Incorporating Harm Reduction into Primary Care

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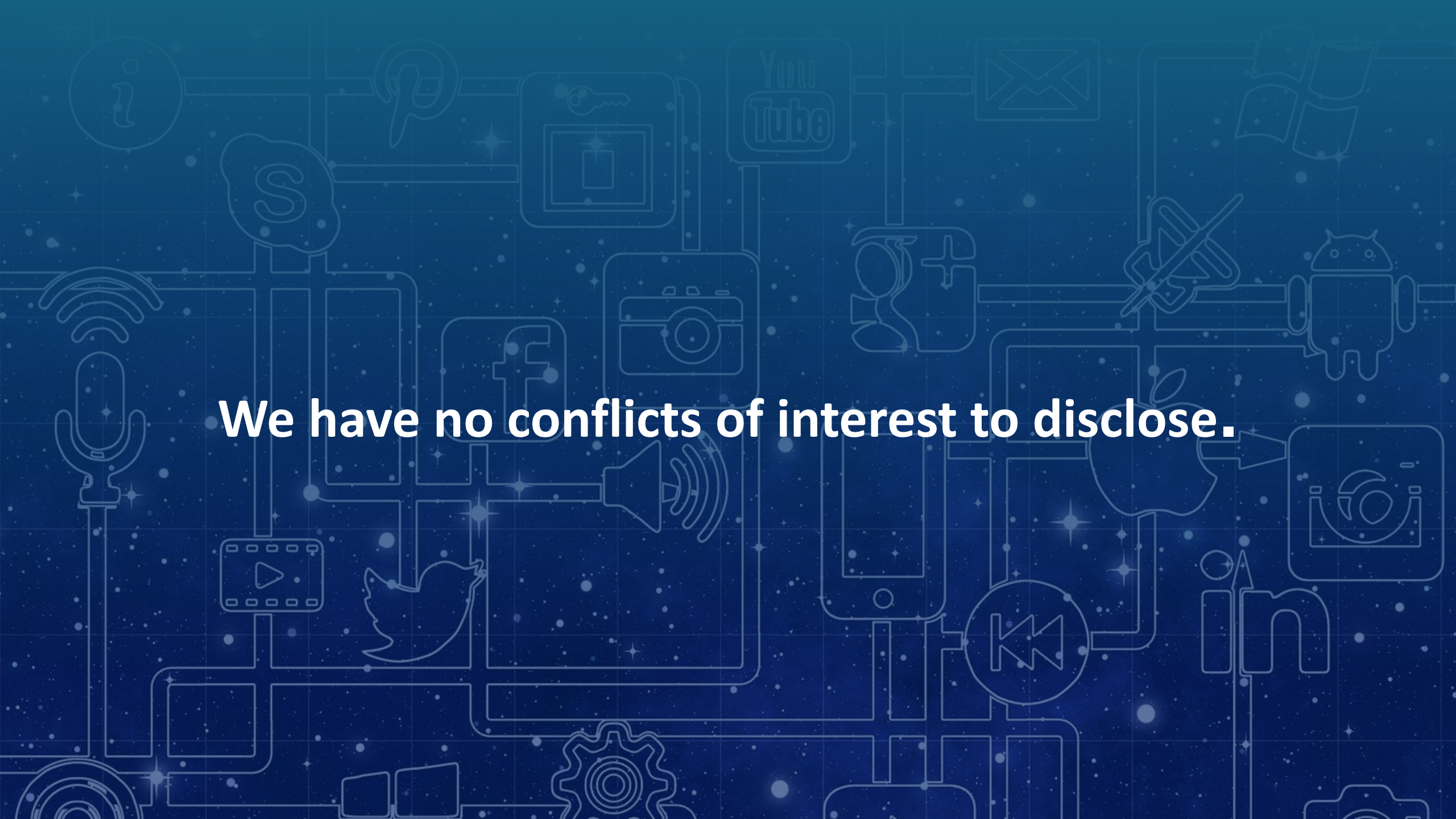
Introduction to Buprenorphine Prescribing in Primary Care
Health Federation of Philadelphia
October 2024


We have no conflicts of interest to disclose.

LANGUAGE MATTERS

The Division of Substance Use Prevention and Harm Reduction (SUPHR) has created the following guide because **language matters**. This document is meant to offer guidance on **how to discuss substance use and people who use drugs**. Our focus on the words we use isn't about being "politically correct," but instead it's about combating stigma and treating people who use drugs with **dignity and respect**.

ROADMAP

- Introductions
- Background
- Case Presentations
- Wrap-up and Reflections

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LEARNING OBJECTIVES

- Describe principles of harm reduction as they relate to primary care practice
- Apply harm reduction principles for patients along the continuum of behavior change
- Emphasis on **communication skills** and **practical management** strategies

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ROADMAP

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HARM REDUCTION DEFINITION

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Harm reduction incorporates a spectrum of strategies from safer use, to managed use, to abstinence, to meet people who use drugs “where they’re at.”

Adapted from the Harm Reduction Coalition

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You are already practicing harm reduction every day!

Harm Reduction is almost everything we do as PCPs

- Most patients do not follow our recommendations exactly as prescribed (think: diet, weight loss, exercise, medication adherence)

Rates of adherence to treatment for SUDs are similar to those of other chronic diseases we treat every day

Other examples of harm reduction interventions:

- Seat belts
- Epi pens
- HPV Vaccine
- Condoms

Adapted from the Harm Reduction Coalition

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HARM REDUCTION CORE PRINCIPLES

- Drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors.
- Non-judgmental, non-coercive provision of services
- Affirms individuals as agents of reducing the harms of their drug use.
- Recognizes the impact of social inequalities on people's vulnerability and capacity to manage drug-related harms.

Adapted from the Harm Reduction Coalition

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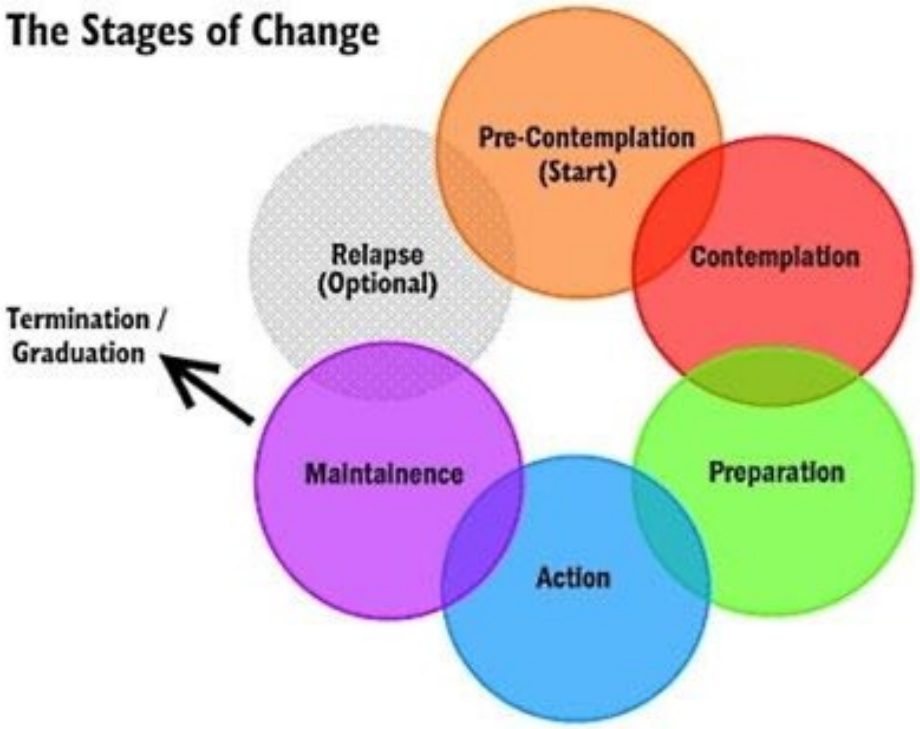
MEETING PEOPLE "WHERE THEY'RE AT"

Behavior change exists on a continuum



Thinking About Change
What change(s) are you considering?
How important is it that you make this change?
How confident are you that you are able to make this change?
How ready are you to make this change?

