Welcome and Opening Remarks
- Jennifer Jordan, Vice President, Regulatory Advocacy, The Hospital and Healthsystem Association of Pennsylvania

Single County Authority - Your Link to Resources
- Kami Anderson, Executive Director, Armstrong-Indiana-Clarion Drug & Alcohol Commission

OUD Screening Processes in the ED – Are you Missing Anything? Discussion
- Sally Regina-Payne, RN, ER Nurse Manager, Clarion Hospital

MAT Warm Handoff – What is your Method? Case Studies and Group Discussion
- Donna Balewick, MD, ED Director, Indiana Regional Medical Center
- Mike Krafick, CRS, Certified Recovery Specialist Supervisor, Armstrong-Indiana-Clarion Drug & Alcohol Commission

Highlighting Harm Reduction Strategies throughout the Region Presentation and Group Discussion
- Alice Bell, Overdose Prevention Project Coordinator, Prevention Point Pittsburgh

Wrap up and Next Steps
- Kate Slatt, Vice President, Innovative Payment and Care Delivery, The Hospital and Healthsystem Association of Pennsylvania
HAP Opioid Learning Action Network (LAN) To Do Items

**Meeting Evaluation—Northwest Regional Virtual Meeting**

You will receive an email later today with a link to the program material and the online evaluation.

If you would like to complete your evaluation now, it can be found at: [https://www.surveymonkey.com/r/lan-033120](https://www.surveymonkey.com/r/lan-033120)

**Resources**

The Opioid Learning Network website contains resource materials, which are there to assist you. You can find the resources here: [https://hapopioidlan.org/Resources-Tools](https://hapopioidlan.org/Resources-Tools)

If you have resources you would like to share, please email them to Marty Kenyon at mkenyon@haponline.org.

**Data Reporting Period and Timeline**

Please submit your hospital’s *monthly* data on the following schedule:

- Quarter 1, 2020 due May 15, 2020
- Quarter 2, 2020 due August 14, 2020
- Quarter 3, 2020 due November 16, 2020
- Quarter 4, 2020 due February 15, 2021
- Quarter 1, 2021 due May 15, 2021

**Save the Date!**

HAP Opioid Learning Action Network Annual Conference on **July 23, 2020** in Harrisburg, PA
HAP Opioid Learning Action Network (LAN)
Northwest Regional Virtual Meeting

Tuesday, March 31, 2020
8:00 AM - 10:00 AM

Login: https://zoom.us/meeting/register/uZUvf-2grDosGzUdQXnkNEup3gtI5DGvc6A
Welcome and Housekeeping

Claudette Fonshell, MSN, RN
HAP Opioid Learning Action Network (LAN) Project Manager
& Director of Clinical Improvement/PURC Program Manager for
Health Care Improvement Foundation
Housekeeping

1. Virtual Meeting Features
   • You can access audio either through your computer or your telephone
   • Introduce yourself in the Chat Box
   • Raise your hand to initiate a question
   • We encourage video sharing

2. Please keep your line muted unless you are asking/answering a question or presenting

3. Poll Question – Tell us what role you associate with at your organization
Welcome and Opening Remarks

Jennifer Jordan
Vice President, Regulatory Advocacy,
The Hospital and Healthsystem Association of Pennsylvania
Kami Anderson
Executive Director
Armstrong-Indiana-Clarion Drug & Alcohol Commission
ARMOT PARTNERSHIPS

• Collaboration is the key!

• Partnerships with three local, rural hospitals: Indiana Regional Medical Center, Armstrong County Memorial Hospital and Clarion Hospital

• Partnerships with local Drug and Alcohol Treatment Providers: ARC Manor, Cen-Clear, Conewago-Firetree, Family Services of Western PA, and The Open Door

• Agreements/contracts with over 20 Withdrawal Management/Residential Drug and Alcohol Treatment Facilities statewide in Pennsylvania
ARMOT GOALS AND OBJECTIVES

• Enhance the linkage between rural hospitals and D&A treatment providers in Armstrong, Indiana and Clarion Counties.

• Screen and assess patients with substance use disorders and refer to supportive services.

