National Substance Use Warmline

A HRSA-supported, free, and confidential tele-consultation service for clinicians

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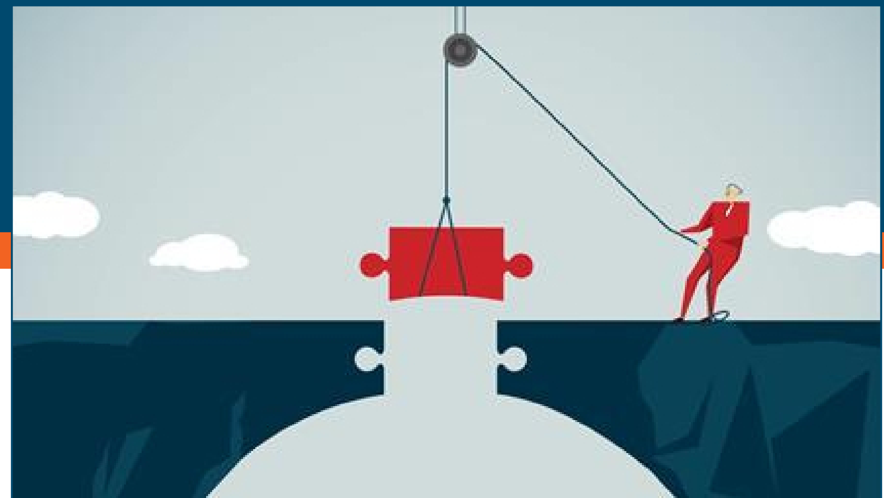
NATIONAL CLINICIAN CONSULTATION CENTER

Translating science into care

Provider support/capacity-building is a cornerstone for improving treatment access and health outcomes



Our guiding principle: “low-barrier” support

Same-day entry to care	Harm reduction approach	Broad availability	Flexibility
Rapid-response, tailored guidance and support	*Practical strategies, respect for callers*	*Readily-accessible, and free!*	*“Options, not answers”; agility to assist across varied practices, experiences, and resource landscapes*

Jakubowski A, Fox A. Defining low-threshold buprenorphine treatment. J Addict Med. Mar/April 2020; 14(2): 95-98.

So– who's behind the Substance Use Warmline?

UCSF
University of California
San Francisco

AETC Program
AIDS Education & Training Center

HRSA
Health Center Program

Multi-disciplinary, multi-professional consultant teams

Principal consultants include experienced primary care & specialty-boarded physicians, specialty clinical pharmacists, advanced practice nurses

How to reach us, what to expect

Clinicians don't need to	What we provide
• Sign-up in advance • Clear their clinic schedules • Memorize a patient's history • Download any apps or special technology • Limit inquiries to complex scenarios, opioids, or patient-specific questions: general questions welcome! **PHI is never collected**	• Evidence-based, practical guidance from professional subject matter experts • Confidential, individualized support • "Wrap-around" access to multi-disciplinary subspecialists • Happy to receive follow-up calls; can send post-consultation info by email – resources, articles