Readiness Ruler

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very

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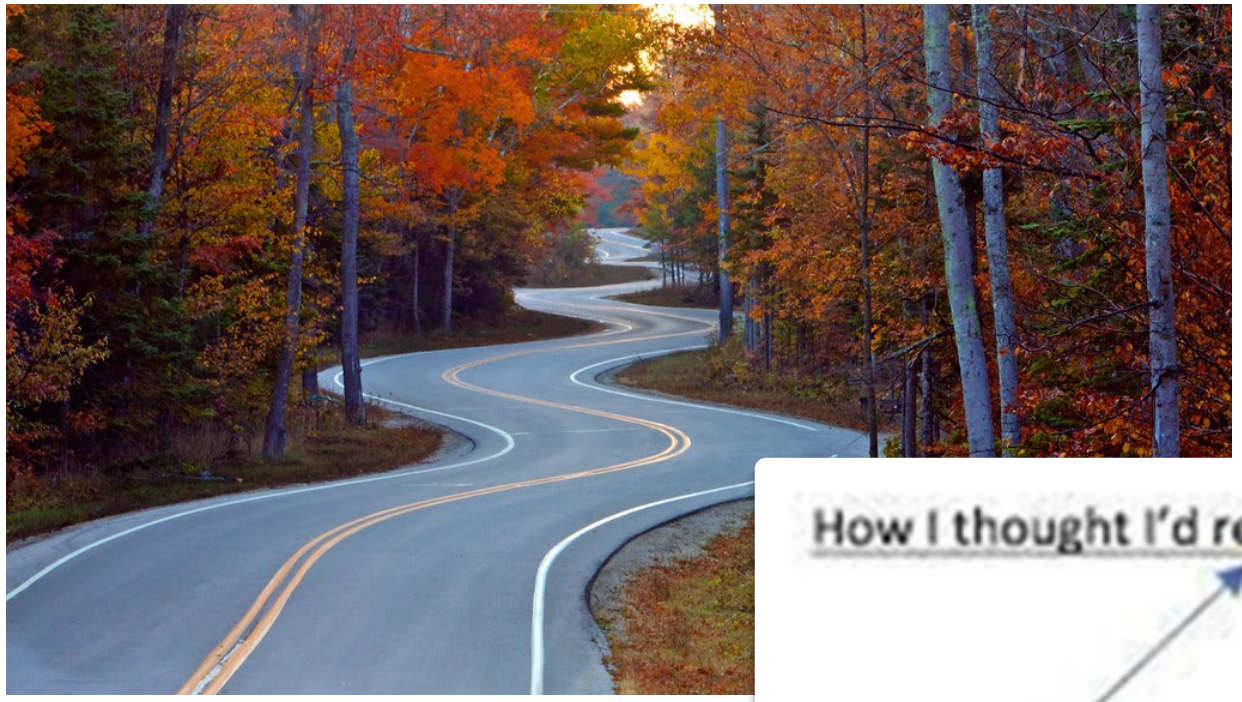
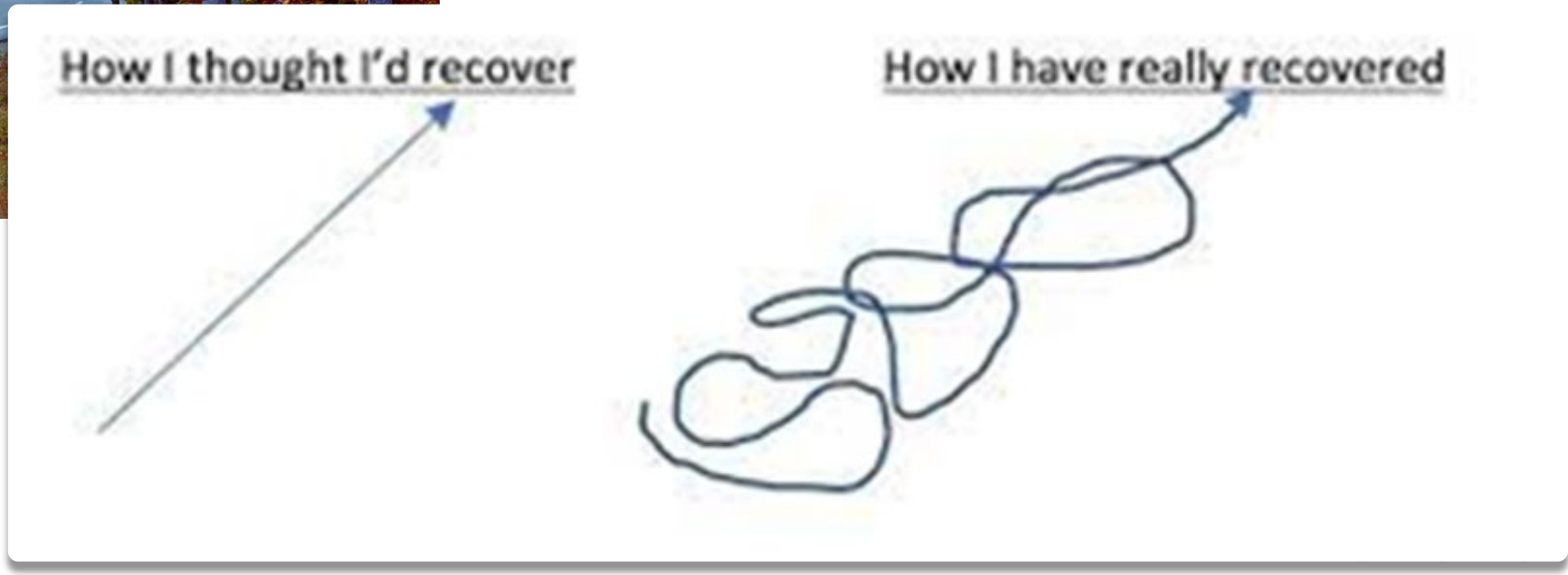
MEETING PEOPLE “WHERE THEY’RE AT”

Reality may look more like this ….





