Welcome!

While we wait to start, please review ways to navigate this webinar.

If you move your **cursor** to the **bottom** of **your screen** you will see a **menu**.

This menu allows you to **control**:

- React ("**Raise Hand**" is under this option)
- Access to the **Chat** box

Camera options are not available for participants. Participants can be unmuted by raising their hand and being recognized by the presenter.

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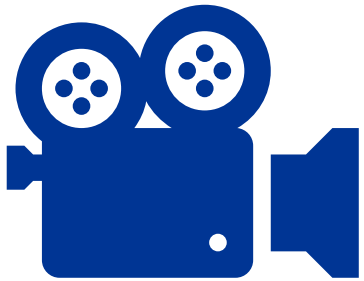
Housekeeping



This session is being recorded to **Tomorrow's Healthcare**.

If you used a forwarded link, we need your **email address**.

Pose questions in the chat to **all participants**.

Please complete the post-session **evaluation**.

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In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. **1.25 hours is approved for this course**.

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Mutual Agreement

- Everyone on every Program Evaluation and Research Unit (PERU) webinar is **valued**. Everyone has an expectation of **mutual, positive regard** for everyone else that respects the **diversity** of everyone on the webinar.
- We operate from a **strength-based, empathetic, and supportive** framework – with the people we serve, and with each other on PERU webinars.
- We encourage the use of **affirming language** that is not discriminatory or stigmatizing.
- We treat others as **they** would like to be treated and, therefore, avoid argumentative, disruptive, and/or aggressive language.

Mutual Agreement (continued)

- We strive to **listen** to each person, avoid interrupting others, and seek to **understand** each other through the Learning Network as we work toward the highest quality services for Centers of Excellence (COE) clients.
- Information presented in Learning Network sessions has been vetted. We recognize that people have different opinions, and those **diverse perspectives** are welcomed and valued. Questions and comments should be framed as **constructive feedback**.
- The Learning Network format is **not conducive to debate**. If something happens that concerns you, **please send a chat during the session** to the panelists and we will attempt to make room to address it either during the session or by scheduling time outside of the session to process and understand it. **Alternatively, you can reach out offline to your PERU point of contact.**

Acknowledgements

- The COE project is a partnership of the University of Pittsburgh's Program Evaluation and Research Unit and the Pennsylvania Department of Human Services; and is funded by the Pennsylvania Department of Human Services, grant number 601747.

- COE vision: The Centers of Excellence will ensure care coordination, increase access to medication-assisted treatment and integrate physical and behavioral health for individuals with opioid use disorder.

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DEPARTMENT OF HUMAN SERVICES

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Program Evaluation and Research Unit

Harm Reduction

University of Pittsburgh | School of Pharmacy

Harm Reduction Opportunities in Health and Public Health Settings: What are we missing?

Mary Hawk, DrPH, LSW
Professor & Chair
Behavioral and Community Health Sciences
University of Pittsburgh School of Public Health

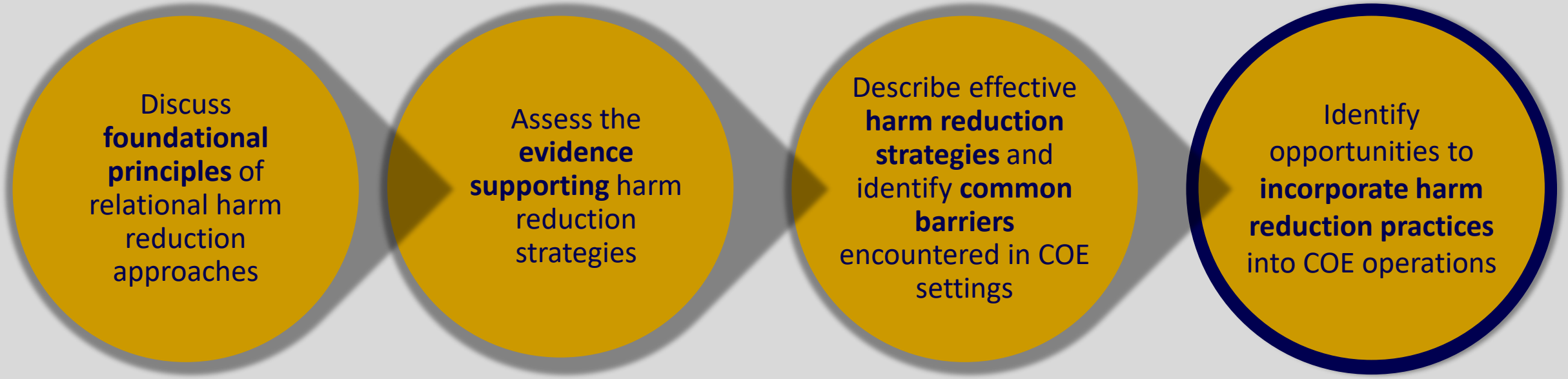
Funding support is provided by the National Institute on Drug Abuse, 1R01DA054832 (Hawk, Kay MPI)

Positionality

I identify as a white cisgender heterosexual woman with no personal experience with substance use disorder (SUD).

In my research, I strive to understand ways my privilege and experiences may influence my understanding of the data.

At the end of this session, you should be able to:



Think of a time you had a great healthcare experience.

What made it great?

Think of a time you were not 100% truthful with your doctor.

What made you hold back?

What is one of your earliest memories of when you learned about people who use substances?

Where my work in this area began.

Positive Health Clinic

Mixed Methods Study

Qualitative Interviews

n = 25 PWH

n = 17 Staff members

Quantitative Surveys

n = 201 PWH

EHR Data

n = 785 PWH

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What we learned

Qualitative Results

- Low-threshold care
- Individualized care
- “Universal” harm reduction

Quantitative Results

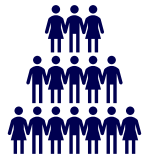
- HR predicts adherence
  - 4.9% of explained variance
- Among active substance use subsample (n=73)
  - 8.8% of explained variance

Harm Reduction Principles for Healthcare Settings

- Humanism
- Individualism
- Autonomy
- Pragmatism
- Incrementalism
- Accountability without Termination

Impact of harm reduction care in HIV clinical settings on stigma and health outcomes for PLWH who use drugs

- ✓ Provider attitudes
- ✓ Provider context



- ✓ Relational harm reduction
- ✓ Experiences of stigma
- ✓ Clinical outcomes

Patient Assessment of Provider Harm Reduction Scale (PAPHRS)

- ✓ Design an intervention
- ✓ Assess acceptability

Quantitative Results

Negative attitudes towards serving PWUD were independently associated with lower harm reduction acceptability (b=-0.29, p=0.001)

- Location: Birmingham, AL versus Pittsburgh, PA b = -0.34, p=0.001
- Race: Black or African American versus White b = -0.45, p=.0.001

Compared to those with ≤5 years of experience, harm reduction acceptability was higher among providers with 6-10 years and >20 years of experience working with people with HIV (b = 0.45, p=0.003 and b = 0.62, p=0.02)

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“I think my only issue with that is just the fear that we'll lose them and recognizing that's a me issue… that’s not a burden I should place on the person that's using.”

