Harm Reduction For STHC Patients With Opioid Use Disorder

Michael P. Kinney

Amy G Burns

Follow this and additional works at: https://digitalcommons.psjhealth.org/gme_wamt_all

Part of the Behavioral Medicine Commons, and the Medical Education Commons
Harm Reduction For STHC Patients With Opioid Use Disorder  
Michael P. Kinney, MD and Amy G. Burns, MD  
Psychiatry Residency Spokane

**BACKGROUND**

- The Opioid Epidemic has led to a precipitous rise in the number of overdose deaths across the United States as well as locally in Spokane. Increasingly, overdose events have involved synthetic opioids such as fentanyl\(^1\).
- Harm reduction strategies are evidence-based interventions for minimizing overdose deaths and chance of relapse\(^2\).
- There are a wide variety of harm reduction strategies available for patients with opioid use disorder. Buprenorphine, methadone, and naloxone are some of the most commonly used harm reduction strategies in addiction medicine; clean needle exchanges and fentanyl testing strips (FTS) are less common\(^1\).
- FTS allow patients to avoid overdose by increasing knowledge regarding what contaminants may be present in street drugs\(^1\).
- This project therefore attempted to address several issues for our opioid related disorder patients. First, expanding available harm reduction modalities with FTS, and second, establishing a baseline and refining future methods to track harm reduction efforts at the clinic.

**AIMS STATEMENT**

All psychiatric residency clinic patients with an opioid related disorder diagnosis will be at least 50% equipped with naloxone by April 1, 2022 as demonstrated by the presence of naloxone on their outpatient medication lists.

**PLAN DO STUDY ACT**

- Data was initially planned to be extracted primarily from Slicer-Dicer using automated reporting. However, an initial portion of the first PDSA cycle revealed failure of Slicer-Dicer to reliably report accurately whether patients had naloxone or Narcan on their medication lists. Automated reporting was dramatically less reliable, finding less than half of patients with naloxone on their medication lists (21% versus 68%, respectively, see figure 1).
- Standardized templates were introduced to Recovery Clinic follow-up progress notes that included documentation via smart-lists on the harm reduction engagement status of the patient.
- Residents were also asked to ensure patients who had already received naloxone kits had it listed as one of their medications in that encounter.

**METRICS: Outcome, process, and balancing**

- **Outcome**: Percentage of patients with opioid related disorder diagnoses who have an active naloxone prescription (68%).
- **Process**: Percentage of patients with an active prescription for naloxone or have a supply at home but have not had this entered into their medication list (20%).
- **Balancing**: Percentage of patients that have opioid use disorders in sustained remission and are neither interested in naloxone nor medication assisted therapy (11%).

**DISCUSSION & NEXT STEPS**

This project likely had a significant effect on the number of patients equipped with harm reduction tools in our clinic population. The initial estimate was 21% of patients having naloxone on their medication lists, while the final review totaled 68% (and potentially as high as 88%). The certainty of this statement is somewhat obscured by the initial statistics being reliant on Slicer-Dicer’s less effective data extraction tools. Since the effect size is not easily quantifiable, it is at least plausible that the apparent increase in patients equipped with naloxone is in part due to standardizing documentation of harm reduction optimization in Recovery Clinic note templates and in difference in sensitivity with manual review. Other obstacles that are relevant when using naloxone’s presence on medication lists to approximate whether patients have harm reduction tools available is that they will often tell nurses that they aren’t actively taking naloxone, which will lead to it being “discontinued” as a medication. Next steps include tracking individual components of harm reduction mobilization, such as FTS distribution, and individual provider feedback regarding resident patient panel’s relative harm reduction optimization.

**REFERENCES**


QI exception letter was obtained from the IRB for this project.