KEY SKILLS

- Person-first language
- Trauma-informed care
- Motivational Interviewing-inspired skills

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KEY SKILLS

- Person-first language

Shifting language to more accurately reflect the nature of the health condition increases support for life-saving interventions

Kelly, 2010; Kennedy-Hendricks, 2017; National Council for Behavioral Health

Other ways to reduce stigma during visits

- Use sensitive, non-judgmental language in assessing risk behaviors
- Normalize a positive response to questions about stigmatized behaviors
  - *"How many times in the last year have you used a syringe after someone else?"* rather than *"Do you share syringes?"*
- Discuss incarceration in ways that don't presume guilt
  - *"Have you every spent time in a correctional setting like jail or prison?"*
- Use inclusive language when inquiring about sexual risk behaviors
  - *"Tell me about your partners"* rather than *"Do you have sex with men, women, or both?"*

Taylor, 2021

KEY SKILLS

- Person-first language
- Trauma-informed care
    - Health care environments are stressful
    - Patient with SUDs have often received suboptimal care in the past
    - People who use drugs often face profound stigma in health care settings

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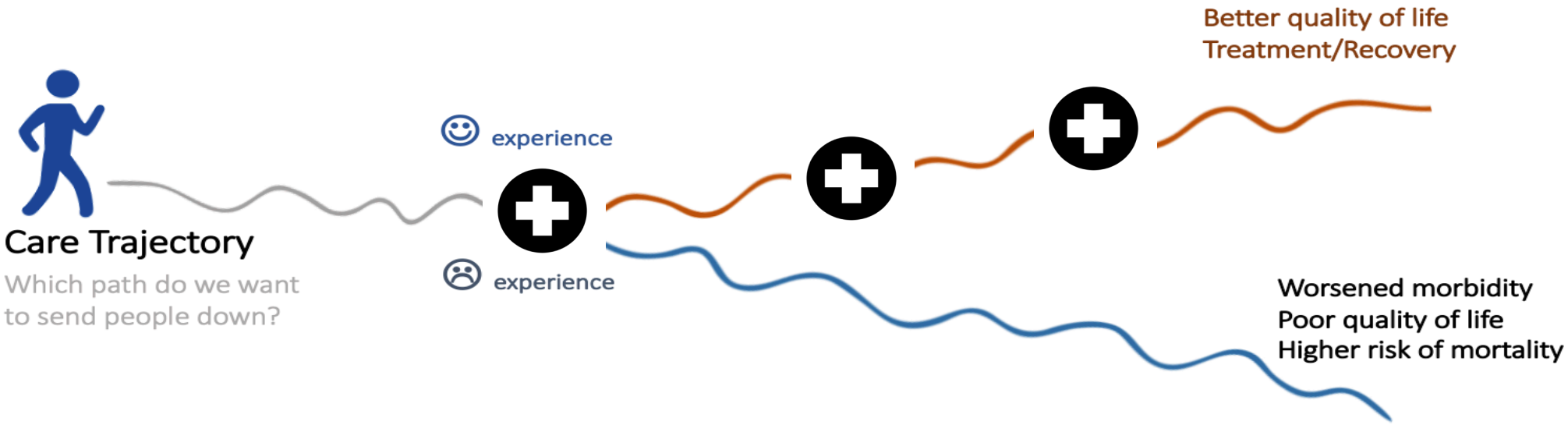
KEY SKILLS

- Person-first language
- Trauma-informed care



Slide courtesy of Rachel McFadden, RN

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KEY SKILLS

- Person-first language
- Trauma-informed care
- Motivational Interviewing-inspired skills

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Persuasion

Convince the person

Provider as expert

Gives in to the “righting reflex”

Decision made by provider

Motivational Interviewing

Elicit motivation for change

Provider as a coach

Seeks to understand

Decision made collaboratively

Slide courtesy of Dr. Scott Steiger

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EXPRESSING EMPATHY

Validation is a process in which a listener communicates that a person's thoughts and feelings are understandable and legitimate.

Can involve active listening, accurate reflection, and conveying empathy / understanding.

Slide courtesy of Dr. Scott Steiger

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EMPATHY & VALIDATION

Level	Description
1) Listening and observing	Listening and paying attention to the speaker. May involve making eye contact, nodding, etc.
2) Accurate reflection	Restating what the speaker has said to convey that you have understood the content of their message
3) Articulating the unverbalized	Inferring thoughts or feelings that may have been implied in the disclosure
4) Validating in terms of sufficient (but not necessarily valid) causes	Validating what the speaker said is understandable given their background or history
5) Validating as reasonable in the moment	Validating what the speaker said is “reasonable in the moment” or justified in terms of their current situation
6) Radical genuineness	Treating the speaker as a valid and capable individual

Slide courtesy of Dr. Scott Steiger

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AVOID ARGUMENTATION

Don’t try to convince & avoid arguing (never works! And sometimes hurts)

Ask open-ended questions to understand the patient’s perspective

Double sided reflection: capture both sides of the issue

Shift focus: move away from the obvious barrier onto a less contentious part of the problem

Slide courtesy of Dr. Scott Steiger

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ROADMAP

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CASE 1: NOT READY FOR TREATMENT

John is a 41 yo man with a history of HTN, chronic back pain and depression who comes to your office after an ED visit for cellulitis.

John tells you that he started buying oxycodone-acetaminophen on the street for his back pain but switched to snorting heroin when that got too expensive. About two years ago, he began injecting several times per day. After his ED visit, he was discharged with a course of antibiotics for cellulitis and a phone number to call for OUD treatment.

During your visit, you talk to John about his OUD, but he states that he wants to quit on his own and is not interested in treatment.

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CASE 1: DISCUSSION

For a patient like John who is not ready for treatment,

- How can you counsel him to reduce the harms of substance use?
- What services can you refer him to?
- Other next steps?

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CASE 1 TEACHING POINTS

1. Create a safe space so patient feels comfortable coming back if and when he is ready.

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CASE 1 TEACHING POINTS

2. Prescribe naloxone for overdose prevention for all patients with OUD whether or not they are interested in treatment

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Opioid Overdose – WHAT TO DO

Recognize An Overdose

- Slow/No Breathing
- Individual does not respond
- Blue or grey or pale lips, finger tips, skin
- Gurgling Noise/ Death Rattle
- Clammy, cold to touch
- Individual is unresponsive
- Slow or no pulse

Reverse An Opioid Overdose

- Shake them, rub your knuckles over their breast bone with pressure 3 times
- Tell them you have Narcan and are going to use it

No response?

- Use Narcan as trained

Next, Call 911

- In Philadelphia you will not get in trouble for calling for an overdose

While waiting

- Start Rescue Breaths
- First clear their mouth, 2 fingers in mouth and sweep
- Tilt head back, lift chin
- Pinch nose, open mouth, breath one breath into their mouth, repeat every 5 seconds until they are breathing on their own or help arrives
- Place the individual on their side with their hands under the head to prevent choking if they should vomit

CASE 1 TEACHING POINTS

3. Counsel on safer use practices and strategies to lower risk associated with injection

Try not to use alone
- Never Use Alone hotline: 877-696-1996
- The Brave App
- Narcan

Brave
Overdose Detection / Brave App

Go slow, use a test dose

Know what you are using. Test strips can be obtained to check for fentanyl, xylazine, benzos
- NEXT Distro (https://nextdsitro.org)

NEXT Distro
STAY ALIVE, STAY SAFE.