• Increase patient admissions to drug and alcohol treatment from hospital/medical settings.

• Educate hospital staff, patients and their families on substance use disorders and recovery.

• Reduce patient ED visits, hospitalizations and inpatient stays.
WARM LINE/ON-CALL RECOVERY SUPPORT

- CRS Staff are available via phone 24/7
- Calls are made to the Crisis Line and the caller is connected to the CRS for resources, treatment information, and/or will be scheduled for an assessment in our office next business day.
- Half of callers are looking for treatment and the other half are looking for resources/information for their loved ones.
- 81% of callers that met with AICDAC staff entered treatment.
ARMOT PROCESS

- Hospital Staff identify patients with substance use disorders for referrals to ARMOT Program
- Hospital Staff briefly explain ARMOT and get patient permission (verbal consent) to make referral
- Case Manager and/or Certified Recovery Specialist meet with patient to further explain ARMOT and options for treatment/recovery support
- Case Manager/CRS assist patient with accessing D&A treatment and other supports directly from the hospital.
ARMOT SERVICES

• Level of Care Assessments & Referral to Treatment
• Coordination of Care
• Recovery Support before, during and after treatment – face to face, telephone, recovery checkups
• CRS staff understand the patient empathetically in a non-judgmental manner and support them
• Self-identify as in Recovery, inspire hope for patients and their family members.
• Education, Information and Referrals for families about addiction and recovery
• Advocacy
COMPREHENSIVE CASE MANAGEMENT SERVICES

• A collaborative process between client and case manager that facilitates access to available resources as well as engagement in the continuum of treatment and support services, while educating clients on the skills necessary to achieve self-sufficiency and recovery from substance use.

• Level of Care Assessments- American Society of Addiction Medicine (ASAM)

• Case Coordination- Service Planning: access to healthcare, basic needs, physical health, emotional/mental health, family, childcare, legal status, education/vocation, life skills, social, and employment

DDAP Treatment Manual
SAMHSA’s TIP 27
RECOVERY SUPPORT SERVICES

- Recovery Support Services (RSS) are non-clinical services that assist individuals and their families to recover from alcohol and other drug problems. These services complement treatment, outreach, engagement, and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate, maintain, and sustain long-term recovery. RSS are not a substitute for necessary clinical services.

- AICDAC employs 8 Full Time Certified Recovery Specialists that are involved in every program.
ARMOT OUTCOMES

- Over 1,600 patients referred to the ARMOT Program since 2015
- 74% of patients referred were screened by ARMOT staff
- 85% of patients that were assessed went to treatment directly from the hospital
- 54% of patients completed D&A treatment
- 82 patients re-engaged with ARMOT after a relapse and were placed back in treatment
- More than 1,700 local hospital staff have been educated on substance use disorders and the recovery process by ARMOT
OUD Screening Processes - Are You Missing Anything?

Discussion

Sally Regina-Payne, RN
ER Nurse Manager
Clarion Hospital
MAT Warm Handoff - What is your Method?
Case Studies & Facilitated Discussion

Donna Balewick, MD
ED Director
Indiana Regional Medical Center

Mike Krafick, CRS
Certified Recovery Specialist Supervisor
Armstrong-Indiana-Clarion Drug & Alcohol Commission
BUPRENORPHINE IN THE ED & WARM HAND-OFF

Donna Balewick, MD
Mike Krafick, CRS
Utilizing Buprenorphine in the Emergency Department

• How to determine a patient is appropriate for MAT
• Policies and protocols for utilizing Buprenorphine in the Emergency Department
• Resources for aftercare/linkage to treatment and community supports
• Importance of co-prescribing and/or distributing Naloxone
Case Study #2  Warm Hand-off

**Connecting Overdose Survivors to Treatment from the ED**

- How to identify a patient is appropriate for Warm Hand-off referral
- Engaging the individual in discussion of treatment options (utilizing CRS when available)
- Screening and Assessment occur bedside in the ED
- Referral to treatment and follow up (extremely important to offer services post warm hand-off)
Donna Balewick, MD
Indiana Regional Medical Center

Mike Krafick, CRS
Supervisor
Armstrong-Indiana-Clarion Drug and Alcohol Commission
Highlighting Harm Reduction Strategies Throughout the Region

Presentation & Facilitated Discussion

Alice Bell

Overdose Prevention Project Coordinator

Prevention Point Pittsburgh
Harm Reduction Strategies for a Public Health Crisis

Alice Bell, L.C.S.W.
Overdose Prevention Project
Prevention Point Pittsburgh
abell@pppgh.org
412-247-3404
Harm Reduction

- Doesn’t minimize harms that can be related to drug use, but accepts drug use as a part of our world.

