Addressing Fentanyl Use in Primary Care Settings

Key "Take-Aways":

1. **If you are a primary care provider who treats chronic diseases, you already have the skill set you need.**
2. **Stigma kills; you should be comfortable asking questions and giving practical advice.**

Presentation Transcript:

Hi, my name is Candy Stockton, and I'm the health officer for Humboldt County. This presentation is part of a video series UCLA's Integrated Substance Abuse Programs is doing in partnership with the California Department of Healthcare Services. The goal of the series is to provide tips and tools to busy clinicians to help them better address the use of substances among their patients. The title of my talk is addressing Fentanyl Use in Primary Care Settings. I plan to cover some practical tips for patients who are knowingly using fentanyl and not interested in quitting at this time. We hope the content's useful to you as you care for patients who use substances.

(00:36) The most important concepts from today are that:

1. If you are a primary care provider who treats chronic diseases, **you already have the skillset** that you need to work with patients who are using fentanyl.
2. And the second is **that stigma kills**. You should be just as comfortable asking questions and offering harm reduction and medical treatment options to individuals who use fentanyl as you are managing patients with diabetes or asthma or other forms of chronic illnesses.

Take a Thorough History:

(01:04) The first thing we are going to talk about is taking a thorough history. You know this, but I also know that in our busy practices sometimes we shortcut this step just a little bit. We kind of assume we know these answers.

So, at some point, and on a fairly regular basis, you should be talking to your patients who use substances **about what routes of substances** they use. How are they using, are they injecting? Are they smoking? Are they snorting, swallowing, booty bumping? What method are they using to ingest substances? Because the advice that we give varies a little bit depending on what the risks are associated with their use.

What are their **sexual practices**? What risks do they have associated with that?

Does the individual themselves have **any concerns about their substance use**? Are they interested in cutting back or trying to quit their substance if they are interested **what's worked for them before**? And are there times or situations where they find themselves **using more than they intended**?

These are all ways to normalize the conversation around substance use. There's a lot of shame and a lot of stigma involved for people who are using substances. Being able to talk about this and ask questions in the same way that we ask questions about other conditions can normalize this. It can say to the patient, *"Hey this is a thing that happens. You are not alone. I am in this with you to help you with your health and healthcare the same way I am with other situations. Even for a patient who's not interested in quitting at this time or not interested in cutting back at this time."*

These are the beginning pieces of motivational interviewing starting to look at what drives the patient's behaviors **what motivates their behaviors** and what makes them interested in change. It's also a great way of **building rapport** so that if you happen to have a patient in that narrow window where they're feeling like change is something they're interested in you are a safe place to talk about that.

Not Ready to Quit?:

(03:02) **Do not assume** that somebody who uses substances or drugs isn't interested or doesn't care about their health.

Do make sure that you **use non-stigmatizing language**. Many times, people who use substances will refer to themselves as addicts. They'll say things like they're clean or they're dirty. And that's okay for somebody who's living that experience to talk about themselves that way. It is not okay for us as providers in the medical system to reinforce that negative and judgmental terminology in much the same way. We try to avoid saying “diabetics” and instead say, “people who are living with diabetes” because we know that individual is more than just the sum of their disease.

For people who are not open to addressing addiction, addiction or substance use disorders at this time, particularly with opioids and fentanyl, it can be helpful to use the terms “tolerance” and “dependence” instead of terms around addiction or substance use disorders, which may actually cause them to become more defensive or less willing to talk about it. And then again, we're working on the assumption that you've gone through these steps with the patient, and you've determined the patient has expressed that they're not interested in quitting and they are knowingly using fentanyl.

I'm not going to be talking about things like fentanyl test strips to screen their drugs because we're assuming this individual already knows they're using fentanyl.

So, the last step is, if possible, if it's acceptable to the patient**, change the use to anything other than injection**. While it doesn't erase the risk of overdose, it does significantly lower it.

Narrow Therapeutic Window:

(04:38) The first thing I cover with my patients who are using fentanyl is the concept of **therapeutic window**. Believe it or not, this is something that people can get. And for fentanyl, the window between the dose that gets the drug effect the patient's looking for and the dose that stops their breathing is **very, very narrow**. And this is an important thing to talk about.