Ptp #16, PA

<5 years

“I've seen it with people… they don't wanna seek care for something that's not even substance-use related because they know that question will come up… They'll feel like they'll be looked at and judged as a substance user or something…. So, they just don't go, it's the trauma of past-experience stigma and not wanting to experience that again.”

Ptp. #17, PA
<21+ years

Organizational Self-Assessment

ORGANIZATION ENVIRONMENT

Literature, brochures, and referral information is available that makes it clear that people who use drugs are welcome.
Literature, brochures, and referral information is available for a range of recovery options.
Language used in printed materials uses language that is non-judgmental.
Materials are inclusive of people of different races, ethnicities, and sexual orientations.
There is a safe space on the premises where people can smoke.

STAFF KNOWLEDGE AND SUPPORT

Staff are trained to discuss or provide a range of substance use treatment options.
Abstinence from illicit drugs is assumed to be the goal for all clients/patients.
Staff are trained about partner agencies that provide harm reduction services.
Staff are trained on how to use non-stigmatizing language when discussing substance use.
There are methods in place to prevent or address staff burnout.
Peer staff members (people with lived or living experience with substance use) are fully trained in discussing a range of care options for people who use drugs.

SAFE AND ACCESSIBLE SERVICES

Staff are supported in challenging negative stereotypes of people who use drugs.

There are clear roles for patient advocacy with other systems and providers.

The organization is located in a neighborhood where clients/patients feel safe.

Security measures feel appropriate for clients/patients.

Partners and family members are involved in treatment planning when clients/patients want them to be.

PEER AND COMMUNITY INPUT

There is a functioning community advisory board (CAB).
The CAB reviews policies prior to implementation.
The CAB reviews literature prior to distribution.
Peers are consulted when decisions about boundary setting are being made.
Peer roles are clearly defined.
Peer staff are fully supported.
Peer staff are fully trained.

CONTINUUM OF HARM REDUCTION CARE

Leave-behind naloxone is distributed to every client/patient.
Sterile syringes/works are provided on site.
Safer smoking kits are provided on site.
Drug testing strips are provided on site.
Improving substance use health literacy is a priority for all clients/patients.
MOUD is offered on site.
Warm handoffs to MOUD treatment is provided on site.
Warm handoffs to harm reduction community partners are offered.
Services are provided on a sliding fee scale when health insurance is not available.

POLICIES AND PROCEDURES

Harm reduction principles are part of the written policy.

Language used in policy and procedures is non-stigmatizing.

Clients/patients are not "fired" if they are late to appointments.

Clients/patients are not "fired" if they do not meet or change treatment goals.

SOCIAL JUSTICE AND ADVOCACY

Services are expedited for clients/patients who are re-entering the community after incarceration.

There are clear expectations around advocating for the needs of clients/patients.

There is a clear anti-bullying policy.

HIPAA and other confidentiality laws are fully addressed.

There is a plan for addressing the needs of clients/patients with outstanding warrants.

Staff are trained that they should NOT check to see if their clients/patients have outstanding warrants.

There is a client/patient-centered plan for doing required urinalyses for justice-involved patients.

Table 1 Internists' Overdose Toolkit for Structural and Relational Harm Reduction

From: Relational Harm Reduction for Internists: A Call to Action

Intervention focus	Structural harm reduction	Relational harm reduction
Universal precautions	• Opportunities to enhance naloxone access ○ Open prescription ○ Prescriptions with refills ○ Over-the-counter access ○ Onsite point of care ○ Vending machines ○ Free local access points ○ Good Samaritan laws • Safe storage and disposal of drug use equipment • Prescription Drug Monitoring Program monitoring	• Normalizing conversations about substance use with all patients rather than waiting for patients to disclose substance use concerns • Prioritize patients' goals; do not assume abstinence as the only positive outcome • Establish policies ensuring patients can continue in care even in the presence of ongoing substance misuse • Normalizing conversations about toxic drug supply and risk of overdose • Discuss concepts of opioid tolerance and relapse • Dispel myths and stigma around fentanyl, overdose, and naloxone • Ask about prior overdoses or knowledge of signs and symptoms of overdose and overdose antagonists • Counsel on signs and symptoms of overdose and how to use intranasal naloxone in clinic and/or at discharge • Ask about barriers to access including copayment, transportation to care, and stigma • Tailor overdose response plans • Have open conversations about drug use, pain, mental health, concurrent substance use disorder, stigma, and self- treatment with substances • Provide regular and inclusive anti-stigma trainings for healthcare workers
Drug supply	• Distribute onsite fentanyl and/or xylazine testing strips in areas where these are legal	• Know low barrier drug checking access points • Develop partnerships with drug checking programs and harm reduction organizations to know about local supply • Advocate for safe supply and provide access to opioid agonists

Thank you

Mary Hawk, DrPH, LSW
mary.hawk@pitt.edu

Relational Harm Reduction for Internists: A Call to Action (Hawk, Kay, Jawa, 2024)

Harm Reduction Principles for Healthcare Settings (Hawk, et al., 2017)

Organizational Assessment Tool

References

Hawk, M., Coulter, R. W., Egan, J. E., Fisk, S., Reuel Friedman, M., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings. *Harm reduction journal*, *14*, 1-9.

Kay, E. S., Creasy, S., Batey, D. S., Coulter, R., Egan, J. E., Fisk, S., ... & Hawk, M. (2022). Impact of harm reduction care in HIV clinical settings on stigma and health outcomes for people with HIV who use drugs: study protocol for a mixed-methods, multisite, observational study. *BMJ open*, *12*(9), e067219..

