EMS Linkages for Public Health Prevention

Kenan Zamore, MPH
DC VS REST OF AMERICA

- Very different core group of users

- Average Opioid addict is older (mean age 54 years), less racially diverse (80% African-American)

- Long history of use

- Concentrated in smaller enclaves within the city (Wards 5, 7 and 8)
WHY FIRE AND EMS DATA?

- **Every** firefighter, EMT and Paramedic can give Narcan. Almost complete coverage of overdoses in the city

- X-Y coordinates, actual location

- Identifying information, including date of birth, patient address, even insurance information. Previous encounters can be examined

- Real-time nature of data allows us to use an outbreak model

- Hospital data is insufficient (a large percentage decline transport)
DATA EXCHANGE

Emergency Response
- Fire and EMS
- Police
- Hospitals

Testing
- Forensic Sciences
- ME

Public Health Response
- DC HEALTH
- Behavioral Health
- Human Services
- Non-profits/Harm Reduction

Criminal Justice System
- Corrections
- MPD and DEA
- Probation and Parole
- US Attorney
OVERDOSE SURVEILLANCE

- 3 pronged strategy – fatal overdose surveillance – medical examiner, death certificate, toxicology

- Non-fatal overdose surveillance – ESSENCE, FEMS

- Dissemination

- Multi-agency work group sharing information

- Accurate picture of the typical opioid user in the District of Columbia/ Respond to and Prevent Overdose Clusters
LINKAGE TO PREVENTION

• 2 key roles:
  - Detect and warn of unusual patterns
  - Feed data for targeted interventions

• Our Goals (Surveillance)
  • Identify Emerging Threats
  • Estimate the magnitude of the problem
  • Monitor risk factors and spread of the problem
  • Evaluate research priorities/effectiveness of interventions
**ODMAP**

**BENEFITS**

- Easy to use, scrubbed, de-identified
- Fast way to disseminate information and reduce data requests

**CONS**

- Insufficient information
- Doesn’t really address clustering
- Inability to add additional layers – eg service areas, homeless shelters, landmarks
KEY INFORMATION SHARED

- Name, DOB, Address
- Location of OD
- Past OD in 90 days, if yes # and time in between
- Transport Destination (Induction vs non-induction facility)

- Sadly, we can not get back data on treatment history or clinical information, other than in aggregate form due to 42 CFR

- Internal Dashboard is only shared with DC Government prevention. Currently working to get it to Harm Reduction

- More data can be shared if patients directly opt in. We are piloting that at treatment intake and with some MAT programs
PREVENTION

- DC HEALTH- 8 rapid peer responders
- Department of Behavioral Health – Mobile Outreach team, providers, crisis responders
- Department of Human Services- Dedicated outreach staff working in service areas
- Fire and EMS- Overdose reversals, can leave naloxone behind in affected areas
- Harm Reduction – Syringe exchange services, treatment, medical care, wraparound services
OVERDOSE RESPONSE FRAMEWORK

Spike Alert

Overdose Spike Cluster

- DBH/ DHS/ DC Health/ Harm Reduction/ FEMS/ MPD organize call for information

- DBH/ DHS/ DC Health/ Harm Reduction inform all providers and deploy outreach workers in the determined location

- Providers and Outreach Workers provide messaging and distribute naloxone

Check-in calls within 24 hours of response

Overdose Spike Non-cluster

DBH/ DHS/ DC Health inform providers

Questions to consider:
- What is the threshold for a non-cluster “call to action”?
- Are we going by the 3 clusters, 8 wards, or quadrants for our approach?
- What is the threshold for a cluster?

List of service providers and their point of contact.

Call information to gather:
- Possibility of the type of drug
- Details of who is overdosing (age, race, housing situation etc.)
- Details of where they are overdosing (street, home, library, etc.)
- Determine messaging
WARNING!

Spike in opioid overdoses in DC in the past 24 hours
(Feb 4, 2020)

mostly Howard University and Kenilworth/East Capitol Street areas

*here are some ways to help avoid a fatal overdose*

Use with a friend who has naloxone/narcan or can call 911

Get naloxone or testing strips from HIPS
10-4pm 906 H st, NE
1 800 676 4477 for delivery

Use less to start to help you figure out an appropriate dose

Offer to help/check in on your friends and family who use
On average, people are overdosing ~3 miles from their residence. We use these paths to inform our communications campaigns – mass transit advertising, media campaigns based on where people will be at what time and common routes to known hotspots.
UTILITY OF EMS DATA

• Viewing overdoses as an ‘outbreak’

• Flooding staff/resources to provide outreach in hot-spot areas

• Linkage to screening, treatment, support services

  • Can be used for weekly/strategic planning. The more data we share the better our partners can allocate their resources and position their staff.

  • We have to be careful not to stigmatize neighborhoods or drive demand. Very fine line, but mostly avoided by taking a harm reduction approach. Telling people why they need naloxone and where to find it is our main focus.
First SBIRT

**Goal:** Home visit from clinical outreach team within seven days of suspected heroin overdose for every victim in DC. Voluntary offer of referral and immediate transport to treatment.

**Results:** 54% of persons contacted committed to treatment plan (including 21% who were transported directly to treatment intake).
SBIRT II Pilot Program:
Use EMS data to drive targeted intervention by Department of Behavioral Health outreach teams

Prioritized names based on consumption of city/emergency services

Mixed success (20% committing to treatment- very difficult population to engage or retain in treatment)
QUESTIONS/COMMENTS?