AD Harm Reduction
for People Who Use Drugs

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Disclosure

- I have nothing to disclose.

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Harm Reduction Academic Detailing (HRAD)

- **Pilot project** funded through CDC + NACCHO *(National Association for County and City Health Officials)*
- **Location**: Franklin County, Ohio
- **Timeframe**: January – October 2023
- **Educational outreach to 15 participants**
  - *3 visits with each participant*
  - *Locations: primary care offices, FQHCs, walk-in clinics, urgent care*
- **Key Components: Resource Guide + access to participants** *(physicians, nurses/nurse practitioners/physician assistants, etc.)*

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Key Messages

Opioid Use Disorder (OUD): a Chronic Relapsing Disease

Understanding Opioid Terminology

Diagnosing Opioid Use Disorder

Naloxone Saves Lives

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Understanding Harm Reduction

- A set of **practical strategies** and ideas aimed at **reducing negative consequences associated with drug use.**
- **A movement for social justice** built on a belief in, and respect for, the **rights of people who use drugs.**
- A **noncoercive, nonpunitive, and nonjudgmental approach** to drugs and drug use that **prioritizes health, safety, and positive change**
- **Centers on the experiences, needs, desires, and dignity** of people who use drugs (PWUD).

Source:- National Harm Reduction Coalition

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Materials Development for HRAD

Critical involvement of PWUD for program and material development:

- Messages representing the current drug landscape
- Crucial context to health behaviors and outcomes
- Strong and trusting relationships with other PWUD
- Acknowledgement of the long history of mistreatment of PWUD by medical professionals, social workers, researchers, etc.

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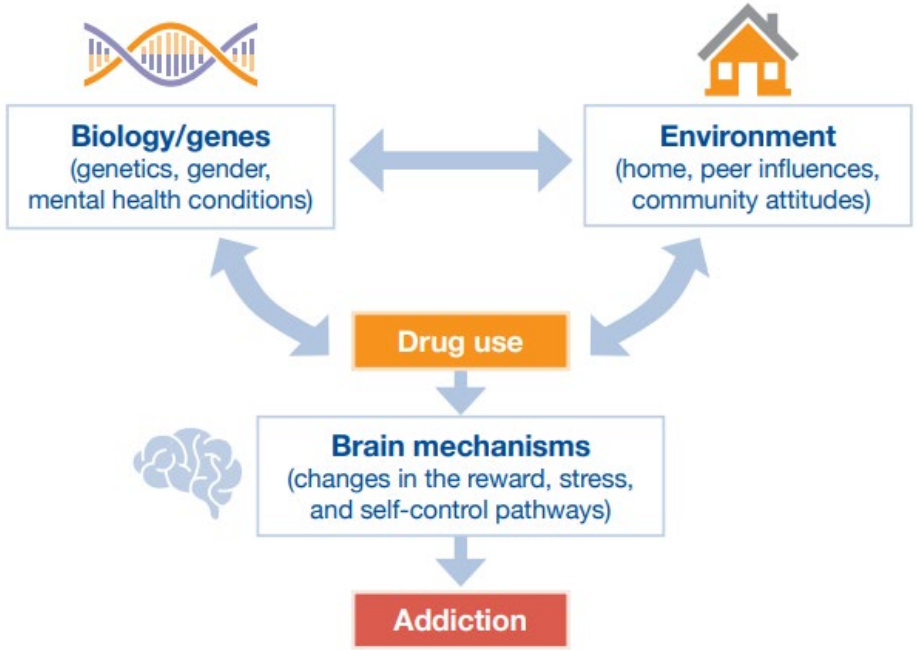
Key Message 1 - Opioid Use Disorder (OUD): a Chronic Relapsing Disease

Nearly 3 million Americans have opioid use disorder.[1]

Even though medical treatment greatly improves outcomes, only 1 in 10 people with OUD receives such treatment.[2]

OUD is *NOT* a moral choice

FIGURE 1. Addiction results from physiologic changes in the brain caused by drug use, against a background of biological and environmental factors.[3]



Choose language to engage patients with OUD in care

Use "person-first" language when talking about substance use.

Changing the language shows that the person "has" a problem, not that the person "is" the problem.[4]

TABLE 1. Words can impact a patient's perception of their care.