- Clean injection site
- Use new needle every time when possible. Never share syringes or drug equipment.
- Refer to needle exchange
- If you have to reuse, clean syringes correctly: How to Clean Your Syringes (cdc.gov)
- Use clean works as well
- PrEP

Angels IN MOTION

PREVENTION POINT

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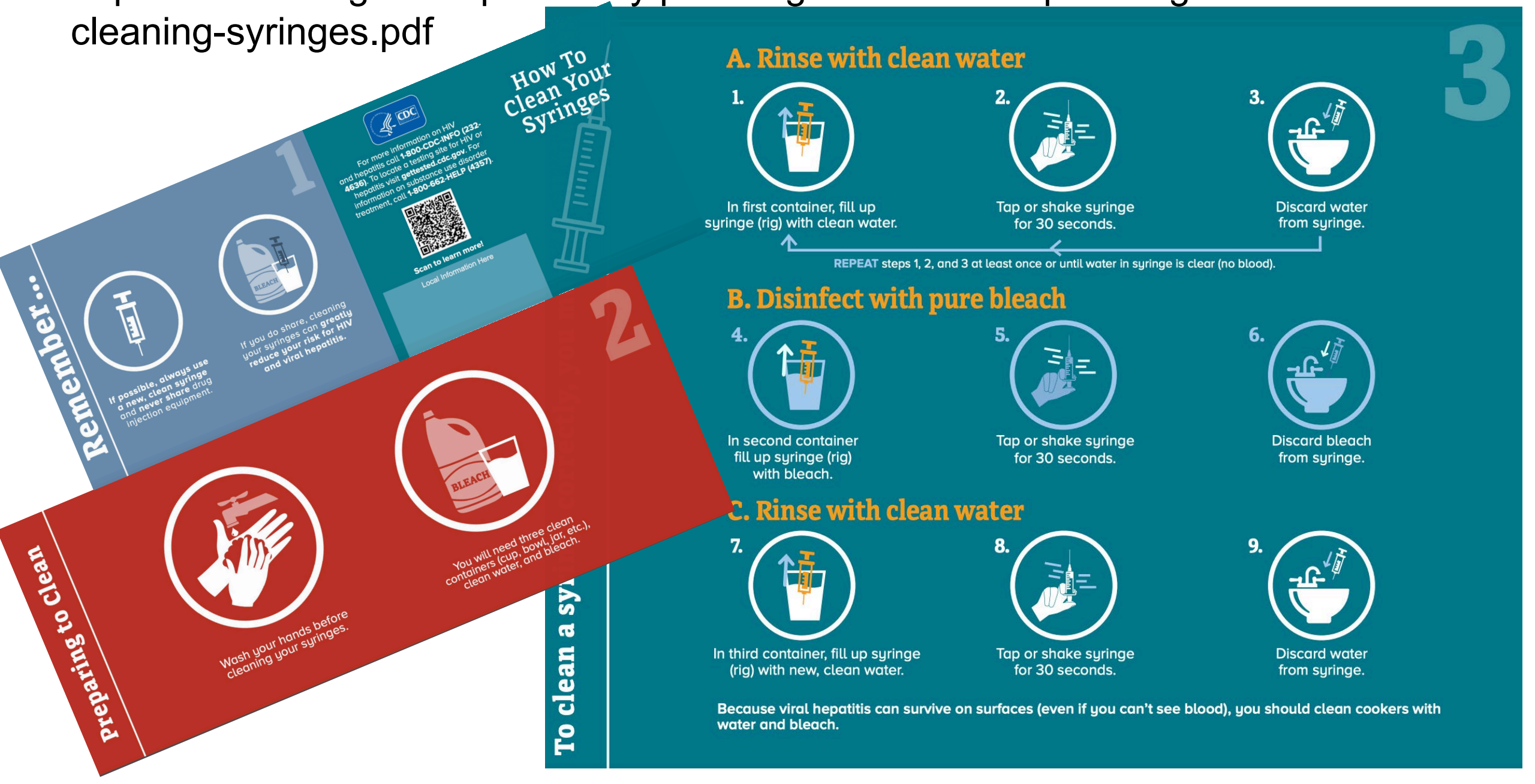
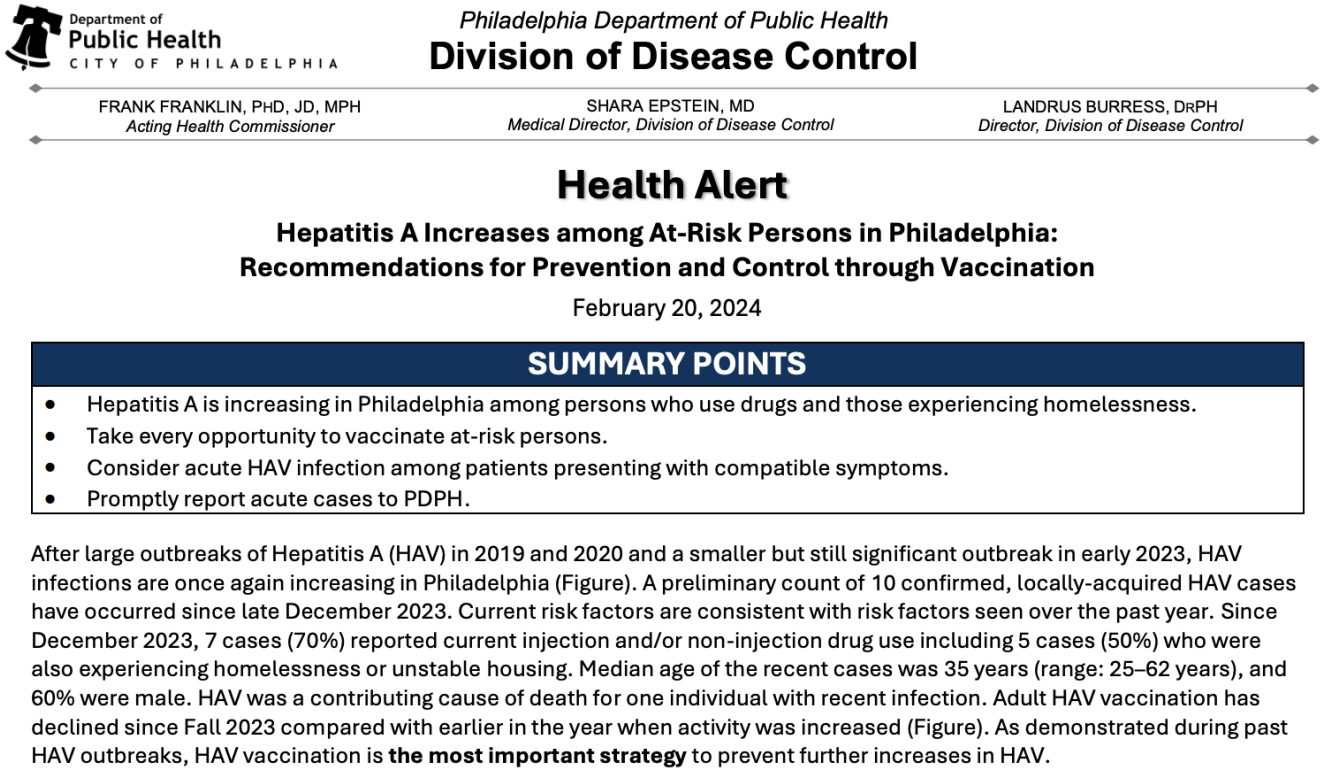
https://www.cdc.gov/hiv/pdf/library/pocket-guides/cdc-hiv-pocket-guide-cleaning-syringes.pdf



