Evaluation of Prevention Point Philadelphia's Level of Care Program

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Background & Program Description

In the United States, preventable opioid-related overdose morbidity and mortality remains a critical public health challenge.[1] Since 2013, the soaring rate of fatal overdoses has been attributed to the emergence of illicit synthetic opioids (e.g., fentanyl and fentanyl analogs) in markets formerly dominated by heroin.[1,2] For the first time, in 2021, there were more than 100,000 overdose deaths nationwide in a single year.[1] Philadelphia has not been spared national trends. In the first 6 months of 2021, there was a 10% increase in overdose deaths compared to 2020.[3]

Improving access to life saving treatment for opioid use disorder is key to overdose prevention yet, in 2019, approximately 25% of inpatient and outpatient treatment slots in Philadelphia remained unused on any given day, according to city officials.[4] To increase access to treatment, Prevention Point Philadelphia (PPP), the city's only sanctioned syringe services program (SSP), initiated a year-long process to receive accreditation by the Philadelphia Department of Behavioral Health and Intellectual Disability Services to provide American Society of Addiction Medicine level of care assessments ("ASAM assessment").

The ASAM assessment is a brief biopsychosocial assessment of medical and cognitive conditions, patient preference(s), previous treatment experiences, recovery roadblocks, and readiness to change conducted to identify the most appropriate type of drug or alcohol treatment for each client, referred to as "level of care" [5] *(**Table 1**).*

Table 1. Dimensions of ASAM Treatment Assessment Tool

Dimension 1	**Acute Intoxication and/or Withdrawal Potential**
Dimension 2	**Biomedical Conditions and Complications**
Dimension 3	**Emotional, Behavioral, or Cognitive Conditions and Complications**
Dimension 4	**Readiness to Change**
Dimension 5	**Relapse, Continued Use, or Continued Problem Potential**
Dimension 6	**Recovery/Living Environment**

To identify individuals interested in an assessment, PPP assessors recruited clients from the syringe exchange, drop-in, housing and other PPP programs. The assessment was done on paper while data was also entered into their electronic medical record and a program-specific database. After the assessment, PPP staff collected vitals and assigned each participant a level of care (see Figure 1) . Next, they sought insurance approval and worked to link clients to a treatment center that provided the appropriate level of care. While completing the assessment took an average of 30-45 minutes, seeking approval from insurance companies and locating an appropriate treatment facility could take several hours, with some participants needing to return the next day. All clients were provided transportation to treatment sites and other offsite referrals (e.g., hospitals and crisis response centers).

Authors: Katie Singley, Kathleen Ward, Denise Botcheos, Silvana Mazzella, & Alexis Roth

Methods

Data Sources: For each client enrolled during the evaluation period (April 2021-December 2021) we extracted secondary data from three sources: a program-specific database, PPP's electronic medical record, and the Pennsylvania Prescription Drug Monitoring Program (PDMP). From the program database, we obtained: socio-demographic information for those assessed as well as those who approached the center but did not receive an assessment. From PPP's electronic medical record, we obtained encounter dates and assessment outcomes such as if participants were successfully linked to their planned treatment facility. From PDMP, we obtained the date(s) medication for opioid use disorder (MOUD) was prescribed and then we calculated the proportion of clients who initiated MOUD within 60-days post-assessment.