Substance Use Warmline: (855) 300-3595 | M-F 9am-8pm EST

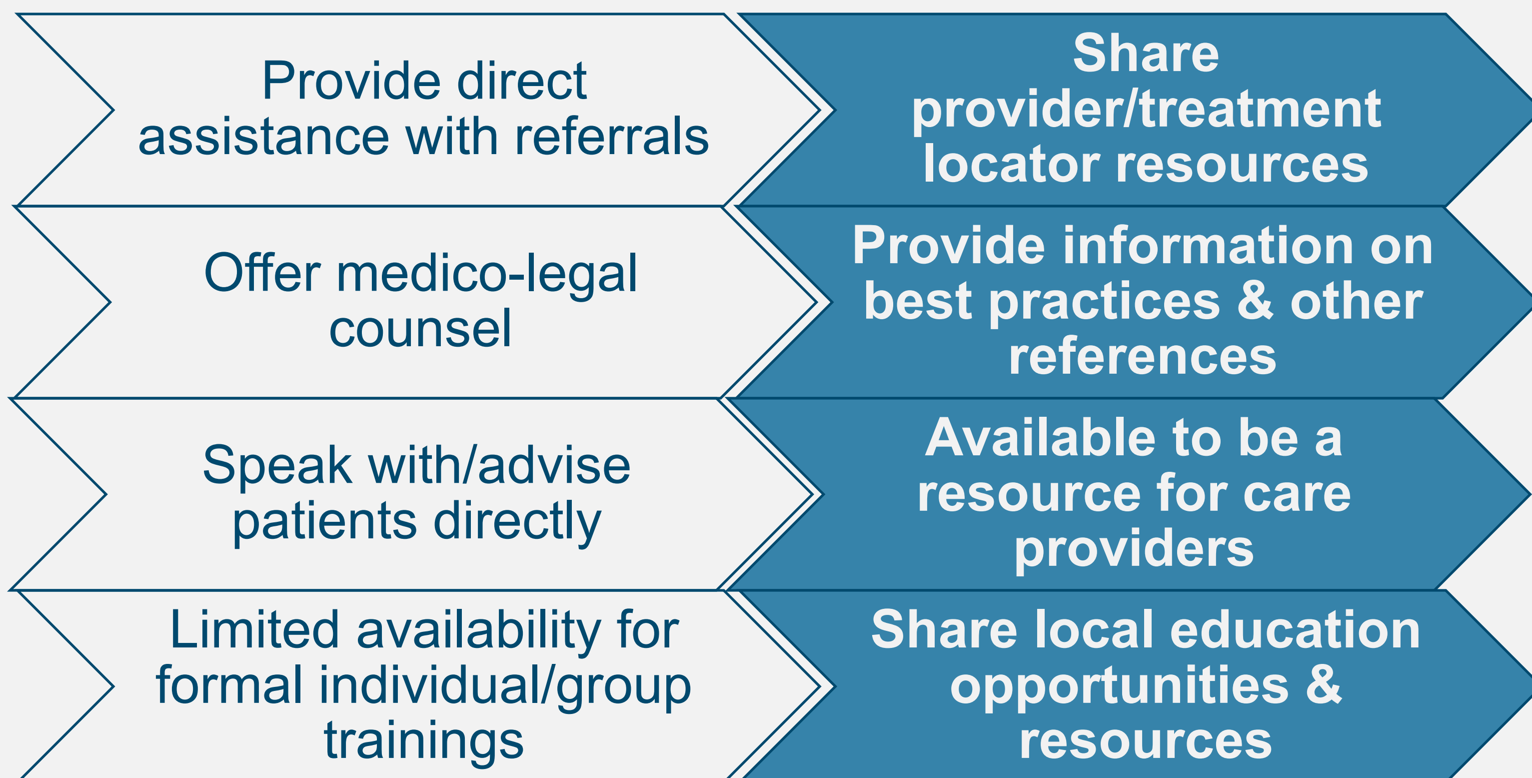
Common topics/areas of inquiry

Assessment, treatment	Medications	Toxicology, monitoring	Focus on safety	Special scenarios
• Opioid, alcohol, stimulants, and other use disorders • Acute intoxication • Withdrawal management and aftercare	• When and how to initiate pharmaco-therapies • Transitions, dosing strategies • Indications, contraindica-tions	• When to order • What it means/how to interpret • How results can inform person-centered care	• Harm reduction • Overdose prevention strategies • Safer opioid prescribing	• Pregnancy • Chronic liver/ kidney disease • Co-occurring pain • Co-morbid psychiatric conditions

Caller diversity: >1/2 physicians, ~1/3 nurses (predominantly advanced practice nurses), pharmacists, substance use navigators (i.e. Bridge programs)

Considerations

Things we cannot do… **…here's how we *can* support**



Wait… there's more!

Quarterly SUD-focused webinars for HRSA BPHC

- ***Tues April 27: Management of Stimulant Use Disorder (email David.Monticalvo@ucsf.edu to register)***
- Previous webinar recordings posted on our website*
  - *Management of Alcohol Use Disorder*
  - *Buprenorphine for Adults with SUD and Co-occurring Pain*
  - *HIV Pre-exposure Prophylaxis for PWUD*
  - *Pharmacotherapy for Depression and Anxiety in Patients with OUD*

*nccc.ucsf.edu

NCCC caller feedback

"So thankful for this resource! Timely, helpful, and clear guidance from experienced experts – so easy to access and great response time!"

"This service is amazing and so very helpful. I have used it several times and always come away feeling informed and ready to provide the best care."

"The person I spoke to was so nice, supportive, and well-informed. I was nervous that my question was kind of a dumb one or something I should have known, but she didn't make me feel like that at all. It was a great experience."

"I view this group as a lifeline when I have questions – it's a fabulous resource for busy providers!"

"The consultant saved my day. The care and concern I received was astounding, the consultant went above and beyond to help me and my patient."

CO calls to the NCCC

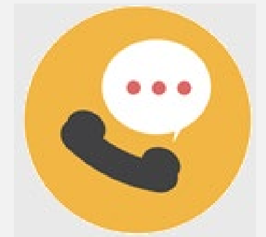
Composite of NCCC calls across HIV Warmline/ Perinatal HIV Hotline, PrEPline, HCV Warmline, and Substance Use Warmline

3 cases from the Warmline

Acute pain management for person receiving buprenorphine

Management of alcohol withdrawal

Newer buprenorphine induction strategies



1. How to address acute pain for someone who has been stable on buprenorphine for OUD?

53 year old woman has been taking buprenorphine (12/3mg daily) for OUD, stable for 3 years – recently experiencing severe acute pain from kidney stones, affecting ability to ambulate → presenting to local Emergency Department.

