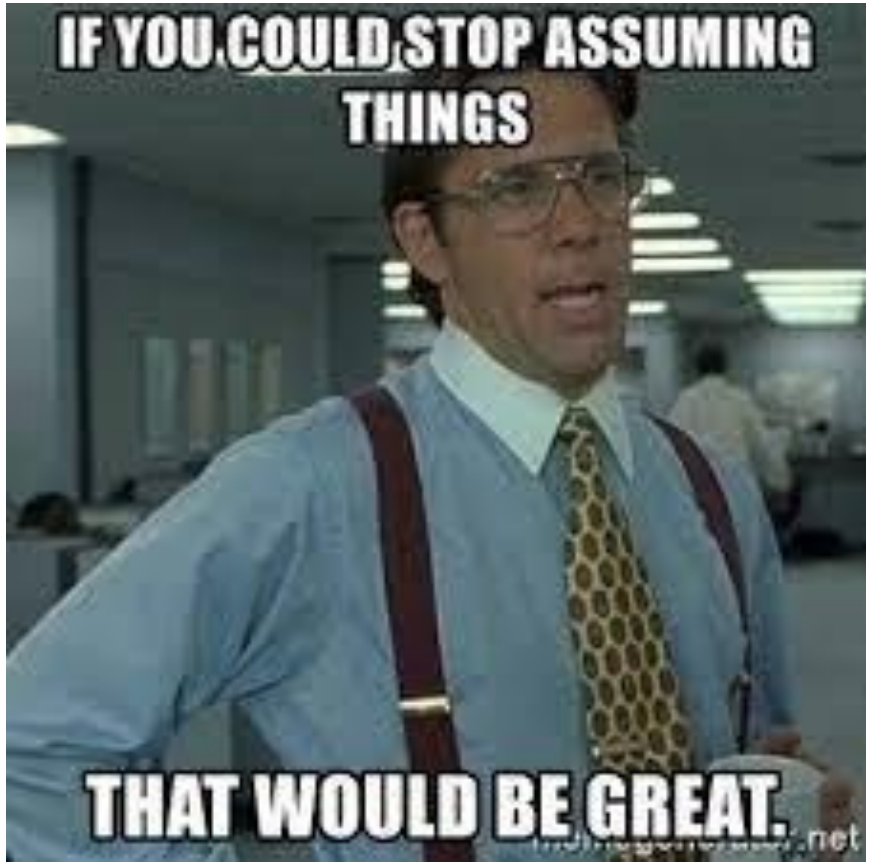
- Respond to every dispatched overdose call in Stanly County
- Staff syringe exchange events with CPs for wellness checks
- Staff monthly wellness clinic at syringe exchange primarily for HIV/Hepatitis C testing
- Ability to perform medical clearance in the field and ER Diversion (alternate destination)
- Detox referral and the ability to follow a detox discharge until bridged to long term care
- Same day MAT appointments
  - Limits number of patients dosed by EMS in the field
- Field Suboxone inductions for those who qualify
- Covid-19 vaccinations and testing
- Community Naloxone distribution
- Resource referrals
- Community outreach and education
- PulsePoint AED App:
  - Placing Narcan kits in every AED in the County
  - Training bystanders in hands only CPR and Naloxone administration
  - Go live date TBD -grant funding

All of this is being done while managing other responsibilities such as hospital discharges, frequent 911 utilizers, Covid-19 related tasks, blood draws, and needs based services

Because of this, it is extremely important to have the right people in the right positions. ***CPs can't do it all***, and having Peer Support and Social Work are vital parts of the program's success

Common Misconceptions and Stigma Change

- Due to the opiate crisis being largely and unnecessarily stigmatized, there are quite a few misconceptions surrounding addiction, treatment, and recovery
- Community education, empathy, and accountability are the best waysto combat these misconceptions



Common Misconceptions

We are enabling drug use by distributing free Naloxone

- Naloxone is not a treatment for addiction. It is a life saving intervention similar to Epinephrine for anaphylaxis or defibrillation for a V-Fib
- Naloxone is cheap and mostly grant covered – little to local taxpayer investment
- BVMs also left on scene
- Individuals can't have a chance of recovery if they don't survive the overdose
- Community reversals decrease 911 call volume