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Harm Reduction

A Compassionate, Evidence-Based Approach to Health & Safety

JADE WELLNESS CENTER

Daniel Garrighan

Corey Policastro

AIMS
ACCESS IMMEDIATE MEDICATION SERVICES

Naloxone Distribution (Opioid Overdose Reversal)

Pros	Why It Matters
🛑 Saves lives	Rapidly reverses life-threatening opioid overdoses
🧠 Works quickly	Takes effect in 1–2 minutes, restoring breathing
👥 Easy to use (nasal spray)	Can be administered by non-medical people (friends, family, bystanders)
💼 Widely available	Available over the counter in many areas
🆓 Often free	Many public health programs, schools, and clinics distribute it at no cost
🧪 No effect if no opioids	Safe to use — won't harm someone not on opioids
🕊️ Non-addictive	Doesn't create a high or risk of misuse
🚑 Gives time for EMS	Keeps the person alive until emergency help can arrive

Barriers to Naloxone Distribution

Cons	Why It Matters
⏳ Temporary fix	Wears off in 30–90 minutes — opioids may outlast it and re-overdose is possible
🤒 Can trigger withdrawal	May cause sudden, painful withdrawal symptoms (e.g., nausea, vomiting, anxiety, sweating)
🧯 Doesn't treat OUD	It's emergency care — not a substitute for long-term treatment
🤷 Limited impact if other drugs involved	May not work well on non-opioids (e.g., meth, benzos, xylazine)
🔁 May need multiple doses	Strong opioids like fentanyl may require 2+ doses for full reversal
😓 Stigma or fear of calling 911	Some people hesitate to use or carry it due to legal or social fears

Substance Checking Services (e.g., Fentanyl Test Strips)

Pros	Why It Matters
🛑 Can prevent overdoses	Detects dangerous contaminants like fentanyl, allowing users to make safer choices
⏱️ Quick and simple to use	Results in minutes; just mix substance residue with water and dip the strip
🧠 Informs safer behavior	People may choose to use less, not use, or take extra precautions if fentanyl is present
🏠 Discreet and portable	Can be used privately and easily carried in a wallet or bag
💵 Low-cost and widely available	Many programs give them out for free; often available through harm reduction sites
🔁 Supports harm reduction	Meets people where they are, instead of insisting on abstinence

Barriers to Substance Checking Services

Cons	Why It Matters
❌ Not 100% accurate	May miss trace amounts (false negatives) or detect non-active fentanyl analogs
🔎 Limited detection scope	Strips can only test for a single substance, fentanyl or xylazine. Cannot test other adulterants like meth
💊 Can't measure potency	Even if fentanyl is detected, strips won't show how much is present
🧪 Requires mixing and caution	Some users may find the testing process confusing or cumbersome
🚫 Still illegal in some places	In a few U.S. states, test strips are technically classified as substance paraphernalia
🤔 Doesn't eliminate all risk	Some may wrongly assume a "negative" test means a substance is safe to use

Housing First Approach

Housing First is an evidence-based approach that provides people experiencing chronic homelessness with permanent housing immediately, without requiring sobriety, treatment participation, or other conditions before getting housing. Supportive services are offered, but housing is not contingent on compliance.

Pros	Why It Matters
🏠 Immediate stability	Housing is provided first, creating a safe base for recovery and well-being
🧠 Improves mental health	Reduces stress, trauma, and chaos associated with life on the streets
💉 Reduces substance use over time	With housing secured, many voluntarily engage in treatment and reduce risky use
💰 Cost-effective	Reduces public costs (ER visits, shelters, jail stays) by $23,000–$31,000/year/person
👉 Supports autonomy	Meets people where they are; respects personal choice and recovery readiness
🔁 Higher housing retention rates	80–90% of participants stay housed long-term, even with co-occurring disorders
🏥 Better health outcomes	Increases access to healthcare, food, hygiene, and case management

Barriers to Housing First Approach

Cons	Why It Matters
❌ Not always paired with treatment	Some argue that optional treatment may delay engagement for those with SUD
🧩 Challenging for some communities	Requires investment in affordable housing and support staff
💸 High up-front cost	Initial funding for housing units, case workers, and wraparound services can be steep
🚫 Community pushback (NIMBYism)	Some neighborhoods oppose housing programs due to stigma or safety concerns
🔄 Complex needs persist	Housing doesn't "solve" SUD or mental illness on its own
📊 Success depends on services	Without strong, coordinated care (mental health, substance use, employment), impact may be limited

What about Abstinence?

While harm reduction doesn't require abstinence, it absolutely supports it as a valid goal — if and when the person chooses it.

- Harm Reduction embraces abstinence when:
  - It's the person's goal (voluntary, not forced)
  - It follows gradual change (e.g., cutting down use before quitting)
  - It's supported with tools like peer support, therapy, and housing
  - It's nonjudgmental and does not exclude people who return to use
- Harm Reduction ≠ Anti-Abstinence
  - Instead, harm reduction says "You don't have to be abstinent to be worthy of help — but if you want abstinence, we'll support you."

Abstinence Integration into COE

- Offer abstinence as a recovery path
  - Promote it as one of several valid outcomes (alongside reduction or Medication Assisted Recovery (MAR))
  - Make space for people who identify with abstinence-based programs (e.g., 12-step, faith-based, SMART Recovery)
- Create customized care plans
  - During intake, let patients self-identify goals (e.g., “I want to quit all substances.”)
  - Offer pathways like detox + residential, abstinence-based outpatient groups, Peer supports in abstinence recovery
- Incorporate peer recovery support
  - Hire peers with lived experience in abstinence-based recovery
  - Offer peer-led groups like AA, NA, Refuge Recovery, or Celebrate Recovery
- Support long-term abstinence
  - Provide ongoing return to use prevention care
  - Offer trauma-informed therapy to address root causes
  - Promote healthy lifestyle tools: exercise, employment, housing, spirituality

Medication Assisted Recovery (MAR)

Medication Assisted Recovery (MAR) the use of medications such as methadone, buprenorphine, and naltrexone to treat opioid and alcohol use disorders. These medications work to reduce cravings, manage withdrawal symptoms, and decrease the euphoric effects of illegal substances.