Language to avoid	Recommended language
addict, abuser, user, junkie	a person with OUD
clean/dirty urine	urine positive/negative for opioids or other substances
treatment failure	return to use, recurrence

Patients with OUD can be less willing to seek treatment if they feel stigmatized.[5]

> *[When healthcare professionals learn about your OUD diagnosis] it all changes. They change, from looking at you with warmth, as if you were a fellow human being, straight to "addict". And immediately you get the "Yeah, no, but your'e exaggerating [your problems]".*[6]

The language used can negatively impact the care clinicians provide to patients with OUD.[5]

Extend the offer for treatment and support

Buprenorphine helps engage patients in recovery and reduces mortality. It has a few misconceptions.[6]

QUESTION	RESPONSE
Do medications to treat OUD replace one addiction with another?	**No.** Medications used to treat OUD protect a person from overdose. They also allow a person to regain function in society.
Will treatment cure someone with OUD?	**No. Just as a person with diabetes is not "cured"** by insulin, people with OUD are not "cured" by medication. They are better able to manage their condition when receiving treatment.

Encourage patients to get treatment and provide continued support and follow-up throughout care, regardless of relapse.

Key Message 2 - Understanding Opioid Terminology

Defining opioid use disorder (OUD)

It is **problematic opioid use** that leads to **significant impairment or distress** that is accompanied by **at least two** of the following **criteria over the past 12 months:**[1]

- ❑ using opioids at higher doses or longer than intended
- ❑ unsuccessful attempts to control or reduce use
- ❑ significant time spent obtaining, consuming, or recovering from opioids
- ❑ cravings for opioids
- ❑ failure to fulfill obligations because of opioid use
- ❑ persistent social or interpersonal problems caused by opioids
- ❑ opioid use displaces social, work, or recreational activities
- ❑ using opioids in hazardous situations (e.g., while driving)
- ❑ use continues despite physical or psychological problems caused or worsened by opioids
- ❑ tolerance: a reduced effect of the drug despite increasing dosages (in patients taking opioids other than as prescribed)
- ❑ withdrawal (in patients taking opioids other than as prescribed)

Mild: 2-3 criteria; Moderate: 4-5 criteria; Severe: 6 or more criteria

Physiologic opioid dependence does **not** equal addiction

Tolerance	Physiologic Dependence	OUD / addiction
• need for **increased dose** of a drug to achieve the same effect • can occur even when taken as prescribed	• **physiologic adaptations** to the chronic presence of a drug to maintain normal function • sudden absence of drug can lead to withdrawal	• uncontrollable drug use **despite harmful consequences**

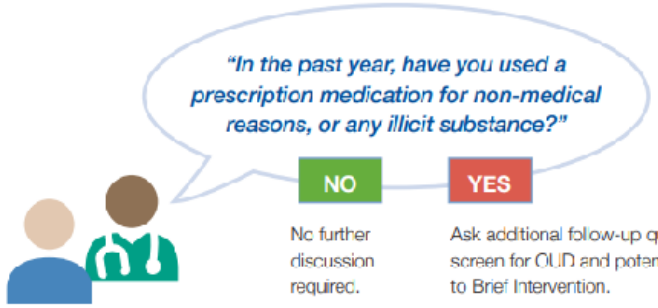
A patient who becomes physically dependent on opioids prescribed for chronic pain or for the treatment of OUD, and takes them as prescribed with no impairment of daily life, is not considered to have an addiction.

Identifying patients with OUD

The Substance Abuse and Mental Health Administration recommends **SBIRT** (**S**creening, **B**rief Intervention and **R**eferral to **T**reatment) to identify and manage patients who may have OUD.[3]

Screening

Universal screening of all patients in primary care normalizes the question and gives all patients an opportunity to disclose use. **Ask a simple question to open the conversation:**



A formal tool like the Drug Abuse Screening Test (DAST-10) provides a format for asking about drug use and opening the conversation to gather information required to diagnose OUD.

DAST-10

Brief intervention

Comprised of one or more 5- to 15-minute conversations, a brief intervention can motivate the patient to change substance use patterns.

Tips for effective, collaborative brief intervention conversations:

- Ask the patient for permission to share information about problematic opioid use.
- Provide information, then elicit the patient's own views.
- Ask if the patient would be interested in resources.
- Summarize and confirm the plan with the patient.
- Schedule follow-up, even in patients who are not ready to start treatment.

Discuss harm reduction with all patients, regardless of treatment selection.

Offer treatment or referral

Do we have a local resource to offer for treatment?