This is why we tell people **never use alone**. Always use with somebody who can intervene. If you stop breathing, if you're overdosing. And if you don't have that person, there is a great resource you can give your patients. It's never used alone. I put the phone number on the screen here, but this is important. You can't mitigate the harm from the disease in somebody who's dead already, right? And because fentanyl does have this very narrow therapeutic window, it's important that we stress this point for people. Never use alone.

Offer naloxone to these patients every time you see them. Don't just assume that because you've given them naloxone in the past that they'll ask for more when they need it. Oftentimes, people are reluctant to share that they've overdosed with a provider. They may also not be willing to share that they use the medication to save somebody else because they may not be sure if that was okay to tell you, you know that they weren't supposed to use it for themselves. They may not share that they've used their naloxone, they've lost it, you know any of those cases. So, you want to make offering naloxone to them the norm every time that you interact with them.

And if it's possible you want to **streamline the process** of getting it. If it's possible to have it available in your clinic to hand it to somebody, that increases the likelihood that they will get it. Sending a prescription to the pharmacy is a great thing to do, but patients may not want to actually go to the pharmacy and acknowledge in front of their pharmacist that they have a reason to have naloxone, or they may just be barriers that keep them from getting there to fill the prescription. So do consider if it's possible having it available to hand out to people.

We want to encourage them to **use test doses** especially after they've had any period at all of abstinence or reduction. Somebody who's been admitted to the hospital for a couple of days, who's been held for 36 hours in jail or went on a trip or a vacation with family members where they weren't able to get access to their drug, even that short period of time can **actually decrease their tolerance for fentanyl and increase their risk of overdose** in the period immediate after that when they resume use. So, using test doses can be a really practical way to for patients to test their response and reduce risk of overdose.

The other thing we advise is **don't mix it with other substances**. A lot of patients will use a combination of opioids, fentanyl, heroin, something else with a stimulant, meth, cocaine, whatever is prevalent in your area. When possible, use substances separately, not together. And if you are going to be using them together it is better to dose them one at a time. So, the opioid first followed by dosing with the stimulant. After that, it does reduce the risk of overdose death a little bit associated with that.

Make sure that they're **keeping their drug supplies secure from children or teenagers** or other people in the house who might be curious or might use it for any reason. Because fentanyl is, again, particularly potent with a very low or narrow window between the dose and that drug effect on you - and the dose that kills you.

Address Common Complications:

(08:08) Just like we screen we send people with diabetes for eye exams to monitor for the development of retinopathy. And we talk to that family that has a family member with severe allergy induced asthma who just cannot imagine getting rid of their dogs about at least keeping them out of sleeping spaces and other ways to minimize allergy and exposure for the person with asthma. We need to be looking at the **common medical complications and symptoms associated with opioid use and with fentanyl use**. And the reason for that is twofold. One, it's the **right thing to do medically**. And secondly, it sets an atmosphere of **acceptance and therapeutic cooperation** that does make that person more comfortable talking with you about when they are having considerations about stopping or cutting back drug use. It makes them more willing to engage in conversations about that in the future.

So, common complications in people who are using fentanyl. **Other opioids or constipation stool softeners** can be a handy treatment for that because untreated **constipation** causes abdominal pain, and increased pain often leads people to use more opioids, which can become this revolving cycle. It is one of those things you want to ask about and treat.

They can have **urinary retention that can develop into mono-neuropathies**. So, if they're sedated or impaired from their opioid use and left in a particular position for a long time, that puts pressure on specific nerve they can develop mono-neuropathies from that. It's something to pay attention to and be aware of if they are coming in with medical concerns or pain complaints, neuropathic complaints.

The other thing that can happen is **cognitive impairment as a consequence of multiple previous hypoxic overdose events**. Particularly, when you're dealing with patients who are a little bit older, but even in younger patients who've had a substantial use history, you want to consider screening with other cognitive screening tool to assess for that.

For people who are using via **injection**, you also have **cellulitis sterile abscesses** that can develop. More recently we're starting to see issues with **necrotic skin lesions**. We're starting to see tranc or xylazine being used in combination with fentanyl which can cause these very serious skin reactions, as well as increasing the risk of overdose, because xylazine does cause its own respiratory suppression and bradycardia associated with it.