Benefits of MAR

- Reduces cravings and withdrawal - Reduces cravings and withdrawal symptoms by targeting the same brain systems affected by substances like opioids and alcohol — but in a controlled, therapeutic way that helps restore balance rather than cause a high.[1]
- Lowers risk of overdose and death - A study from NYU Langone Health reported that individuals with OUD receiving MAR were 80% less likely to die from an opioid overdose compared to those not receiving MAR. [2]
- Improves retention in treatment - A study published in JAMA found that patients on buprenorphine or methadone were more than twice as likely to remain in treatment compared to those who didn't use MAR. The National Institute on Drug Abuse (NIDA) says retention is significantly better with MAT—sometimes by up to 50% or more.[1]
- Supports whole-person recovery - Allows people to function in daily life — work, take care of family, go to school — while addressing the biological side of OUD. Counseling and support services can be added to address emotional, mental, and behavioral aspects.[1]
- Reduces criminal activity and incarceration - MAR has been shown to reduce drug-related crime by stabilizing people's lives and supporting behavior change.[3]
- Evidenced-based and widely recommended - Endorsed by the CDC, WHO, SAMHSA, and major medical organizations as the gold standard of treatment for opioid use disorder

(1. NIDA, 2021; 2. NYU Langone Health, 2021; 3. NIJ, 2021;
4. SAMHSA, 2021)

Barriers to MAR

- Stigma and Misunderstanding - Some people believe MAR is just “replacing one drug with another,” especially in abstinence-only recovery communities. Stigma can discourage individuals from starting or continuing treatment.
- Access and Cost Barriers - Not all areas have access to certified providers or clinics. Some medications or treatment programs may not be covered by insurance or may be expensive.
- Potential for Misuse or Diversion - Medications (e.g. methadone, buprenorphine) can be misused or diverted if not managed properly. Requires structured programs and often daily supervision, especially in early stages.
- Side Effects - Medications can cause side effects like constipation, sleep issues, mood changes, or hormonal shifts — though most are manageable.
- Requires Commitment and Monitoring - Many programs require regular appointments, urine screens, and compliance checks, which can feel intrusive or burdensome.

JADE
WELLNESS CENTER

AIMS
ACCESS IMMEDIATE MEDICATION SERVICES

Daniel Garrighan & Corey Policastro

JADE Wellness Center: Center of Excellence
AIMS: Accessing Immediate Medication Services

JADE WELLNESS CENTER

- JADE Wellness Center offers several levels of care
  - Partial Hospitalization (PHP) - 20 hours/week
  - Intensive Outpatient (IOP) - 9 hours/week
  - Outpatient (OP) - 2 hours/week
  - Aftercare / Individuals – 1 hour / month
- We are a Certified Assessment Center
  - Allows for a 48 hour level of care assessment and for direct admissions into treatment services

- JADE Wellness Center is a proud Center of Excellence
  - Engaging individuals with opioid use disorder in Peer Services

- Our Peer Supports are all Certified Recovery Specialists
  - CRS services are available to all Allegheny County residents, assisting in building Recovery Capital and navigating clinical needs.
- Medication services available through Buprenorphine (Suboxone/Sublocade/Brixadi) and Naltrexone (Vivitrol/ReVia) for OUD and AUD.
- Offering psychiatric co-occurring capable tracks, supported by two full-time SUD psychiatrists.

AIMS

ACCESS IMMEDIATE MEDICATION SERVICES

The AIMS program is designed for individuals who need immediate access to medication for Opioid use disorder (MOUD) without traditional barriers. It also catered to those individuals looking for flexible scheduling options and virtual services.

- Simplified intake and treatment processes accessible through the Phone App or Web Portal
  - Prompt access to one of JADE's trusted doctors, typically with same-day appointments or within 24 hours (Monday through Friday).
- Use of cutting-edge technology with the JADE Phone App (available on iOS and Android) or Online Client Portal for easy, low-barrier access and efficient service.
- Prescribing options are buprenorphine, naltrexone, and select non-narcotic “comfort medications” as needed.
- Clients must be enrolled in a Medicaid Healthchoices MCO accepted at JADE Wellness Center:
  - CCBHO Allegheny County & Carelon Westmoreland County

JADE WELLNESS CENTER AIMS ACCESS IMMEDIATE MEDICATION SERVICES

AIMS
ACCESS IMMEDIATE MEDICATION SERVICES

Medication Services

Our goal is to continue to be on the cutting edge of evidence-based SUD medicine interventions

- Buprenorphine-naloxone (Suboxone)
- IM Buprenorphine (Sublocade/Brixadi)
  - Onsite Induction
  - Individualized medication care
  - Serviced through both South Side and Monroeville offices
- Extended-Released Naltrexone (Vivitrol)
  - Once a month, non-narcotic injection for opioid and alcohol return to use prevention

HOURS

- Monday / Wednesday /Friday : 8:30 a.m. to 5:00 p.m.
- Tuesday / Thursday 10:30 a.m. To 7:00 p.m.

Follow-up by a Certified Recovery Specialist after the initial appointment, ensuring ongoing support in the client's treatment journey.