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Key Message 3 - Diagnosing Opioid Use Disorder

Diagnosing opioid use disorder

CUD is **problematic opioid use** that leads to **significant impairment or distress** that is accompanied by **at least two** of the following **criteria over the past 12 months:**[1]

- ❑ using opioids at higher doses or longer than intended
- ❑ unsuccessful attempts to control or reduce use
- ❑ significant time spent obtaining, consuming, or recovering from opioids
- ❑ cravings for opioids
- ❑ failure to fulfill obligations because of opioid use
- ❑ persistent social or interpersonal problems caused by opioids
- ❑ opioid use displaces social, work, or recreational activities
- ❑ using opioids in hazardous situations (e.g., while driving)
- ❑ use continues despite physical or psychological problems caused or worsened by opioids
- ❑ tolerance: a reduced effect of the drug despite increasing dosages (in patients taking opioids other than as prescribed)
- ❑ withdrawal (in patients taking opioids other than as prescribed)

Mild: 2-3 criteria; Moderate: 4-5 criteria; Severe: 6 or more criteria

Addiction to opioids can be managed with effective medications

The goals of medications for the treatment of OUD are to:

1. **Relieve withdrawal symptoms**
2. **Block effects of other opioids**
3. **Reduce cravings**
4. **Restore normal function**

Three medications FDA approved to

Each one reduces the risk of death, improves treatment retention, and decreases opioid misuse. Methadone and buprenorphine are first-line choices for CUD treatment and are more effective at preventing overdose than long-acting naltrexone.[2-7]

TABLE 2. Tailor the choice of agent to the patient.

	Buprenorphine*	Methadone	Naltrexone injection
Mechanism of action	 **Partial agonist:** partially activates opioid receptor	 **Full agonist:** activates opioid receptor	 **Antagonist:** blocks opioid receptor
Who can provide treatment	any prescriber with a DEA license**	federally-regulated opioid treatment program	any prescriber
Dosage forms	sublingual film or tablet, buccal film, or long-acting injection	liquid or tablet	long-acting intramuscular injection
Treatment delivery	no daily clinic visits required	supervised daily administration or limited take-home treatment	monthly injection
Patient characteristics	buprenorphine is preferred for most patients	patients with multiple unsuccessful prior treatment attempts, and/or who need daily structured support	• patients who can be abstinent from opioids for 7-10 days prior to starting • patients who cannot use agonist therapy

*Buprenorphine is often combined with naloxone in a sublingual formulation (e.g., Suboxone) to prevent misuse if injected; naloxone in sublingual formulations has little or no effect if taken as prescribed.
**The DEA license needs to have Schedule III authority.

Detoxification and abstinence alone are not effective. Without medications, patients with OUD are > 2.5 times more likely to die of an overdose.[8]

Detoxification = observed opioid withdrawal with medical management of symptoms

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Key Message 4 - Naloxone Saves Lives

Naloxone saves lives

Just like wearing a seatbelt, applying sunscreen, or having a fire extinguisher, simple steps can be taken to keep those who use opioids and their loved ones safe.

Overdose checklist

❑ **Prescribe naloxone for anyone at risk for overdose**[1,2]

- **history of substance use disorder or overdose**
- opioid dose > 50 morphine milligrame equivalents (MME) per day
- renal or hepatic dysfunction
- co-prescribed benzodiazepines or other sedatives
- tobacco use, COPD, asthma, or sleep apnea
- loss of tolerance for recent abstinence (as from recent dose reduction or during incarceration)

❑ **Educate patients and family members about the signs of opioid overdose**[3]

Check	Listen	Look	Touch
• sleepy • heavy nodding • deep sleep • hard to wake • vomiting	• slow or shallow breathing (1 breath every 5 seconds) • snoring • raspy, gurgling, or choking sounds	bluish or grayish: • lips • fingernails • skin	• clammy sweaty skin

❑ **Train patients and family how to respond to an opioid overdose**

1. Check for a response.
2. Shout out for help, call 911, and get naloxone.
3. Check for breathing. If not breathing normally, give naloxone and start rescue breathing.
4. Use a second dose of naloxone if no response to the first dose after two minutes.
5. Place patients who are breathing, but unresponsive, in a recovery position (on their side, not back).

Discuss harm reduction strategies with all patients

Like wearing seat belts simple steps can help all patients with OUD reduce risks to their health.