Syringe Exchange is Enabling

- An individual suffering from addiction is going to use, whether they have clean needles or not
- Prevents disease transmission and reduces need for medical interventions
- Prevents dirty needles from being left in public places
- Provides basic life necessitates:
  - Food, clothing, tents, sleeping bags, sanitary items, condoms, fentanyl test strips, etc.
- Provides Peer Support and counseling
- 2 hot meals daily
- Education on safe using techniques to better prevent illness/injury
- On site medical director able to prescribe

More Misconceptions

Suboxone is just trading one drug for another

- True, but Suboxone lessens withdraw symptoms, gives an individual the ability to “function”, and does not kill you if you take it. Sounds like a pretty good trade off to me.
- Each 4mg strip has 2mg of Naloxone
  - Very difficult to overdose, even if abusing it
- We don’t hand out Suboxone like Halloween Candy
  - Must meet certain qualifiers and be motivated to enter recovery
- While Suboxone is the gold standard for Opiate Use Disorder treatment, it isn’t for everyone.
  - All options are given to and discussed with patients prior to dosing. If it’s not for them, they don’t get it

Addiction is a choice

- Deciding to use may be a choice, but becoming addicted is not
- Many outside factors influence addiction
- 8-12% of all patients prescribed and opiate develop an addiction
- 80% of individuals addicted to heroin first started off abusing Rx opiates
- A 5-day Rx for an opiate can exponentially increase your odds of developing dependence/addiction
- Untreated or undertreated Mental Health Disorder play a large role
- Alteration of the Limbic system in the brain

Community Partnerships and Relationships

- Building strong relationships with community resources must happen in order to be successful
- It is better to have a lot of people who are good a few things, than a few people who are ok at a lot of things
  - You can't have both
  - We must know our limits and not try to do it all ourselves
- Some things we are not able to do ourselves, but we can support
  - Syringe exchange, etc.
- Easier for the patient to get the resources they need
- Work together and be nice
  - Other agencies may have access to grant funding you may be able to tap into

The stigma surrounding the opiate crisis is the #1 deterrent keeping people from being successful in recovery

If you were constantly put down and demeaned by public servants whose only job is caring for you, would you be motivated to enter recovery?

Things will never get better until we start doing things differently and treating all patients with respect

Stigma Change

We must hold our co-workers accountable. We can no longer tolerate treating patients badly.

Examples taken from multiple agencies across the state. This is not just a local issue, it's a state and national issue that I've seen firsthand