JADE WELLNESS CENTER AIMS ACCESS IMMEDIATE MEDICATION SERVICES

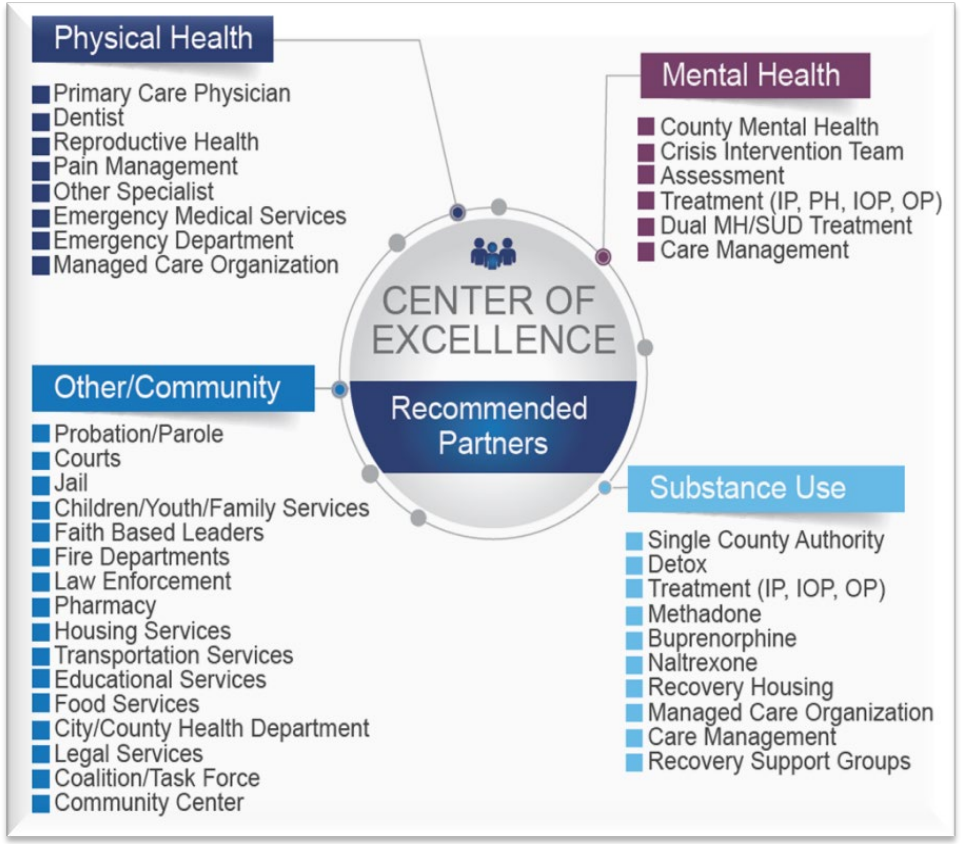
AIMS
ACCESS IMMEDIATE MEDICATION SERVICES

Center of Excellence- CRS services

- Engage and motivate OUD members to stay active in treatment
  - No longer just urgent, immediate needs. Goal is to develop long term rapport
- Education surrounding the disease of SUD
- Build Recovery Capital
  - Move away from a 'return to use response' model
- Assist in initiating treatment OR finding the best treatment for the individual

Assist in coordinating outside resources, including but not limited to:

- Housing Services
- Transportation
- Educational Services
- Food Services
- PCP
- Dental
- MCO
- Recovery Support Groups
- Community Center
- Legal Services



Contacts

- Locations
  - Monroeville:
    - 4105 Monroeville Blvd. Monroeville, PA 15146
  - South Side:
    - 809 Bingham St. 1st floor Pittsburgh, PA 15203
  - Wexford:
    - 101 N. Meadows Dr., Ste. 234 Wexford, PA 15090
- Scheduling
  - Call: 412-440-7478
  - Scheduling hours: Monday-Friday from 9am-5pm
  - Schedule online: https://form.jotform.com/241704337811149

Call: 412-380-0100

Website: www.myjadewellness.com

Contacts: https://myjadewellness.com/contacts/

AIMS
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Contacts

- Monroeville:
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Email: aimssupport@myjadewellness.com

Request Appointment
https://myjadewellness.com/access-immediate-medication-services/

JADE WELLNESS CENTER AIMS ACCESS IMMEDIATE MEDICATION SERVICES

Low-Barrier MOUD Care - A Mobile MOUD Clinic

A Powerful Partnership

AHN Center for Inclusion Health

Mission: To transform our health care system through the development of innovative clinical care models, advocacy, training and research to better serve all people, including those experiencing social and health exclusion.

Prevention Point Pittsburgh

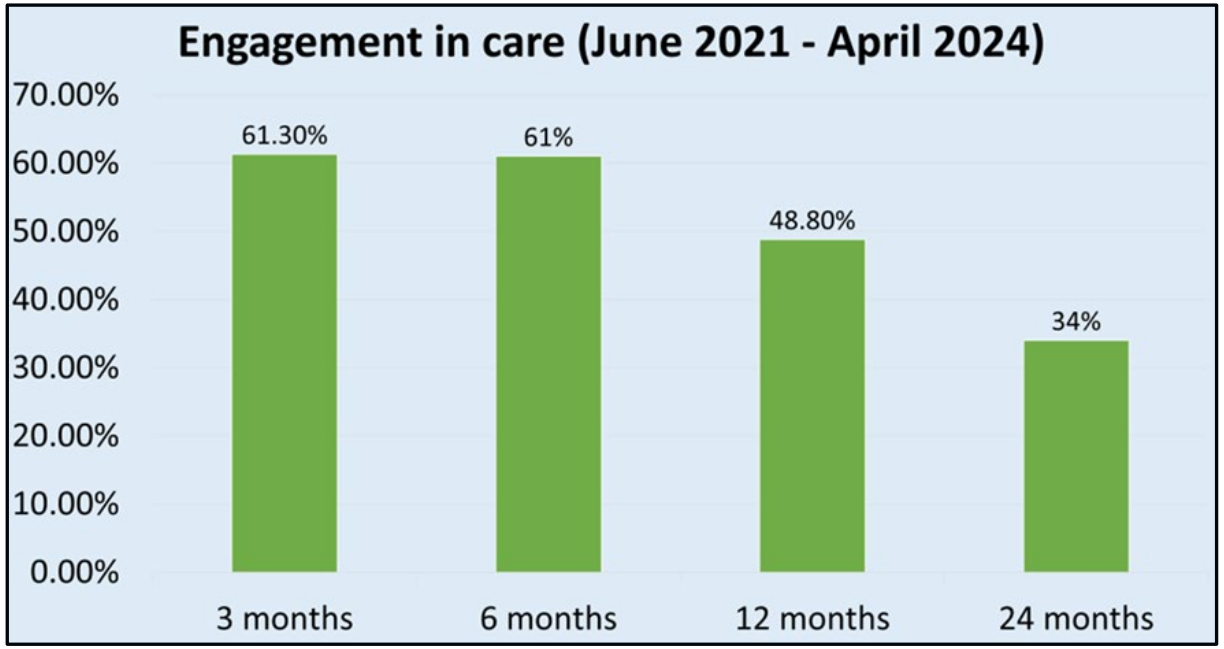
Mission: To promote and advocate for the reduction of harms associated with injection and other forms of drug use, and to reduce the risk of HIV/AIDS, Hepatitis C, other blood-borne infections, and overdose.