CASE 1 TEACHING POINTS

4. Address other health issues related to substance use

- HIV and HCV testing and treatment
- Immunizations – Hep B, Hep A, Tdap
- Offer PrEP



Department of Public Health
CITY OF PHILADELPHIA

Philadelphia Department of Public Health
Division of Disease Control

FRANK FRANKLIN, PHD, JD, MPH
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Health Alert

Hepatitis A Increases among At-Risk Persons in Philadelphia: Recommendations for Prevention and Control through Vaccination

February 20, 2024

SUMMARY POINTS

- Hepatitis A is increasing in Philadelphia among persons who use drugs and those experiencing homelessness.
- Take every opportunity to vaccinate at-risk persons.
- Consider acute HAV infection among patients presenting with compatible symptoms.
- Promptly report acute cases to PDPH.

After large outbreaks of Hepatitis A (HAV) in 2019 and 2020 and a smaller but still significant outbreak in early 2023, HAV infections are once again increasing in Philadelphia (Figure). A preliminary count of 10 confirmed, locally-acquired HAV cases have occurred since late December 2023. Current risk factors are consistent with risk factors seen over the past year. Since December 2023, 7 cases (70%) reported current injection and/or non-injection drug use including 5 cases (50%) who were also experiencing homelessness or unstable housing. Median age of the recent cases was 35 years (range: 25–62 years), and 60% were male. HAV was a contributing cause of death for one individual with recent infection. Adult HAV vaccination has declined since Fall 2023 compared with earlier in the year when activity was increased (Figure). As demonstrated during past HAV outbreaks, HAV vaccination is **the most important strategy** to prevent further increases in HAV.

CASE 2: TREATMENT DECISION

Lisa is a 34 yo woman with a history of depression and prior prescription OUD.

She has been in recovery for the last 5 years, but recently lost her job and has scheduled a telehealth visit to talk about low mood. You ask about whether the stress has led her to think about using again and she tells you that she has gone back to buying oxycodone pills from her neighbor.

After acknowledging how difficult her situation is, you mention the option of medication treatment for OUD. She is not sure and asks you about how to decide the best medication option.

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CASE 2: TREATMENT DECISION

How do you counsel Lisa on treatment options?

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CASE 2 TEACHING POINTS

1. Counseling patients on starting treatment

The best treatment option is the one that works for the patient

That being said, medications for OUD are the evidence-based option. These treatments are life saving. Not every patient will want this, but help patients make the most informed decision by appropriately discussing the risks and benefits.

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CASE 2 TEACHING POINTS

Challenges for patient conversations

1. Misinformation: “replacing one addiction with another”, “not really clean”
2. Prior negative experience: Many have tried meds, either in healthcare or non-healthcare settings, and may have had bad experiences (e.g. precipitated withdrawal, rapid taper for detox)
3. Unrealistic expectations: “I want to be on this just for a few months”

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CASE 2 TEACHING POINTS

Discussion points with patients

- What does it mean to be in recovery?
- Elicit patient values and preferences – previous experiences, structure, convenience, etc
- Informed decision-making regarding risks or challenges with each type of treatment

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CASE 2 TEACHING POINTS

Talk to patients about options – Handout examples

Know your options for successful treatment

There are pros and cons to each treatment for opioid use. Whichever you choose, we will work with you towards success.
We hope you will have questions after reading this. Please share any questions with your medical team.

Medicines for Treating Opioid Use Disorder:

What you need to know when choosing the best treatment for you

September 2020

CA BRIDGE

CA BRIDGE

Buprenorphine (Suboxone®, Subutex®, Zubsolv®)	Methadone	Naltrexone (Vivitrol®)	No Medication
BENEFITS • It is a well-studied medicine, and safe for long-term use. • People who take buprenorphine are less likely to overdose or die than people who do not take it. • It blocks cravings and prevents feeling "high" if you slip and use. • It is more effective for chronic pain than methadone or naltrexone. • It blocks withdrawal symptoms (unlike naltrexone or no medications). • You can get to a comfortable dose in a couple of days (faster than with methadone). • It does not produce a "high." • Most people get it from a primary care doctor who can provide up to one month of medicine at a time—no need to go every day or go to a special clinic. • Some people prefer the counseling and support of a methadone clinic—many	**BENEFITS** • It is a well-studied medicine that is safe for long-term use. • People who take methadone are less likely to overdose or to die than people who do not take it. • It blocks cravings and prevents feeling "high" if you slip and use. • It helps with chronic pain, but less than buprenorphine. • It blocks withdrawal symptoms (unlike naltrexone or no medications) and may take longer to get to a comfortable dose than buprenorphine. • It does not produce a "high" if taken at the right dose. • Methadone users are less likely than those who don't take it to relapse, get HIV, or go to prison. • Methadone clinics offer counseling and case management support. • You do not need to go into withdrawal before	**BENEFITS** • It blocks opioid and alcohol cravings and stops you from feeling high if you use opioids. • You only need to get the shot once a month. • It is not an opioid and does not cause withdrawal symptoms if you stop taking it. • Even though studies show buprenorphine and methadone are as helpful, some AA/NA groups, treatment programs, and police/judges may prefer naltrexone. **CAUTIONS** • You are more likely to relapse and overdose in comparison to results from buprenorphine or methadone. • Upon the first injection, if you have opioids in your system you will likely go into withdrawal. You must go through detox first and not use for 1-2 weeks. • It can be very hard to start. Unlike methadone and buprenorphine, it does not help with	**BENEFITS** • Some patients prefer to be off all medicines, even when there is a higher risk of relapse and overdose. • Medication side effects are avoided. The side effect of no medication is increased risk of relapse and overdose death. **CAUTIONS** • You are much more likely to relapse, overdose, and die in comparison to results from buprenorphine or methadone. • Cravings and withdrawal are not controlled when you are not taking medicines, and if you slip and use it can be much harder to stop. • Your tolerance goes down when you don't take any opioid medicine. That means if you return to using, you have a bigger risk of dying than if you took methadone or buprenorphine.

https://bridgetotreatment.org/resource/medicines-for-treating-opioid-use-disorder-what-you-need-to-know/

CASE 3

Lisa decides to start on buprenorphine and successfully undergoes induction. She is now on a stable dose of 16 mg buprenorphine-naloxone daily for several months and has been following up every 4 weeks.

However, she continues to use benzodiazepines and occasional cocaine.

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CASE 3

How do you discuss Lisa's ongoing use of other substances in a patient-centered way?

How do you manage risks for Lisa?

How do you document your medical decision-making?