People who use long-term opioids will **have increased dental complications, dry mouth, increased caries**. So regular dental care and oral hygiene are important.

Men who use opioids regularly will develop will often **develop low testosterone**. Other complications associated with that including **erectile dysfunction**. Women who use opioids regularly will commonly develop **menstrual irregularities**. And because of this and kind of the **lower fertility rate**, they may be having **unprotected sex** and not using contraception regularly because they may think it's not possible for them to get pregnant. It is possible for them to get pregnant and possible for them to get pregnant before they resume having regular menstrual cycles. So, it is important to talk to women about that and make sure that their contraceptive needs are addressed.

And then the other thing that we need to keep in mind is that long-term opioid use is a risk factor for **osteoporosis**. You should consider a screening all postmenopausal women who have a history of long-term opioid use, and men over the age of 50 who have a history of long-term opioid use. You want to consider this an independent risk factor for osteoporosis.

Address Common Complications:

(11:51) The next thing, and this one I admit is tricky is that people who use drugs commonly have **both acute and chronic pain conditions**. There are several reasons why this is true. When you're impaired, you're more likely to suffer accidents or injuries. You're also more likely to have been exposed to and start using opioids regularly if you're suffering from pain in the first place. This can become another one of those spiraling cycles.

It's important that you **do not write off pain complaints** in your patients who use drugs as drug seeking behavior. Of course, they are seeking a drug if they're having pain because they want to feel better just like everybody else does. That doesn't mean that they're lying about or misrepresenting the pain that they're experiencing. Untreated pain can lead to increased use of illicit opioids which can lead to increased risk of overdose death.

Make sure that you are **evaluating all pain complaints** for their underlying medical causes. These can be signs of more serious problems like infection in joints or other complications from IV drug use, but they can also just be chronic underlying conditions.

Do offer appropriate pain management modalities for this patient. That does not mean that you should be offering them opioids for their pain. **Opioids are often not the best treatment for pain**, depending on the circumstances for anybody, not just people who use. But in a situation where it would be appropriate to prescribe opioids for somebody, say for a few days after they've had a fracture, it would still be appropriate, with the right monitoring conditions in place, to prescribe opioids for an individual who has that type of injury even if they also have a substance use history. Appropriate modalities can include things like **NSAIDs and acetaminophen, topical agents such as lidocaine, physical therapy, mindfulness**. Do be cautious about using muscle relaxers and gabapentin. It's not that they're never appropriate but they can increase the risk of overdose death a little bit depending on the quantities that they're used in and how the patient uses them. And do avoid benzodiazepines because mixing benzodiazepines with opioids is particularly increases the risk for overdose death.

Practical Advice:

(14:05) What is the practical advice you can give? I know for me as a provider, and I'm imagining I'm not the only one that I can get frustrated when people keep coming back to me with the same medical problem and I just don't have anything to offer. There are things that you can offer even for people who are not willing to engage in conversations about reducing their use or quitting their use.

One of them is, again, remembering that people with substance use and even opioid use have increased dental complications. Dental complications are frequently painful, right? So again, this revolving cycle. So, **encouraging people** to brush and floss daily and get regular **dental care**, talking to them about **warning signs of skin infections** and monitoring for these on a regular basis, **getting vaccinated** against hepatitis A and B since they have an increased risk of contracting Hepatitis C, making sure if that they've had their HPV vaccines and pneumonia vaccines as appropriate for age, tetanus vaccines. These are all things you can do to help protect the health of the person who's using drugs.

The other thing is **reinforcement**: *"You matter. You are valuable as a person. We provide care to you regardless of whether or not you're willing to or able to stop using at this time."* Just like we continue providing care to our patients with diabetes who are not controlling their blood sugars and our patients with congestive heart failure who will not take their diuretics and are in and out of the office in fluid overload every other week right? We know how to care for individuals who are still in the grips of their uncontrolled chronic disease.

We offer the **harm reduction and symptomatic care and advice** that they are willing to work with. And then because cognitive impairment's not uncommon in this population, you may want to **write down or give**

printed copies of important advice or instructions, particularly because a lot of patients with heavy use habits will use shortly before coming into the office. They are not too sick to make it into the office from withdrawal symptoms, which means they're likely under the influence to some degree when they come into your office.