Prescribe intranasal naloxone (e.g., Narcan) to prevent overdose

Recommend or provide immunizations
(hepatitis, pneumococcus, tetanus)

Screen for infections
(especially HIV, hepatitis C)

Other harm reduction strategies:

- For patients who use opioids alone, recommend **www.neverusealone.com** or the 1-800-484-3731 hotline to prevent unintentional overdose.
- For those who inject, **discuss sterile injection practices** to reduce the transmission of bloodborne pathogens like HIV and hepatitis C; link with a syringe exchange program or prescribe insulin needles.
- **Recommend fentanyl test strips,** if available.
- Evaluate whether **pre-exposure prophylaxis (PrEP) is indicated** for HIV prevention.

Be aware of other substances: Xylazine

Xylazine-involved drug overdose deaths in Ohio have risen 5 fold from 2019 to 2021.[4]

What to know about xylazine

- Xylazine is being added to illicit fentanyl to prolong euphoria.[5]
- It is a veterinary medication with no human indication. It acts as an alpha-2 agonist, like clonidine.
- Skin ulcers, abscesses and other ischemic complications may occur regardless of the method used (e.g., injection, snorting, swallowing, or inhaling).
- Naloxone should be administred for any suspected opioid overdose. Naloxone will NOT reverse the effects of xylazine.

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Local Resource Cards

If you are not ready to stop using drugs, always use safely.

Always have naloxone available.

- Know the signs and symptoms of opioid overdose.
- Give naloxone if needed and call for help.
- Order naloxone online at tinyurl.com/CbusNLXN (scan QR code).

Never use alone.

If you can't use with others, try one of these options.

- Visit neverusealone.com or call 1-800-484-3731.
- Use an app like "The Brave App" or "Canary – Prevent Overdose."

Test for fentanyl.

- Order fentanyl test strips online at thesoarinitiative.org.

Use clean equipment.

- Get supplies at Safe Point (1267 W. Broad St.) or online at SafePointOhio.org.

COLUMBUS & FRANKLIN COUNTY ADDICTION PLAN
Bridging the Gap for Opiate & Drug Addiction Recovery

Central Ohio Hospital Council

If you are ready to talk about your drug use, we are here to help.

If you feel lost and overwhelmed, there is help.

If you don't have the energy to take care of yourself, there are local clinics that understand your needs.

You can talk to someone who won't judge you and work with people who know what it takes to change.

Get help today.

- Scan QR code.
- Visit cfcap-columbus.hub.arcgis.com.
- Email cfcap@columbus.gov.

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Bridging the Gap for Opiate & Drug Addiction Recovery

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Local Resource Guide – Franklin County, Ohio

MENTAL HEALTH PROFESSIONALS	RESOURCE	WEBSITE	PHONE #	Notes (days/hours open; restrictions; other important information)
Psychiatrists	PrimaryOne Health	www.primaryonehealth.org	614-645-5500	Psychiatric CNP's on staff at various locations, M-F, 8am-5pm
Counselors	PrimaryOne Health	www.primaryonehealth.org	614-645-5500	M-F, 8am-6pm, various locations
Counselors	Columbus Public Health	https://www.columbus.gov/publichealth/programs/Alcohol-and-Drug-Abuse/Alcohol-and-Drug-Program/	614-645-6839	Monday-Friday by appointment. Columbus Public Health is on the bus line and offers sliding fee scale. Counselors, Social Workers and Chemical Dependency staff provide services, and individual sessions as needed for dual diagnosis issues.
SUPPORT GROUPS	**RESOURCE**	**WEBSITE**	**PHONE #**	**Notes (days/hours open; restrictions; other important information)**
Recovery support groups	Alcoholics Anonymous (AA)	Meeting Finder: https://www.aa.org/		Smart Recovery, Tuesdays at 4:30 p.m.
	Narcotics Anonymous (NA)	Meeting Finder: https://www.na.org/meetingsearch/		
SUBSTANCE USE	**RESOURCE**	**WEBSITE**	**PHONE #**	**Notes (days/hours open; restrictions; other important information)**
Treatment – inpatient	OSU East - Talbot Hall	https://wexnermedical.osu.edu/locations/talbot-hall	614-257-3760	Detox: 8:00-4:00 By scheduled appointment 7 days a week. Walk-ins 8-12:00 M-F
Treatment – outpatient	CompDrug	www.compdrug.org	614-224-4506 Option 2	M-F 6:00 a.m. to 1:00 p.m. and Saturday 6:00 a.m. to 9:00 a.m.