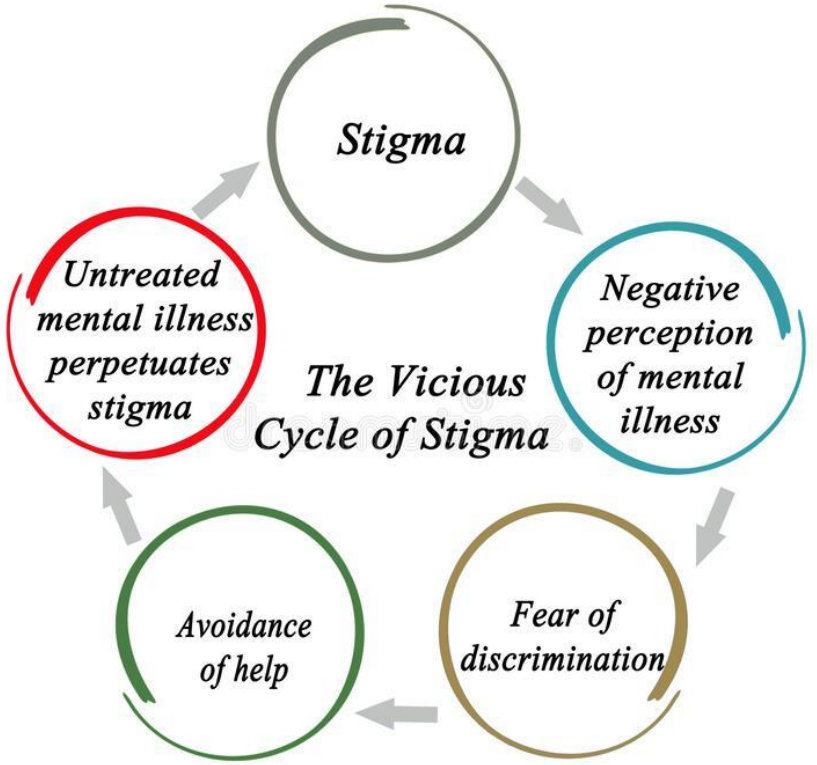
First, do no harm

Examples of Stigma Based Public Servant Issues

- Standing over a patient demeaning them when they wake up
- Holding a patient down when he vomits, so he vomits from his NPA that is still in place
- Asking a patient what they took just to belittle them. If you gave Narcan, and it worked, you know what they took. There is no need to unnecessarily embarrass them on scene
- Taking narcan and clean syringes from the patient and citing “natural selection should take over.”
- Threatening to arrest them when there is no basis for arrest
- Placing a 34fr NPA in a 130lb female pt, causing enough bleeding to warrant suction
- Sternal rubs that cause significant injury
  - Slapping a patient in the face to try and wake them
- Rapid pushing multiple doses of Narcan
  - Worsening withdraws, increased agitation leading to additional injury, flash pulmonary edema

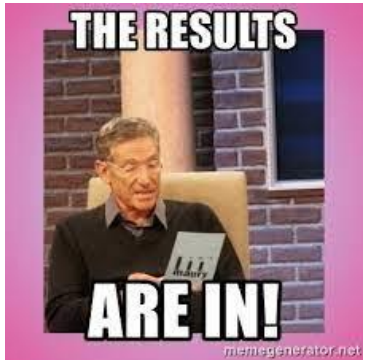
Stigma Change

- How would you feel if your family member got treated this way?
  - Because if you're not related to someone struggling with addiction already, chances are you will be in the future
- Do we treat STEMI patients bad because they had a poor diet?
- Do we treat COPD patients bad because they smoke?
- We must get buy in from our co-workers and our mutual aid agencies
- CIT training, when taught correctly, has the potential not only to change minds, but to change attitudes
- You don't have to incorporate harm reduction efforts in your agency, all you have to do is not be a jerk to patients
  - This is the number one form of harm reduction. When an individual who has no one or nothing sees that someone cares, it could be the motivator they need to enter treatment



Data/Results

- Community Paramedics have responded to over 500 overdose calls since May 2019
- 100+ Naloxone kits and BVMs left on scene post overdose
- 100+ Naloxone kits distributed through community engagement
- 180 individuals trained in overdose recognition, hands only CPR, and IM and IN Naloxone administration
- 45 referrals to treatment
  - 30 to outpatient treatment
    - 7 Suboxone inductions
  - 10 to detox
  - 5 to long term inpatient



- We must remember that most of our patients are not interested in treatment
- Peer support plays the role in changing this from the majority to the minority
- The main purpose of sharing this data is to show that if this can be done in a small, rural community with high stigma and few resources, it can be done anywhere

Data/Results

- Of the 7 field Suboxone inductions, 100% of patients have remained successful in recovery
- 85% of all referrals remain in active recovery and have not utilized the 911 system for substance use related issues
- Stanly County is now out of the top 10 in overdose deaths, ED visits, and EMS encounters
  - This is after spending many years in the top 3 in all categories

How Do We Measure Success?

- Reduced deaths for patients, increased access to care, and a decrease in 911 utilization are all ways we can measure success
- Individuals who are now able contributing members of society, legal issues resolved, families brought together, and improved quality of life are ways our patients would measure their own success
- Employee satisfaction is another way we measure success. By providing our CPs with an expanded scope of practice, a progressive Medical Director and giving our providers the ability to make a difference produces employees that are proud of the position they are in. This directly affects patient care, producing more positive outcomes in the community
- The opportunity to follow a patient from their most desperate, fragile and vulnerable point in their life to being a sober, successful, productive individual who is meeting their goals exemplifies success for me. It makes me proud to be a small part of a much bigger picture. When we improve the quality of life for one, we improve the quality of life for the community.
- Dr. Tripp Winslow says it best:
  - *"Even if we can save one person, this program will prove to be beneficial. Some studies are not only about the numbers, but more about the people who experience positive outcomes."*

Conclusion

- Not ever agency needs to focus on substance use/mental health, but it's doable
- Community Health Needs Assessments can help you gauge where to put your efforts
- Bottom-up approach to CP/MIH lets you build your program specific to your needs
- Apply for grants to get started, then use the grant period to justify your existence
- Learn, train, and increase your knowledge. Become an expert in your field.
- This isn't easy. It becomes frustrating. It can be overwhelming. The reward is worth every bit of it.
- Working to better your community is your number one priority, but working to improve your agency and decrease burnout should be your second

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