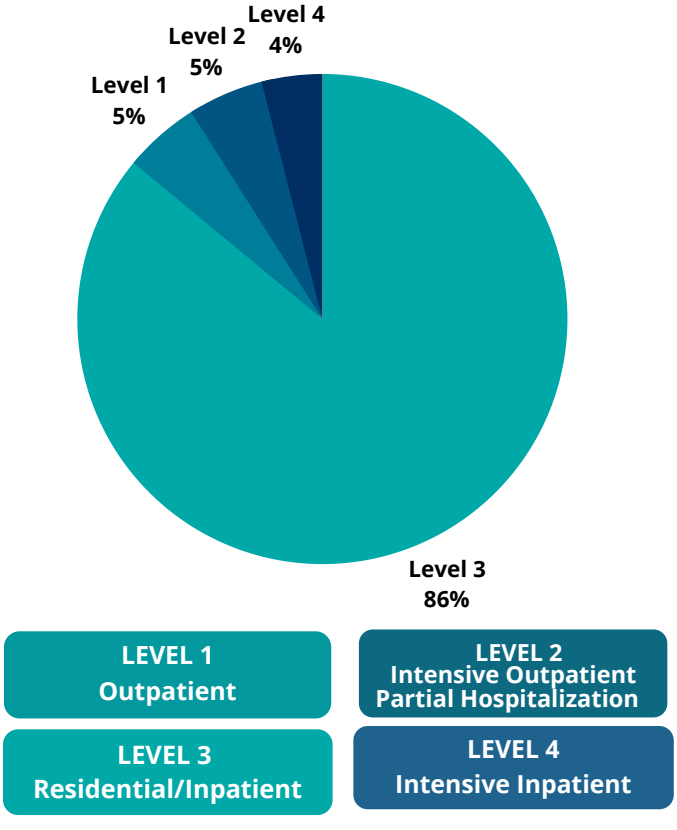
Primary data included a client satisfaction survey, completed by 45 participants, that measured satisfaction with services provided and interactions with staff. In addition, we conducted qualitative interviews with nine sequentially recruited clients representing those who were linked to care (n=61) and those who were not (n=41). Of those interviewed, 8 were linked to care and 1 was not. These interviews covered a range of questions about the assessment experience and barriers and facilitators to treatment within the context of any previous treatment experiences.

Analysis: For quantitative data, descriptive statistics were calculated for participant characteristics, service delivery, level of care, MOUD initiation and retention, as well as satisfaction. For qualitative data, we transcribed interviews coded and then used an open and inductive approach to identify themes that corresponded to the domains of the semi-structured interview guide. Interviews were coded by two research assistants who took analytic memos which were discussed at weekly meetings to identify key findings and select exemplar quotes. As a core component of data analysis, findings were discussed and confirmed through biweekly meetings and informal interviews with PPP staff.

Results

Assessment program engagement and outcomes: During the first 9-months of implementation (April 2021 – December 2021), program staff had 345 encounters with 256 unique participants; 58% of whom (n=129) initiated the assessment. Of these, 17 left before they completed the process and the records for 7 people were missing data about linkage. These 24 people were removed from the analysis. Of the individuals who initiated an assessment (n=129), 105 (81%) completed the process, defined as having a level of care assigned, and 62 of these participants (59%) were successfully linked to treatment (**Figure 1**).

Figure 1. Level of Care Assigned (n=105)



The majority (89%) were referred to inpatient treatment; the most common referral sites were Kirkbride, Beacon Point, and Eagleville. The next most common type of care participants were referred to was intensive outpatient/partial hospitalization (6%), followed by outpatient (5%). Most participants had been prescribed MOUD previously and 46% of participants were prescribed MOUD within 60 days of being assessed.

Of the 43 clients who completed the assessment but were not linked to care, we were able to ascertain information regarding non-linkage from the electronic medical record. The most common reason participants were not linked included: a treatment slot not being available (n=23) and the client needing a medical clearance prior to initiating treatment (n=13). Less common reasons for non-linkage were due to participants being referred to Behavioral Health Special Initiative (BHSI) (=4), being referred to a crisis response center (n=2), Community Behavioral Health not approving the client for treatment (n=1), and a treatment site refusing to take participant (n=1) (**Figure 2**).