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CASE 3 TEACHING POINTS

1. Medications for OUD only address opioid use disorder!

Do NOT discontinue buprenorphine if you are seeing improvement in OUD

Combining Buprenorphine With a Benzodiazepine

Previous Approach

Benzodiazepines and buprenorphine are a toxic combination.

New Findings and Recommendations

Withholding buprenorphine because of benzodiazepine use could result in harm from untreated opioid addiction that outweighs the risks of concomitant use of these medications.

The Next Stage of Buprenorphine Care for Opioid Use Disorder

Stephen A. Martin, MD, EdM; Lisa M. Chiodo, PhD; Jordon D. Bosse, MS, RN; and Amanda Wilson, MD

Annals of Internal Medicine, 2018

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Health care professionals should take several actions and precautions and develop a treatment plan when buprenorphine or methadone is used in combination with benzodiazepines or other CNS depressants. These include:

- Educating patients about the serious risks of combined use, including overdose and death, that can occur with CNS depressants even when used as prescribed, as well as when used illicitly.
- Developing strategies to manage the use of prescribed or illicit benzodiazepines or other CNS depressants when starting MAT.
- Tapering the benzodiazepine or CNS depressant to discontinuation if possible.
- Verifying the diagnosis if a patient is receiving prescribed benzodiazepines or other CNS depressants for anxiety or insomnia, and considering other treatment options for these conditions.
- Recognizing that patients may require MAT medications indefinitely and their use should continue for as long as patients are benefiting and their use contributes to the intended treatment goals.
- Coordinating care to ensure other prescribers are aware of the patient's buprenorphine or methadone treatment.
- Monitoring for illicit drug use, including urine or blood screening.

Source: FDA.gov

CASE 3 TEACHING POINTS

2. Meet the patient where he/she is and support their needs

- Reinforce and strengthen relationship
- Increase social supports
- Address underlying issues e.g. mental health
- Referrals as appropriate (e.g. inpatient treatment for severe benzo use disorder)
- Increase structure (shorter follow-up)

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CASE 3 TEACHING POINTS

3. Documentation

- Counsel patients on risks
- Statement of risks and benefits

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A WORD ABOUT URINE DRUG SCREENS

Use as a tool to better support recovery and address return to use NOT to discharge from buprenorphine or compel to more intensive settings

Considerations during COVID

USES OF DRUG TESTING

Previous Approach

Drug testing indicates which patients are unsuccessful and should be removed from buprenorphine treatment.

New Findings and Recommendations

Drug testing is a tool for supporting recovery rather than a method of punishment.

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Annals of Internal Medicine, 2018

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Down the drain: Reconsidering routine urine drug testing during the COVID-19 pandemic☆

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Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Considering the harms of our habits: The reflexive urine drug screen in opioid use disorder treatment

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WHAT HAPPENS WHEN…

MY PATIENT USES OPIOIDS?

Reassure patient (and yourself) that this is a normal part of the disease course.

Normalize this issue

Reinforce successes

- “slip” vs. full return to use
- “think back to X months ago and tell me how this would have gone…”

Reframing situation and focus on patient strengths

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MY PATIENT USES OPIOIDS?

Treatment strategies

- Keep engaged!
- Closer follow-up
- Address concurrent stressors or medical conditions
- Increase dose of buprenorphine if reporting cravings or withdrawal symptoms and not at max dose
- Consider long-acting injectable buprenorphine (Sublocade and Brixadi – more on that soon!)
- Consider referral to opioid treatment program for methadone if needing more structure, but caution in requiring this because often “higher level of care” = No care

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MY PATIENT USES OPIOIDS?

Harm Reduction

- Review with patient that tolerance may be decreased and urge them to use less
- Make sure they have naloxone
- All the Harm Reduction tools

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MY PATIENT USES OPIOIDS?

Document decision-making

- Patient has reduced use of illicit fentanyl/heroin/opioids, has not overdosed, [other improvements] and benefits of continued buprenorphine treatment outweigh risks.
- I have discussed risks of concurrent substance use with patient and provided naloxone and counseling on overdose prevention strategies.

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MY PATIENT WANTS TO STOP BUPRENORPHINE:

Buprenorphine should be prescribed “as long as it continues to benefit the patient”

Discuss reasons for stopping

- What does it mean to be in recovery?
- Is this coming from the patient or pressure elsewhere?
- Are other chronic medical and psychiatric conditions well-controlled?
- If tapering, slow and patient-centered

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MY PATIENT MAY BE DIVERTING THEIR BUPRENORPHINE?

- What to worry about?
- How to discuss the issue
- Offer alternatives
  - Supervised dosing (if available)
  - Injectable long-acting buprenorphine (Brand Name: Sublocade or Brixadi)
  - Higher level of care
  - Ultimately may need to stop prescribing for a period of time and be willing to try again in the future

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ROADMAP

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- Case Discussions
- **Wrap-up and Reflections**

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The New York Times Magazine

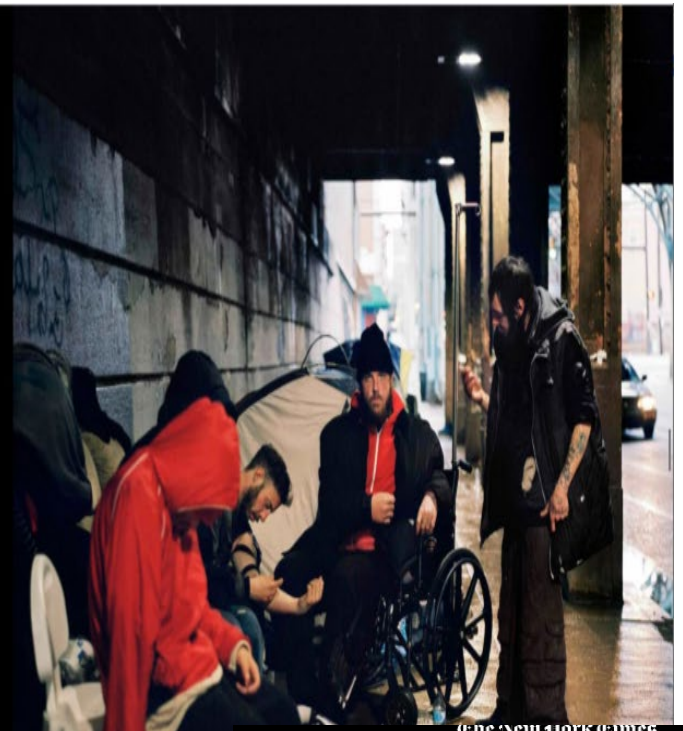
Account

October 10, 2018

FEATURE

Trapped by the 'Walmart of Heroin'

A Philadelphia neighborhood is the largest open-air narcotics market for heroin on the East Coast. [redacted] come from all over, and many never leave.