Mobile MOUD Clinic

- Began in 2019; Pittsburgh
- Four mobile community sites
- Multidisciplinary team
- Harm reduction approach
- Low-barrier access to:
  - Medications for OUD
  - Transportation
  - Syringe Services Program
  - Peers with lived experience
  - SDOH care coordination
  - Behavioral health care

Low-Barrier Services and Engagement in Care

Accessible	• Community sites – targeted neighborhoods
Walk-Up Services	• No appointment needed
Transportation Support	• Lyft support provided
No Cost	• Visits and medication covered for patients who need it



- N = 1,087 patients
- Mean age = 45 years
- Avg. appointments per patient = 12.65
- 61% = 5 or more appointments
- 46% = 10 or more appointments

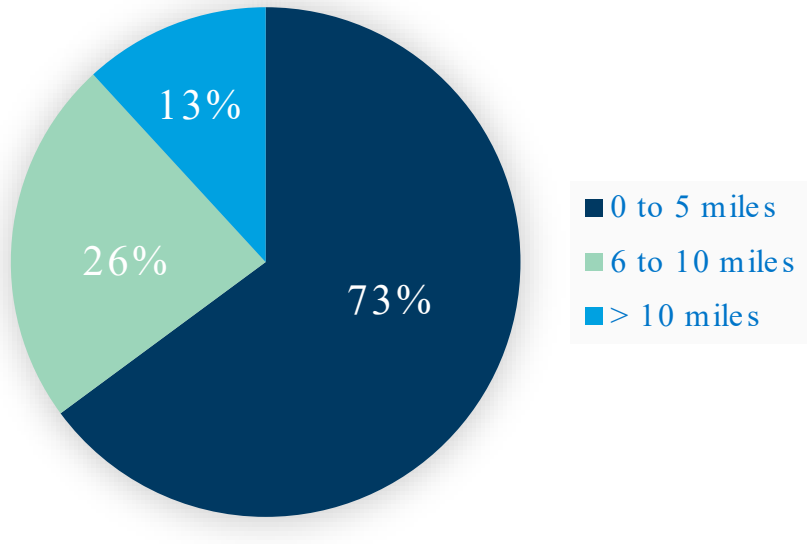
Source: EPIC and Athena electronic health record data, June 2021 – April 2024

Demographics

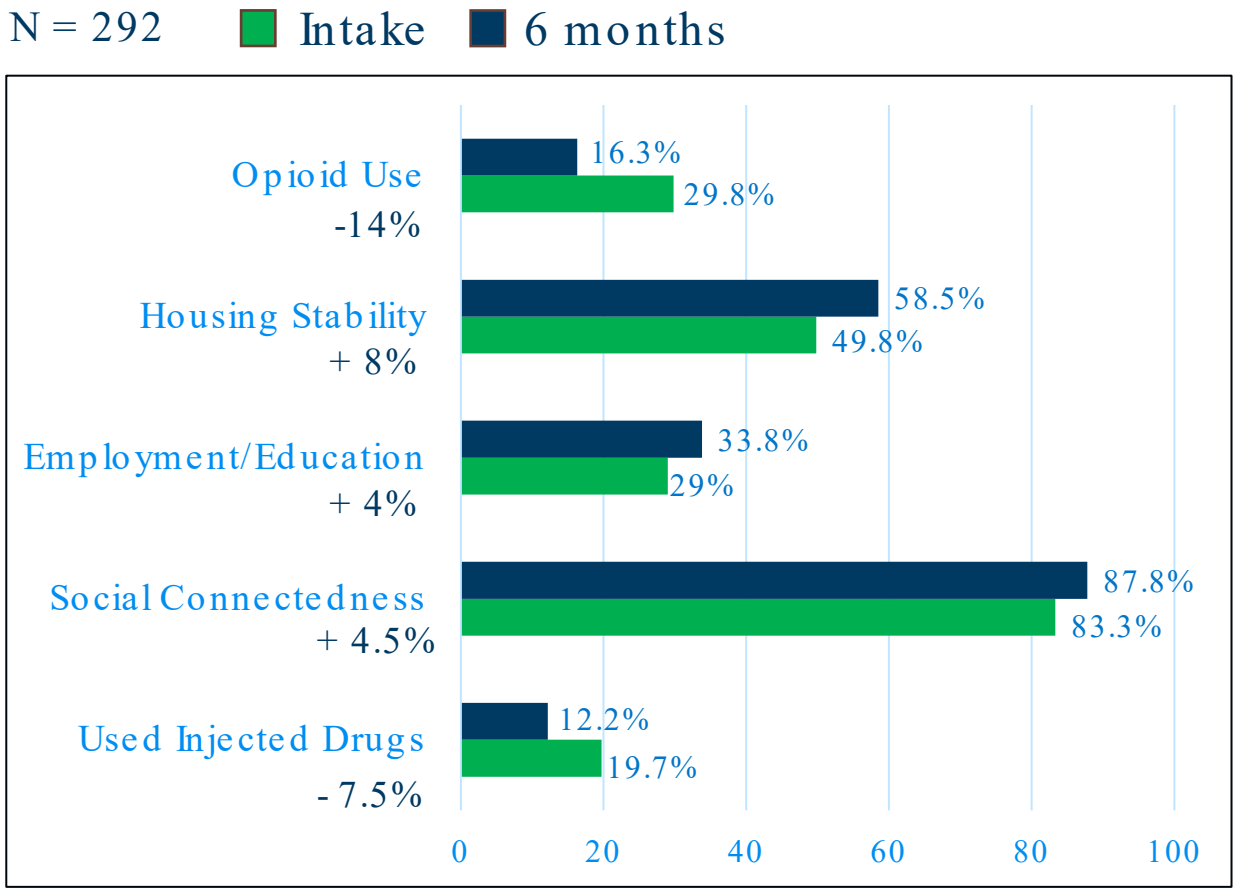
- N = 858
- 35-44 years = median age
- 56.5% Male
- 71 % White; 18% Black; 2.6% Multi-Racial