Resources:

- *Mental health professionals*
- *Support groups*
- *Substance use*
  - *Treatment – inpatient*
  - *Treatment – outpatient*
  - *MOUD & behavioral therapy*
  - *HR services (SSPs, naloxone, wound care, etc.)*
- **Other resources**
  - *Tobacco cessation*
  - *STI clinics*
  - *Housing*
  - *Transportation*
  - *Childcare*
  - *Other available programs or resources*

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HRAD - Evaluation Process

• Pre-evaluation survey

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Harm Reduction

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Balanced information for better care

Please rate your level of agreement with the following statements.

	Strongly agree		Neutral		Strongly disagree
1. I know the criteria for diagnosing OUD.	5	4	3	2	1
2. I have a process to screen patients for problematic opioid use or misuse.	5	4	3	2	1
3. I know the treatment options available for patients with OUD.	5	4	3	2	1
4. I can advise patients on the best OUD treatment option based on their preferences.	5	4	3	2	1
5. I can advise patients with OUD on harm reduction tools and direct them to resources locally.	5	4	3	2	1

Name (PLEASE PRINT): _____ **Degree**: _____

Today's date: _____

Please return to the academic detailer or fax to the Alosa Health at (857)-350-9155 or scan and send Email to info@alosahealth.org

• Post-evaluation survey

Please rate your level of agreement with the following statements.

	Strongly agree		Neutral		Strongly disagree
1. I utilize person-first language when talking about and with patients who have opioid use disorder (OUD).	5	4	3	2	1
2. I feel that learning about harm reduction resources is relevant to my practice.	5	4	3	2	1
3. I know the criteria for diagnosing OUD.	5	4	3	2	1
4. I have a process to screen patients for problematic opioid use or misuse.	5	4	3	2	1
5. I know the treatment options available for patients with OUD.	5	4	3	2	1
6. I can advise patients on the best OUD treatment option based on their preferences.	5	4	3	2	1
7. I provide patients with OUD harm reduction tools to prevent overdose.	5	4	3	2	1
8. I discuss the role of naloxone with every patient with OUD.	5	4	3	2	1
9. I recommend immunizations and screen for infections in patients with OUD.	5	4	3	2	1
10. I am aware of the local harm reduction resources which I can recommend to my patient.	5	4	3	2	1

As a result of these visits:

	Strongly agree		Neutral		Strongly disagree
11. I will screen patients for non-medical opioid use.	5	4	3	2	1
12. I will prescribe buprenorphine for at least one patient with OUD.	5	4	3	2	1
13. I will recommend naloxone and other relevant harm reduction strategies to patients with problematic opioid use or a history of overdose.	5	4	3	2	1

Can you provide an example of how the information provided by the academic detailing program has been useful in your practice?

_____

_____

Providers concerns and barriers

Concerns:

- *Stigma*
- *Lack of education*
- *Support and advisory system not established*
- *Legal landscape*
- *Lack of support from healthcare system*
- *Paraphernalia*
- *EHR terminology*

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Impact of the Academic Detailing

Implementation of the Academic Detailing into “sensitive topics” like Harm Reduction presented itself as extremely beneficial:

- **Providers are more open** in one-on-one setting regarding their knowledge, understanding and feelings
- Multiple meetings **build the relationship** between detailer and lead to better understanding of healthcare providers needs
- Utilized stories from encounters with PWUD to **personalize the messaging**
- Detailer is able to **change providers behavior** and, in many cases, completely change providers outlook at the Harm Reduction needs, criteria and approaches
- Academic Detailing leads **to knowledge, acceptance and implementation of Harm Reduction** in communities

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Balanced information for better care

Results of HRAD

- Total of **47 visits completed** with **17 providers and healthcare practitioners**
- Program participants reported increased knowledge of local resources, comfort providing harm reduction options, and knowing criteria for diagnosing OUD

Recommendation for improvements based on HRAD:

- Explaining Harm Reduction and OUD terminology to reduce stigma
- Extensive need for education and information delivery to healthcare providers regarding available Harm Reduction strategies
- Address systematic barriers such legislative restrictions, health systems limitations
- Address providers individually while addressing their personal beliefs, knowledge and needs to reach a goal of wide implementation of the Harm Reduction

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