The New York Times

Account

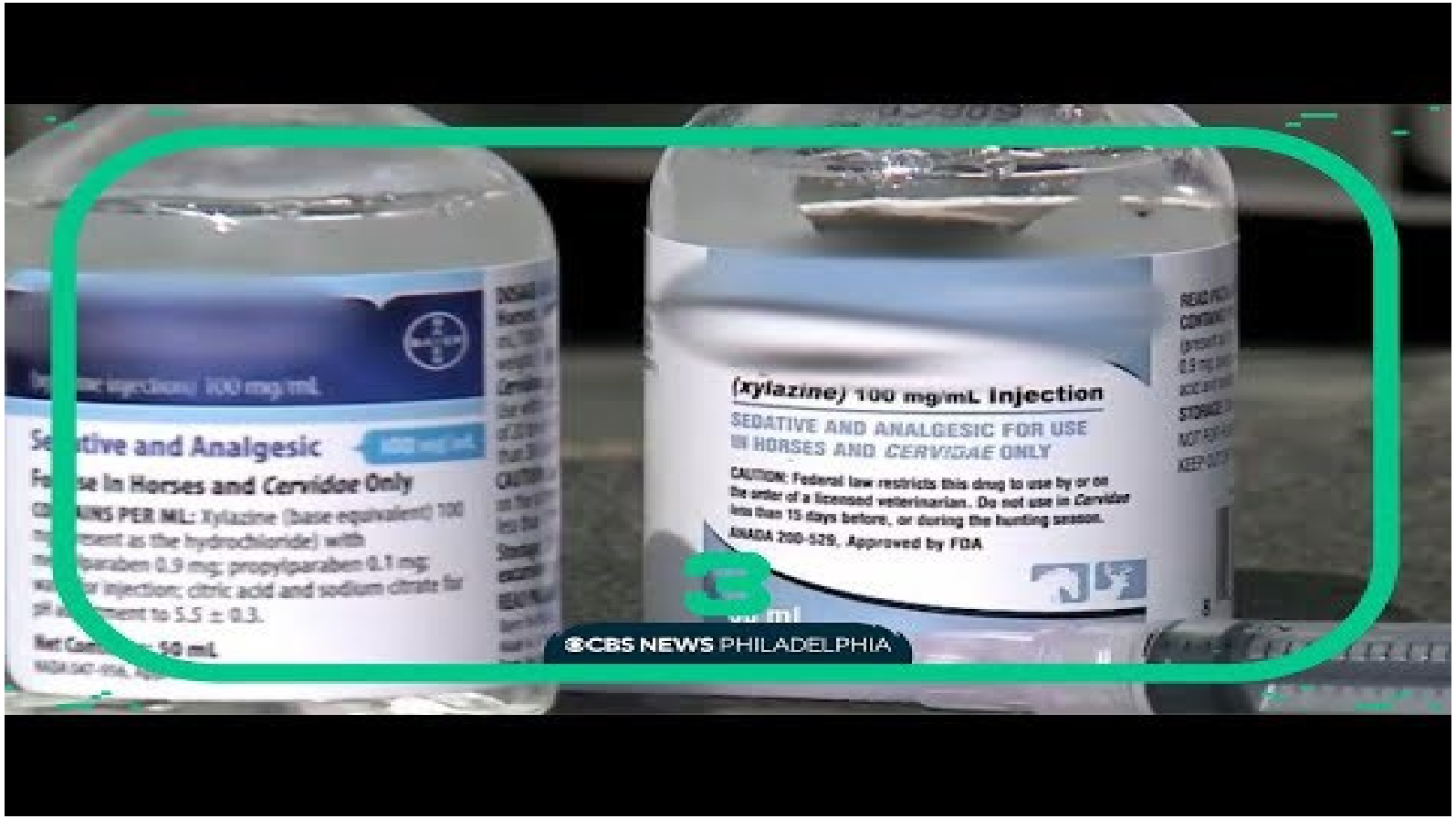
Jan. 7, 2023

PHILADELPHIA —

Tranq Dope: Animal Sedative Mixed With Fentanyl Brings Fresh Horror to U.S. Drug Zones

A veterinary tranquilizer called xylazine is infiltrating street drugs, deepening addiction, baffling law enforcement and causing wounds so severe that some result in amputation.

“Tranq” -- January 2023

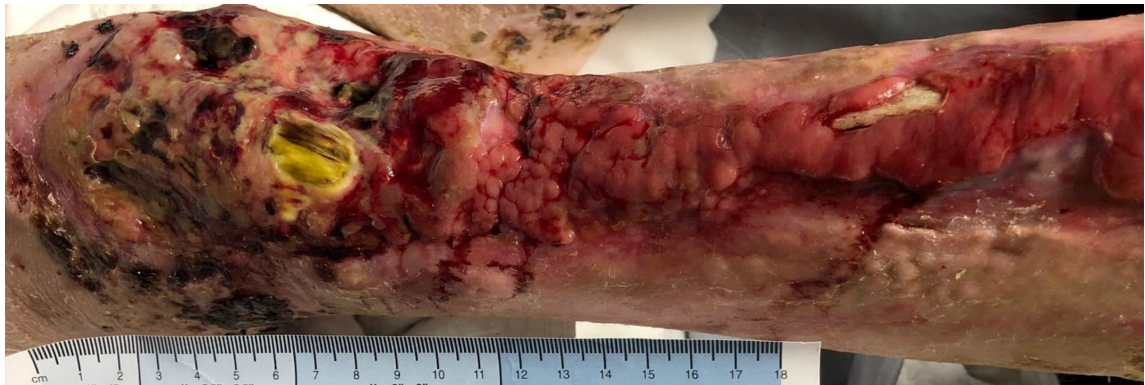


Xylazine (“Tranq”)

- Non-opioid sedative, analgesic and muscle relaxer used in veterinary medicine
- Longer euphoric effects and similar sensation to benzos
- Side effects: hypotension, CNS depression, respiratory depression, bradycardia, wounds
- Increasingly found in drug supply and in overdose deaths (34% of ODs in 2021 in Philly)
- Associated with complicated withdrawal syndromes
  - Expert opinion suggest treat with clonidine, tizanidine, benzos, consider for heavy fentanyl users prophylactically
- implicated in poorly healing necrotic wounds – often not infectious, not always at site of injection

McNinch, JR; Maguire, M; Wallace, L. A Case of Skin Necrosis Caused By Intravenous Xylazine Abuse. F. Abstract 559 Journal of Hospital Medicine. https://shmabstracts.org/abstract/a-case-of-skin-necrosis-caused-by-intravenous-xylazine-abuse/. September 2nd 2021.