Patient Distance to Site

Sites = Northside, Hill District, Carrick, Homewood

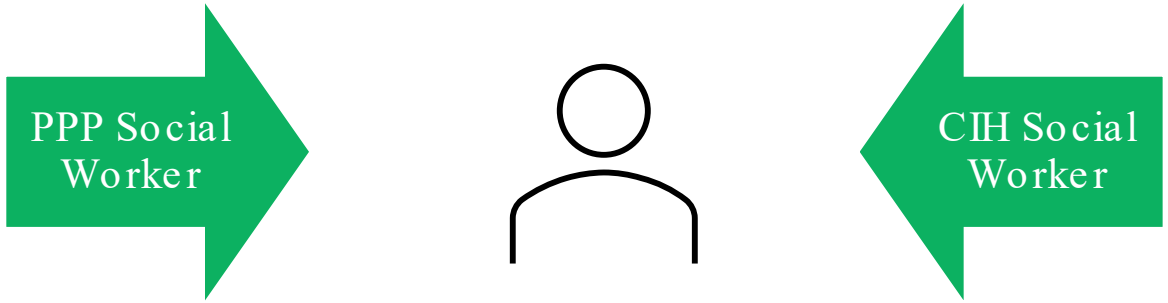


National Outcome Measures and Drug Use (Intake vs 6 Months)



Source: Patient self report data from the SAMHSA Government Performance Results Act (GPRA) between 2021 –2025, AHN Center for Inclusion Health grant program and EPIC electronic health record data, 2021 –2024.

Why Prioritize Connecting Patients to Insurance?



MA Benefits

- Dental services
- Family planning
- Mental health
- ….and more!

Capacity

- Daily volume
- New patients
- Transitions of care

Sustainability

- Grant funds
- 90-day policy
- Case by case evaluation

Empowerment

- Patients to partners
- Take ownership of health

Nearly 70% of Uninsured Patients Connected

April 2024 – March 2025

80 of 116 uninsured patients (69%) have been connected to insurance.

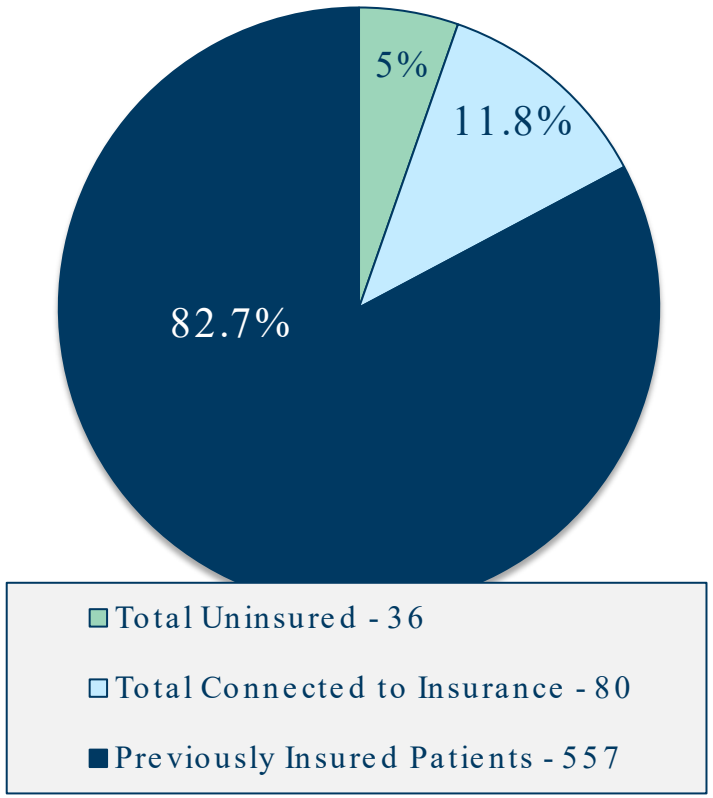
673 patients were treated with a total of 4,278 provider visits.

Our social work team collaborates to ensure insurance application completion.

Consistent engagement with patients to address all issues that may cause complications in obtaining coverage is critical.

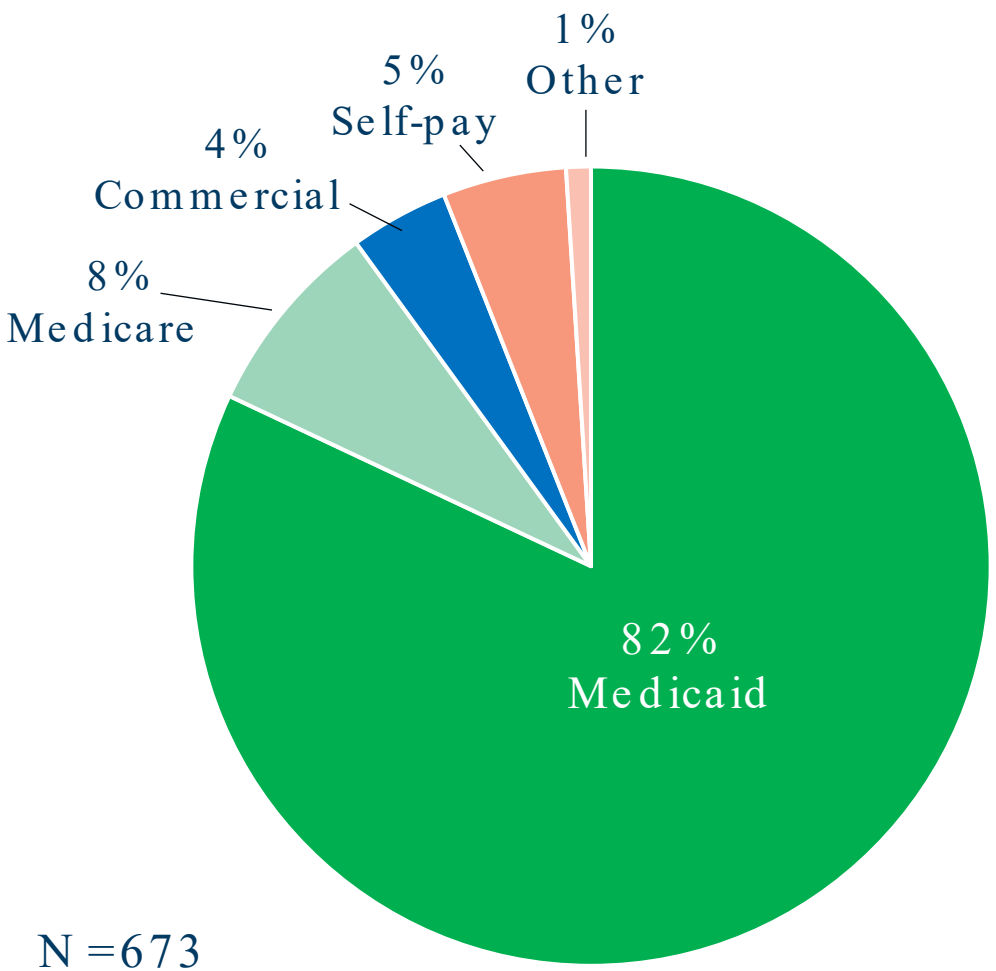
> *Linking patients to insurance is a critical first step, but the real magic happens when that insurance card becomes a gateway to truly comprehensive and whole-person care.*