- Does a particular drug-related harm come from the drug use itself, or is it due to legal status, stigma or other factors?

- Example: Heroin doesn’t cause HIV. If sterile syringes are always used or heroin is ingested without needle use, heroin use would not cause HIV.

- Fentanyl does not cause overdose, taking an unknown dose that is greater than your body is accustomed to, causes overdose. If people know what is in their drug supply, overdose risk is reduced.
Prevention Point Pittsburgh

Harm Reduction Services

- Providing Sterile Injection Equipment to prevent HIV & Hep C since 1995.
- Testing for HIV and Hepatitis C
- Case Management, assistance to treatment
- Overdose Prevention & Response Training
- Naloxone Distribution since 2005.
- Wound Care Consultation Clinic
- Education on safer injection.
- Safer Smoking Supplies
- Fentanyl test strips for drug checking
- All Services Free of Charge
- Anonymous/Confidential
- Low Threshold
Allegheny County Accidental Drug Overdose Deaths
2000-2017*

85% of cases include more than one drug

*Data from Allegheny County Medical Examiners Annual Reports. Includes all overdose deaths where these drugs were present at time of death, alone or in combination with other substances.
Supply Reduction Without Increased Access to Treatment and to Naloxone Had Devastating Consequences.

- Since 2010 Prescription Opioid Overdose deaths plateaued, but overall opioid overdose deaths more than doubled, primarily driven by illicit fentanyl overdose deaths.
- In addition to overdose deaths, Hepatitis C infections have increased 250% since 2010. Rural states have seen Hep C increase of 364%.
- HIV Outbreaks: Over 200 injection-related HIV cases rural, Scott County, Indiana, from 2015 outbreak.
- Lowell/Lawrence, MA – 129 cases of HIV; CDC concerned about possible outbreaks in small towns/rural areas without access to SEP.
- Huntington WV - 80 injection-related HIV cases, up from 8 or 9 annually.
- Restricting access to sterile injection equipment is not effective strategy.
If you believe that the opioid epidemic is in fact iatrogenic, as you do, if you believe we must restrict prescribing to reverse it, then we have the highest ethical standard to not further harm people as we try to fix this problem.

Akin to a surgeon removing an instrument left in an abdomen, we would not rip out what we left behind and tell you to get out of our office.

We would very carefully repair the problem and serve you with the utmost care and caution until that issue and any complications were managed.

Phillip Coffin, MD, MIA
San Francisco Department of Public Health
Plenary Session Harm Reduction Conference, Baltimore, MD
October 23, 2014
The Medication IS the Treatment rather than “assisting.”

Research shows people do just as well on bup or methadone alone as methadone plus counseling.

Counseling, therapy, support groups can undoubtedly be beneficial for some, BUT the benefits of medication are not contingent on auxiliary treatment.

In the age of fentanyl, refusing medication to someone because they don’t go to counseling may be a death sentence! Opioids Replacement medication should be more easily available than illicit fentanyl in order to reduce deaths.

MA Retention in OUD Treatment
An emergency response to the opioid overdose crisis in Canada: a regulated opioid distribution program

Mark Tyndall

Simply warning people to avoid fentanyl or the plethora of new synthetic analogs is both naive and ineffective.

Although it is widely accepted that liberal prescribing practices have contributed to the current crisis,...[e]ncouraging physicians to reduce their opioid prescriptions in an environment where the illegal alternatives are lethal is harmful. Abruptly cutting people off their prescription will likely lead to withdrawal. A reduction in the overall number of prescriptions creates a shrinking supply of diverted drugs, the unintended consequence of which may be to push people, many of whom were not even known to be chronic opioid users, into much more unstable and dangerous drug markets. People who once had consistent access to either prescribed or diverted pharmaceutical opioids are suddenly in grave danger of being poisoned by a single lethal purchase.