Johnson et al, Increasing Presence of xyalazine in heroin an/or fentanyl deaths, Philadelphia, PA 2010-2019. InjuryPreventionBMJ February 2021

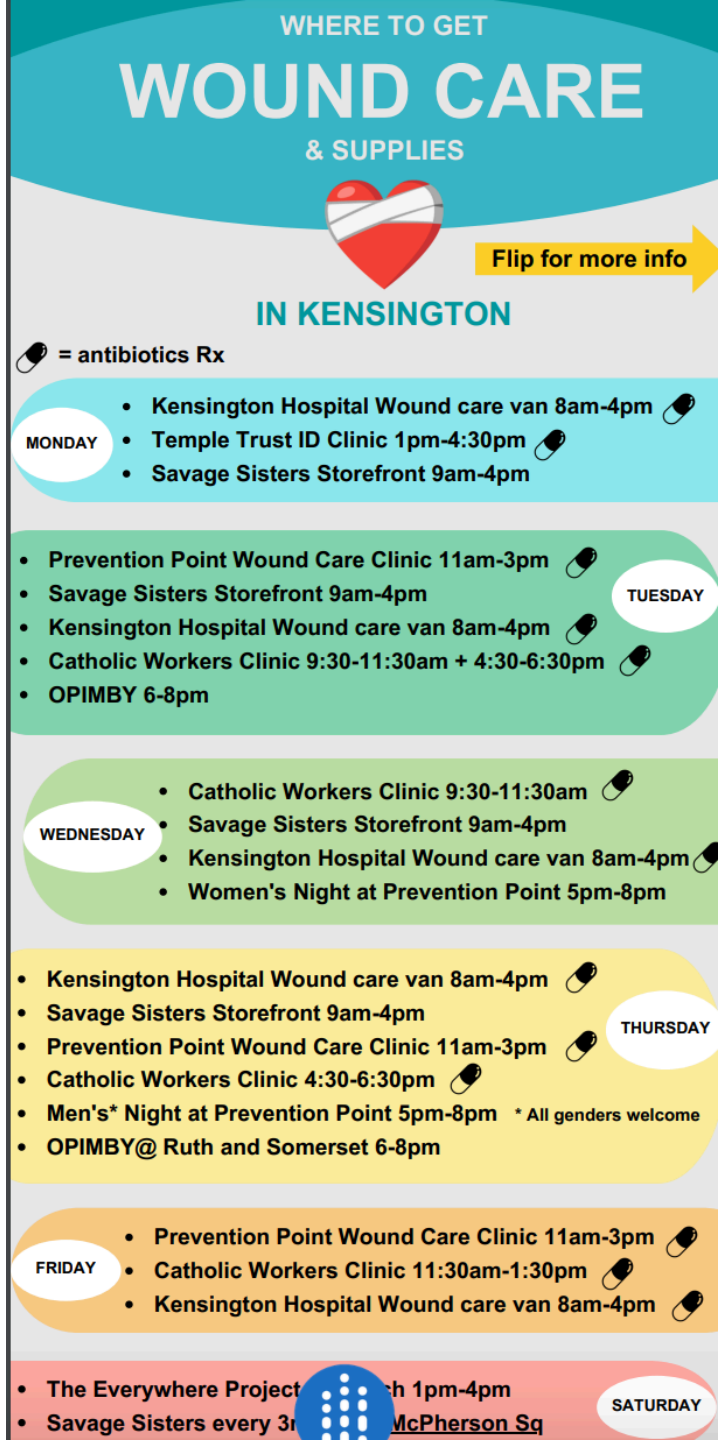


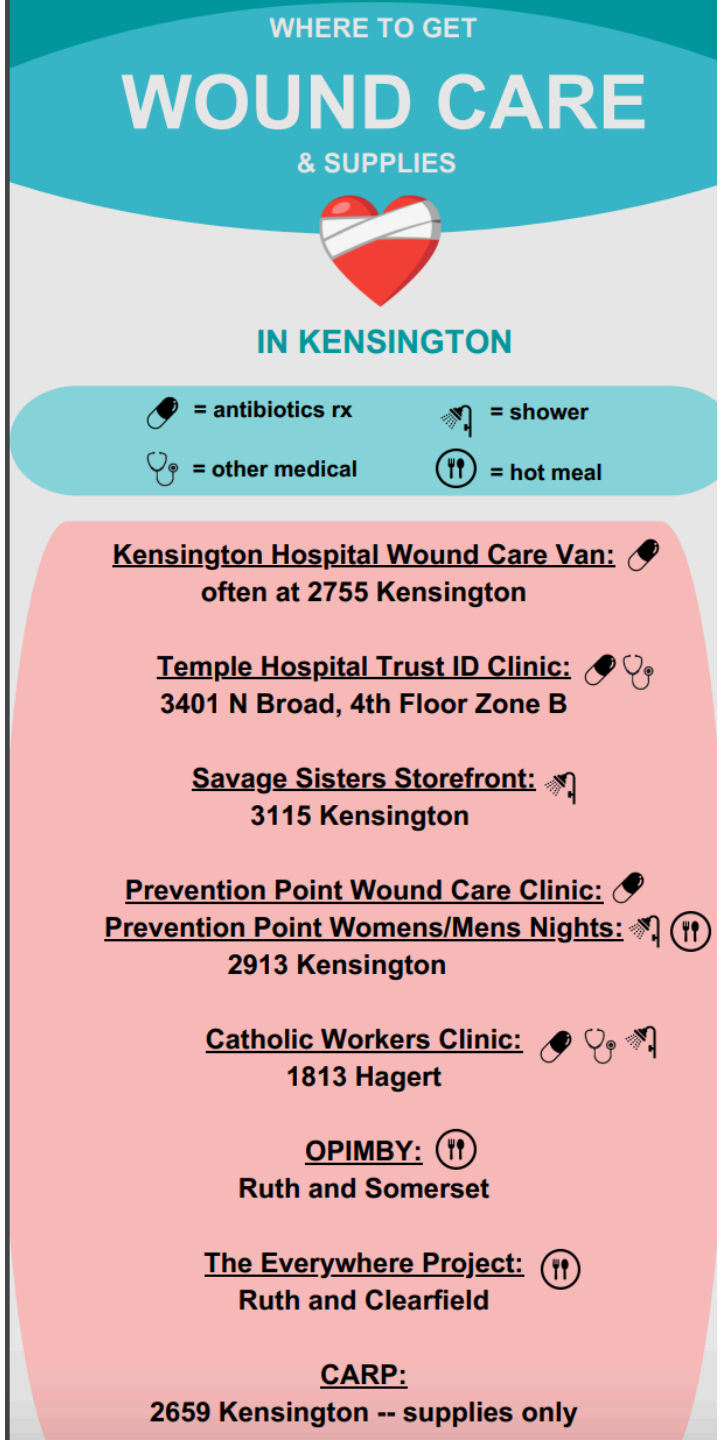
The figure to the right demonstrates emergency department utilization for skin and soft tissue injuries from Q1 2019 to Q4 2021.

Number of ED Visits

Rate per 10,000 Visits

Emergency Department Visits for Skin and Soft Tissue Infections with Co-occurring Drug-related Diagnoses*





Updated schedules: www.substanceusephilly.com

Wound Care

SURGE Substance Use Response Guidance and Education

Resources for you:

- Kensington Wound Care Schedule
- Kensington Hospital Mobile Wound Care Initiative
- Self Wound Care Instructions
- Harm Reduction Guide (BCCDC)
- Wound Care Supplies
- Wound Care Do's
- Wound Care Don'ts
- Wound Infection in Clinical Practice: Principles of Best Practice (2022 Update)

Wound Training

- Molnycke Clinical Learning Hub (Free): https://www.molnlycke.com/education/
- Wound Care Education Institute https://www.wcei.net/courses
- NASTAD Wound Care and Medical Triage for People Who Use Drugs to resources under wounds: https://nastad.org/sites/default/files/2023-04/PDF-Wound-Care-And-Triage.pdf

Brief tips for you to follow:

- Peroxide, alcohol, or bleach are **NOT** acceptable means of cleaning a wound. Soap and water, or even just clean water, is preferred.

WRAP-UP

- Reflections
- Questions

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THANK YOU

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