Figure 2. Participant Outcomes

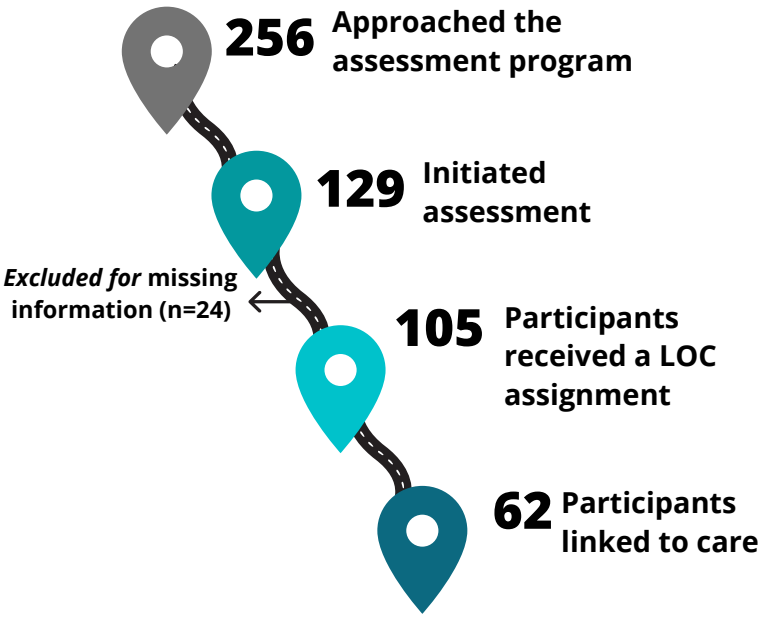
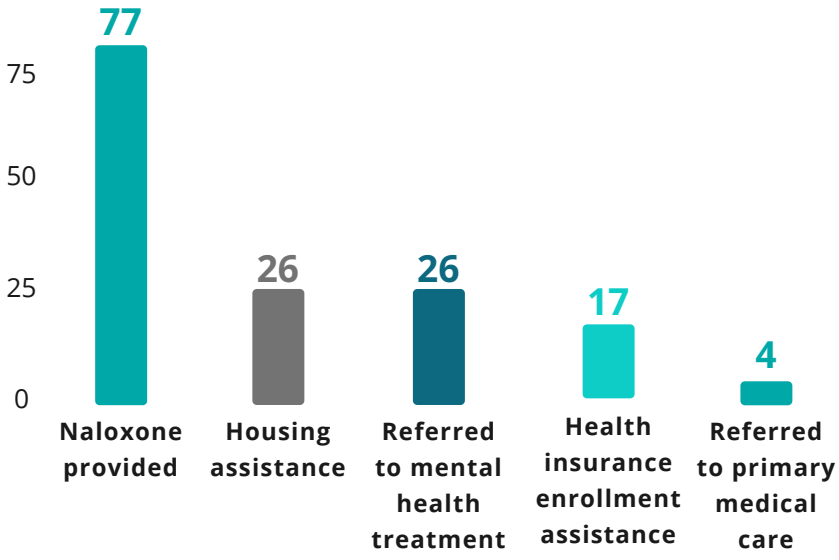


Figure 3. Other Services or Referrals by LOC Staff



Other services received: In addition to treatment referrals, LOC staff provided participants with overdose education, naloxone, transportation, assistance enrolling in health insurance, benefit assistance information, and referrals to the following co-located programs within PPP: wound and primary care (HIV and HCV medical care), housing assistance services, and mental health services (support groups) (**Figure 3**).

Program satisfaction: Client satisfaction with the service(s) they received was between 83% and 100% for all items measured (**Figure 4**).

Figure 4. Satisfaction Survey

100%
would come back if they needed help again

97%
said this service helped them

90%
said their needs were met

88%
would recommend this service to a friend

Participant socio-demographics: Demographic information was available for 129 participants who initiated the assessment. Most were non-Hispanic white (59%) men (73%) with majority between the ages 26-45. We compared individuals that completed the assessment process to those who did not to determine if the two groups varied by socio-demographic characteristics. There were no statistical differences in gender or race, but younger participants were more likely to complete an assessment than older participants (p=0.05).

Interviews

Among the nine clients completing a qualitative interview, program satisfaction was overall positive. PPP's reputation in the community for being welcoming and respectful made PPP a trusted location for the LOC assessment. The location was convenient, close to public transportation or in the same neighborhood where they reside. They typically came to PPP for other services which is how many found out about the program. Participants noted that they were typically seen by assessment program staff as soon as they expressed interest.