Although a number of important “upstream” interventions are critical to our response, including a functioning system for treating addiction, supportive housing programs, screening programs for at-risk youth, a cultural shift in how we view drug users and a reduced reliance on the criminal justice system, these will come too late for the families who will lose a loved one this year or the next. We cannot simply give up on the current group of chronic opioid users who are playing a form of “Russian roulette” with every injection or inhalation.

The public health response to any poisoning epidemic should be to provide safer alternatives for people at risk. In the case of the overdose crisis, this would mean providing a regulated supply of pharmaceutical-grade opioids to people at highest risk of overdose. Any options to expand access to pharmaceutical-grade opioids runs counter to prevailing narratives regarding the origins of the current overdose crisis. However, it is now clear that the rapid rise of overdose deaths across the country is a result of illegal, unregulated and lethal synthetic compounds that have largely replaced the regular street supply.
EFFECTIVE NALOXONE DISTRIBUTION
Prevention Point Pittsburgh
Cumulative Data - July 2005- December 2019

97% of Naloxone Rescues Performed By Individual Who Use Opioids

Third Party Implemented

Total Number of Individuals Who Received Naloxone
Total Number of Overdose Reversals
NUMBER ONE priority: Put naloxone in the hands of those most likely on the scene and first to respond, individuals who use opioids, themselves. Reached through SSP's, Jails, Hospitals, SUD Tx Programs, Homeless Service Programs, Medical Clinics.

Make naloxone EASILY available and plentiful enough to saturate communities of people who use drugs. Pharmacy dispensing has had minimal impact as PWUD’s are not likely to access. Hospital dispensing is essential component of effective strategy.
An almost 2000% increase in naloxone distributed through SSP, jail, hospital ED’s, SUD Tx Providers, Pharmacies, ACHD.

The U.S. Drug Enforcement Administration reports that the number of people in Pennsylvania who died of drug overdoses decreased by 18 percent between 2017 (5,456 deaths) and 2018 (4,492 deaths).

Allegheny County was responsible for 32% (305 out of 964) of the decrease in deaths seen 2017-2018 statewide.
Allegheny County, Pennsylvania
Accidental Drug Overdose Deaths    2000-2018

2018: 41% Decrease in Deaths

2018: 77% of deaths involve Fentanyl and/or analogues
87% of cases include more than one drug

*Data from Allegheny County Medical Examiners Annual Reports. Includes all overdose deaths where these drugs were present at time of death, alone or in combination with other substances.
The idea: If you know they're about to inject, snort, smoke or swallow fentanyl, you'll take smaller doses, avoid using alone, and make sure you have naloxone handy in case of overdose.

Even when someone assumes they have fentanyl, the experience of testing the drugs and seeing positive confirmation that it's fentanyl has an impact.

It encourages people to use more safely.
Hepatitis C, increased by more than eight-fold in the 10-county Southwestern Pennsylvania region, driven by the spike in injection drug use and shared needles, creating an explosion of hepatitis C among younger injection drug users.

Sterile syringes cost about 7 to 10 cents each (about $185/year average) when purchased in bulk, compared to the cost of treating hepatitis C — which can range from $50,000 to $80,000.

Adopting Public health approach, treating people with compassion, instead of criminalizing and policing, is effective strategy for other problems as well!
No one gets HIV, Hep C, Endocarditis or COVID19 from a sterile syringe.

Restricting supply of sterile syringes has been ineffective public health policy. We need to increase access to sterile syringes.

Example: Wisconsin Law “Drug paraphernalia” excludes:
   1. Hypodermic syringes, needles and other objects used or intended for use in parenterally injecting substances into the human body.