Insured vs. Uninsured Patients
March 2025



Source: EPIC electronic health record data, March 2025

Payer Breakdown



N =673

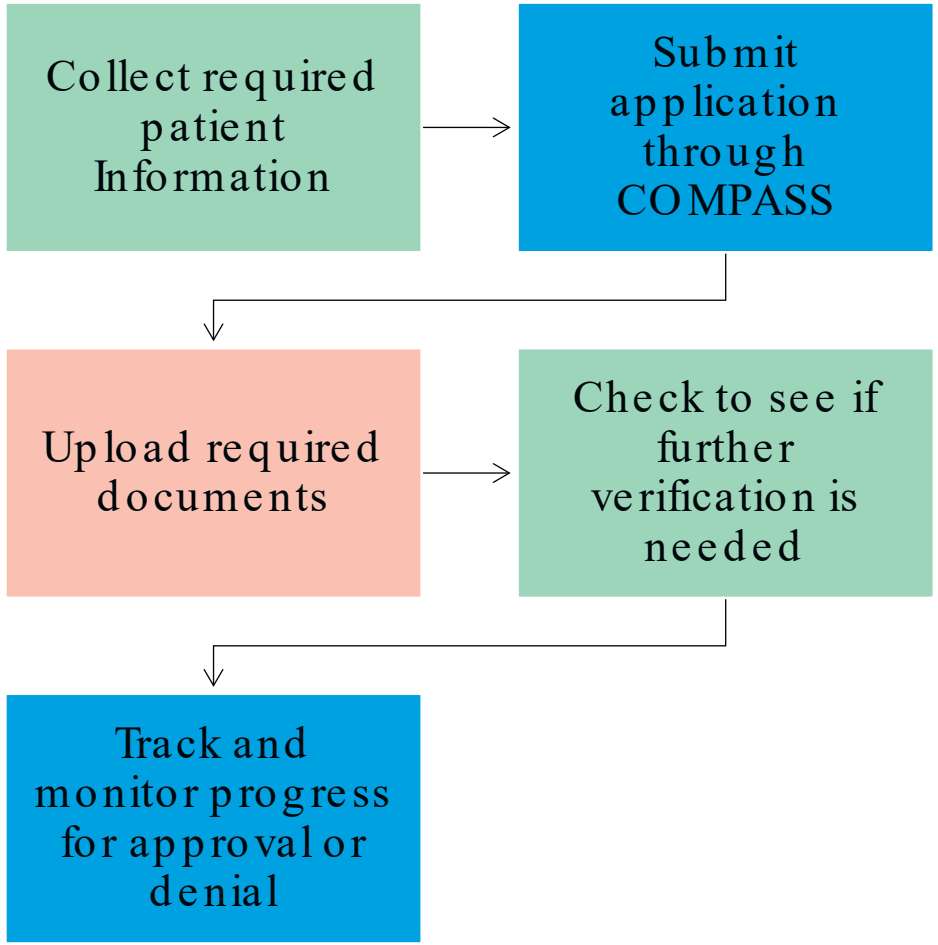
Source: EPIC electronic health record data, March 2025

Insurance Gap Funding

- Staff and medical visit support for patients who are un/underinsured
- Adjustment codes used for medically necessary services
- "Hold" for billable services until insurance obtained or adjustment warranted

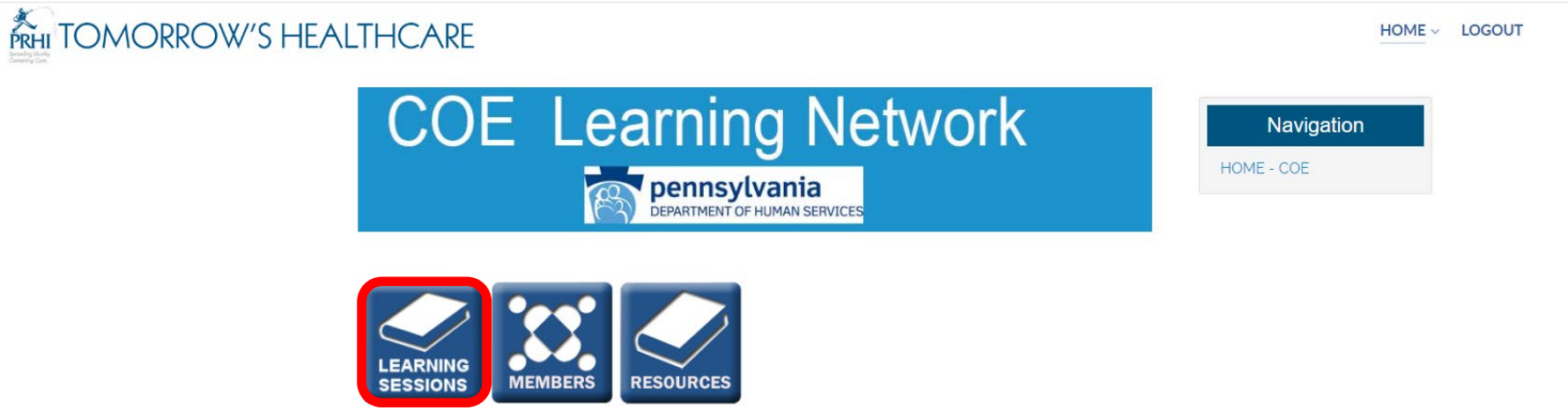
- Pharmacy fill costs covered for patients who are un/underinsured
- Four pharmacies
- Government & foundation grants fund medications until patient obtains insurance

Workflow to Connect Patients to Medicaid



Questions?

Wrap up and Next Session



- To request CEs, complete the **session evaluation**.
- Slides and recording available on Tomorrow's Healthcare

- **Next Session:** Mobile Engagement– June 18th at 12pm

References

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