"They respect me. They didn't treat me wrong because of what I use, you know, they treated me well with respect, not as an outsider."
-Latina female mid -40s

"I thought it was just a needle exchange and they handed out food....until I went in and actually experienced the love and the care everyone had for me there."
- White male, early 30s

Participants also described many barriers linking to a treatment site after completing an assessment. Barriers included homelessness, lack of transportation, no bed availability at the appropriate level of care, dissatisfaction with treatment referral site, and miscommunication between sites. On the other hand, participants reported interpersonal relationships (ex: friends & family), spirituality, stable housing, and PPP providing transportation to treatment as being facilitators to care. Timely services were described as a facilitator to care while increased wait times for services were a barrier to treatment linkage and adherence. Withdrawal symptoms such as uncontrollable vomiting and sweating were also reported as a barrier to seeking and adhering to a treatment program. Participants felt this was even more acute with precipitated withdrawal related to fentanyl use.

"The process is painstaking...takes forever. Yeah and all that matters, we in, and get sick, and they don't want to [give] any kind of meds. If you don't sneak nothing in...You won't go a lot of times, you won't go. A lot of people don't go because that - the process alone makes you not want to go."
-White female, late 40s

Staff reported insurance-related barriers that prevented them from linking participants. For example, the most common level of care requested was medically assisted detoxification. However, the insurance provider would only approve this higher level of care for participants that previously pursued a lower level of care (i.e., outpatient care). The linkage process was improved when staff had the ability to coordinate directly with the treatment facilities. However, there are limited treatment facilities with the ability to communicate and treat participants who speak Spanish, which was another significant barrier identified by staff.

Most participants were either on MOUD or interested in taking it. Previous experiences with MOUD were mixed. Some participants found it helpful, but others reported negative experiences with MOUD. These experiences were often associated with withdrawal. Some reported going into precipitated withdrawal when trying to initiate MOUD. Another participant reported that he did not feel his medication was at the proper dose because he could not feel any relief from withdrawal symptoms. One participant expressed frustration when he requested to switch MOUDs (from buprenorphine to methadone). They were unaware they had to wait two days before starting a new MOUD. He discontinued treatment to avoid withdrawal symptoms.

While mentioned by only a few of the participants due to its novelty in the Philadelphia drug supply at the time of the interviews, the presence of xylazine, or tranquilizers, was reported as a barrier to detoxing and starting treatment. One participant reflected that xylazine treatment options were limited and detox facilities were unable to help him manage his intense withdrawal symptoms. This was confirmed by staff reports that xylazine was becoming more common and made it difficult to connect participants with the appropriate treatment level because insurance carriers were unfamiliar with xylazine's impact.

"I'm not even concerned about the fentanyl anymore. I can handle an opiate withdrawal. I can handle being uncomfortable. But, tranq [xyalzine] is just on a completely different level."
-White male, late 30s

Summary & Discussion

Embedding LOC assessments within the SSP was designed to reflect the "no wrong door" philosophy.[6] The goal was to increase access to treatment by providing clients with an assessment, necessary first step to accessing treatment, within the SSP, a trusted institution where they were already receiving services. Importantly, the program was implemented during the COVID-19 pandemic which caused staff and treatment bed shortages with both the SSP and at the treatment facilities to which clients were referred.

Despite these challenges, during the first nine months of the program, LOC staff provided education and other support services to 256 Individuals. In addition, 129 completed the assessment and assessors were able to locate CBH approved substance use disorder treatment for nearly half of these clients. While individuals had mixed experiences with treatment sites, overall satisfaction with the LOC assessment program was high with the vast majority stating they would return to the service if needed.

Importantly, embedding this service within PPP allowed assessors to provide clients with other needed harm reduction services such as naloxone for overdose prevention as well as housing and insurance assistance, and emergency medical services. Taken together, these results of this evaluation suggest that is is feasible and acceptable to implement a LOC assessment service within a SSP. Other studies of longer duration would be needed to understand whether this approach is sustainable, whether this co-located approach produces better treatment uptake than assessments occurring outside of this setting, and what it takes to scale and/or transfer this service outside of this multi-service SSP. Despite these limitations and challenges, our findings suggest that clients benefit from this approach.

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