We’ve had Syringe Exchange Programs in Pittsburgh and Philadelphia for over 20 years, it’s time to adopt common sense policy to allow these programs to expand to other communities. We need to get rid of the paraphernalia provisions of the Controlled Substances, Drugs, Device, and Cosmetic Act. It makes no sense for it to be illegal to possess a sterile syringe or a fentanyl test in most of Pennsylvania.
Physicians Can and Should Provide Access to Sterile Injection Equipment

- Prescribing syringes should be one element of a comprehensive relationship between the physician and the patient and should be done within the context of the patient's overall medical and health needs, as part of a non-judgmental, culturally sensitive interaction that includes an openness to discussing injection-related activities and a willingness to provide links to other needed programs and services.

- Physician prescription of injection equipment is legal in 48 jurisdictions.

- Physicians generally have broad discretion to prescribe drugs and devices that they believe are medically beneficial for their patients. Several major medical and legal societies, including the American Medical Association, the Infectious Diseases Society of America, and the American Bar Association all support efforts to improve IDUs' access to sterile syringes, including physician prescription.
Of 73 visits to PPP’s wound care consultation program, when people were asked the question “If you hadn’t come here for this problem, where would you have gone?”

- 9 people reported they would have gone to ED.
- 19 stated they would have gone to a “clinic,” “urgent care,” or their PCP.
- 50 stated they would have done “nothing” or treated the problem themselves.
Harm Reduction Practices in Hospitals

- **Reduce Overdose Deaths:**
  - Provide naloxone in hospital ED’s and other outpatient settings. People should leave with naloxone!
  - Dispense buprenorphine and insure additional doses available.

- **HIV, Hep C, Endocarditis, soft tissue infections.**
  - Offer testing for HIV, Hep C.
  - Prescribe/Dispense sterile injection equipment.

- **Foster effective, compassionate, provider relationship with patients.** End “policing” role, prevent patients leaving AMA.
  - Provide medication to prevent withdrawal symptoms and keep patient comfortable.
  - Treat whatever health issues people present with.
Harm Reduction and COVID-19

- Continuing to provide life-saving supplies
  - The Sec of Health declared SSP’s to be essential, life-sustaining services.

- Offering information for people who use drugs
  - How to protect yourself
  - What to do if you are sick
  - Guidance on particular risks and concerns.
BE AWARE that some early symptoms of withdrawal and COVID-19 infection are similar. These include fever and muscle soreness. If symptoms include a persistent cough, it could be COVID-19.

YOU ARE AT AN INCREASED RISK OF BECOMING SERIOUSLY ILL OR DYING because
1. COVID-19 infection will worsen breathing impacts of opioids, benzos, and alcohol
2. Opioid withdrawal may worsen breathing difficulties
3. Smoking, including drugs like crack or meth, makes breathing problems worse

DIFFICULT TO INHALE: If you smoke drugs, like crack or meth, cigarettes or vapes, COVID-19 infection will make it more difficult to inhale smoke. Smoking drugs, cigarettes, or vapes will worsen breathing problems.
Increase access to Effective Treatment

Electronic Prescribing of Controlled Substance (EPCS)

DEA Policy: Questions and Answers for Prescribing Practitioners (EPCS)

DEA Guidance: Use of Mobile Devices in the Issuance of EPSC

Telemedicine

On January 31, 2020, the Secretary of the Department of Health and Human Services issues a public health emergency (HHS Public Health Emergency Declaration).

Question: Can telemedicine be used under the conditions outlined in Title 21, United States Code (U.S.C.), Section 802(34)(D)?

Answer: Yes. While a prescription for a controlled substance issued by means of the Internet (including telemedicine) generally be predicated on an in-person medical evaluation (21 U.S.C. 829(e)), the Controlled Substance Act contains certain exceptions to this requirement. One such exception occurs when the Secretary of Health and Human Services has declared a public health emergency under 42 U.S.C. 247d (section 319 of the Public Health Service Act), as set forth in 21 U.S.C. 802(34)(D). In January 2020, the Secretary, with the concurrence of the Acting DEA Administrator, designated that the telemedicine allowance under section 802(34)(D) applies to all controlled substances in all areas of the United States. Accordingly, as of March 16, 2020, and continuing for as long as the Secretary’s designation of a public health emergency remains in effect, DEA registered practitioners in all areas of the United States may prescribe for all schedules II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

• The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
• The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
• The practitioner is acting in accordance with applicable Federal and State laws.

Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule II-V prescription to the pharmacy.

The term “practitioner” in this context includes a physician, dentist, veterinarian, or other person licensed, registered, or otherwise permitted by the United States or the jurisdiction in which s/he practices to prescribe controlled substances in the course of his/her professional practice (21 U.S.C. 802(21)).

Important note: If the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services, so long as the prescription is issued for an individual medical purpose and the practitioner is acting in the usual course of his/her professional practice. In addition, for the prescription to be valid, the practitioner must comply with applicable Federal and State laws.
Increasing access to HR supplies

- Provide harm reduction supplies at all points of contact.

- Provide more supplies so people don’t have to come as often.

- Access to safer smoking and snorting supplies is now critical as well as injection equipment!

- More critical than ever that people have naloxone as 911 may not be able to respond!
Now is the time to discontinue the failed strategy of arresting and incarcerating people for health issues.

One day after Philadelphia courts closed until April 1 to limit the spread of the coronavirus, Police Commissioner Danielle Outlaw notified commanders Tuesday that police will be delaying arrests for nonviolent crimes, including drug offenses, theft, and prostitution.

Conditions at the Allegheny County Jail create “the perfect storm for a potential COVID-19 outbreak,” local activists said in an online statement that calls for the mass release of people held at the jail.

Posted Sunday, the statement outlines several factors that make the jail an especially risky environment: close quarters make social distancing practically impossible for the facility’s 2,201 occupants; inmates often lack basic hygiene items; and the high turnover of people at the jail increases the chances the virus will spread, both inside and outside the building’s walls.

“It will become an incubator for COVID-19 within the county and the surrounding region,” said Bret Grote, co-founder and legal director of the Abolitionist Law Center.
Drug arrests now account for a quarter of the people locked up in America. Over the last 40 years, we have spent trillions of dollars to wage a “War on Drugs”.

Drug use has not declined, but millions of people—disproportionately poor people and people of color—have been caged and then branded with criminal records that pose barriers to employment, housing, and stability, all critical factors in a person’s ability to maintain a life without illicit drug use.

One in three black men can expect to be incarcerated in his lifetime. Compare that to one in six Latino males and one in 17 white males.

The effect of the War on Drugs on communities of color has been tragic. At no other point in U.S. history have so many people—disproportionately people of color—been deprived of their liberty.

And now, these individuals will disproportionately be effected by the COVID19 virus, as a result of our failure to address problems related to drug use from a harm reduction perspective, and our continued reliance on a failed strategy of punishment and incarceration.
“In March, he would have turned 30. I hear others talk about their children and sometimes feel so sad and so envious that they have the rest of their lives with their children, that they will likely have grandchildren, and a lifetime of companionship...a future built around whatever happens with their children. I won't have that.

I went through twenty five years of struggle to raise Nick. It wasn't easy. I was Nick's mom. Now I'm nobody's mom. I put so much in to trying to teach and protect him and was ultimately a failure in the end.

That's not entirely true though. Nick was a stellar human being...he just had problems and eventually, his problems, not knowing his limitations, his desire for escape , resulted in the ultimate escape. I think I'll always believe I could have or should have done something differently. I think I'll always have guilt and always feel it as the ultimate unfairness.”

Kate Duncan 2014
“Harm reduction is the radical notion that drug users are people.”

– Iowa Harm Reduction Coalition
Wrap Up and Next Steps

Kate Slatt
Vice President, Innovative Payment and Care Delivery
The Hospital and Healthsystem Association of Pennsylvania
Upcoming Key Dates

- April 2, 2020 Office Hour Call
- April 16, 2020 Webinar
- May 7, 2020 Office Hour Call
- Ongoing Collection of Tools/Resources
  Submit to mkenyon@haponline.org
- Save the Date! July 23, 2020 Annual In-Person Event
Thank You!

Please fill out the following evaluation by April 7th
https://www.surveymonkey.com/r/lan-033120
HAP Opioid Learning Action Network (LAN)
Northwest PA Regional Virtual Meeting
Tuesday, March 31, 2020

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