Sexual and Reproductive Health Care:

(16:16) **Sexual and reproductive healthcare** is incredibly important. You do want to talk about harm reduction for the individual whether that's condoms, PrEP or PEP as appropriate. You want to be aware that patients who have substance use disorders, it may be particularly women, but men as well may be engaging in transactional sex, whether that's exchanging sex for drugs or sex for money for drugs that is something that's more common in this population. You want to ask non-judgmental questions about that risk and provide advice about protecting themselves if that is what's happening.

You also want to provide education about **all forms of harm reduction**, right? So not using in high-risk situations or taking steps to protect yourself if you use you are using in high risk situations. So again, keeping in mind that somebody has just taken fentanyl or other opioids, particularly by injection, is likely to be impaired. And if they're doing that in an area where they are other people that they don't know and trust, they're at risk of non-consensual sex in that area. So, we counsel against using in areas where that risk might occur. Careful to express that **this is not a blaming the patient** if that does happen to them, but this is a help taking steps to minimize their risk, and also openly acknowledging that risk so that **they can come to you** and seek care if that is something that happens to them.

You also want to discuss their **sexual practices in terms of risk of transmission of STIs** and offer other screening or regular screening for STIs if it's appropriate based on their risk factors.

You want to talk to all patients with a uterus who are using substances **about what their pregnancy wishes are** and encourage larks for those patients who are not interested in pregnancy at this time. Educate them about morning after treatments as well as making it easy for them to access those if it's what they desire. And then for patients who are wanting pregnancy or undecided about pregnancy, you want to talk to them about the **benefits of getting stable on treatment** before pregnancy, as well as the benefits of entering treatment after pregnancy occurs. So, having those conversations, and ensuring them it's safe to come forward and talk about it before they become pregnant, is one of the best tools we can use for getting those women into early prenatal care and early treatment which is important for them and the baby they're carrying.

Clinical Pearls:

(18:46) **Sedatives** including sleeping pills, benzodiazepines, carisoprodol otherwise known as soma and alcohol all **increase the risk of overdose**. You want to be careful about prescribing these medications, if it's appropriate to do so. You want to do so only under more insured circumstances and having clearly documented the rationale behind doing that. But in general, you want to avoid those medications.

False positive RPRs and BDRLs are relatively common in people who use some form of opioids. So, you want to make sure that you're getting **FTA confirmation** of those tests and not just going based on the initial screening tests.

Another thing that's a relatively new development is that many **jails and prisons now will continue MOUD medications for opioid use disorder** in people who were previously taking them prior to the to their intake into the jail. I don't mean to suggest that most of your patients who use substances will face jail time at some point, but some of them might. And for those who do, it can be a time to talk to them about the fact that they may be heading into a jail setting. And if your community is one of those that allows them to continue MOUD when they're admitted to jail, then getting started on that before going into jail can be a good way to help make sure that they're not experiencing withdrawal. And it may be a time when they're highly motivated to consider treatment when they may not have been in the past. So do find out what the **policies in your area** are around this and talk to your patients about it where it seems appropriate.

And then the last one is that in DC and in every state, except for Delaware and Kansas, **physicians can legally prescribe and dispense syringes** for the legitimate medical purpose of reducing the risk of communicable diseases associated with injection drug use. You can get people connected with syringe services programs that offer a full spectrum of services. That is obviously a great option, but in many areas you will not have robust syringe service programs. And one of the things that we can do to help minimize the risk of harm in our patients is to make sure that they have access to clean syringes to use for every injection. So that is another clinical pearl that all of you who live anywhere other than Delaware and Kansas can use.

Be an Advocate for your patients:

(21:07) **Be an advocate** for your patient. Use the same skills you use to help patients with their other chronic diseases. Base it off of compassion, knowledge and evidence-based practices and collaboration to build a treatment plan that works for your patient. Don't assume that your goal, the goal of them stopping all drug use, is their goal. And don't assume that just because that isn't their goal that they're not willing to do anything else to work on improving their health.

Thank you so much for your time today. Bye.