ED provider calling:

- ***Can I prescribe an opioid?***
- ***Should I discontinue buprenorphine?***

CA BRIDGE
TREATMENT STARTS HERE

Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder
Emergency Department / Critical Care

Continue Maintenance Bup
Divide dose q4-8hrs
(e.g 4mg Bup SL QID)

↓

Non-opioid analgesia

↓

- Promote calm and comfort
- Regional Anesthesia
- Acetaminophen and NSAIDs
- Gabapentinoids
- Alpha-2 Agonists
- Ketamine & Magnesium
- IV Lidocaine

↓

Additional opioids

↓

Option 1 High affinity full agonist opioids: Fentanyl; Hydromorphone

Option 2 Additional Bup: Increase SL Bup; Start IV Bup

↓

Taper down to maintenance dose Bup

Promote calm and comfort
Anxiety, fear, depression are common. Instill sense of control, provide education on self-management techniques such as mindfulness meditation. Reduce noise, uncertainty, confusion. Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status.
TREAT UNPLEASANT SYMPTOMS:
Diphenhydramine 25-50mg PO q8h prn insomnia/anxiety
Tizanidine 2-4mg q6h prn muscle spasms
Ondansetron 4mg PO q6h prn nausea
Trazadone 50mg PO qhs prn insomnia
Melatonin 3mg PO qhs prn insomnia
Lorazepam 0.5-1mg PO prn anxiety
Antipsychotics prn psychotic disorder symptom control
Nicotine replacement prn tobacco dependence

Regional Anesthesia
Peripheral nerve blocks: superficial cervical plexus, brachial plexus, radial/med an/ulnar, PECS, erratus plane, TAP, femoral, sciatic, posterior tibial.
Spinal and Epidural anesthesia

Acetaminophen and NSAIDs
Acetaminophen and NSAIDs, when not contraindicated, should are the foundation of a multimodal analgesic strategy.

Gabapentinoids
In opioid depenent patients, the calcium channel inhibitors gabapentin and pregabalin reduce postoperative pain and reduce opioid consumption. Gabapentin 300-600mg PO TID.

Alpha-2 agonists
Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing affects. e.g. **Clonidine** 0.1-0.3mg PO q6-8h prn pain or anxiety (NTE 1.2mg/day, hold if BP <100/70).

Ketamine & Magnesium (NMDAR antagonists)
Ketamine is the most potent non-opioid analgesic for opioid tolerant patients. A brief infusion of 0.3mg/kg IV over 15min is followed by 0.3-1mg/kg/hr as needed.
Magnesium is also an NMDAR with analgesic and opioid sparing effect. eg. 30-50mg/kg bolus followed by 10-mg/kg/hr.

IV Lidocaine (Na channel antagonist)
Opioid sparing analgesic. A bolus of 1-1.5mg/kg is followed by 1.5-3 mg/kg/h. Contraindications include cardiac dysrthymias. Must monitor serum levels after 24hrs.

High Affinity Full agonist Opioids
Hydromorphone, fentanyl, and sufentanil can be added to maintenance Bup to provide synergistic analgesia. Titrate to analgesia and side effects. This will NOT cause withdrawal.

Additional Bup
There is no clinical ceiling on Bup analgesia. SL Bup can be given as frequently as q2h. IV Bup is a potent analgesic start at 0.3mg IV and titrate as needed. At higher doses respiratory depression does occur.

Guidelines are options for multimodal analgesic therapy. Use clinical judgement and avoid use if contraindicated.

The CA Bridge Program disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

NOVEMBER 2019

PROVIDER RESOURCES
California Substance Use Line — CA Only (24/7) 1-844-326-2626
UCSF Substance Use Warmline — National (M-F 6am-5pm; Voicemail 24/7) 1-855-300-3595

Resources https://cha.com/opioid-safety/coloradomat/clinical-resources/

Consultant recommendations

Buprenorphine should not be stopped, since it is effectively treating OUD

Pain should be treated – un/undertreated pain may lead to return to use

Buprenorphine can be used as analgesic (“split dosing” for pain)

For acute pain, options include:

1. Non-opioid approaches to address kidney stones
2. Split dose to 4mg 3x/day (may not be sufficient to fully treat severe pain)
3. Consider temporary increase in buprenorphine (e.g., 4mg taken 4x/day)
4. Short course of opioid agonists (< 7 days) with careful monitoring: be prepared for possible questions from payer or pharmacy if co-prescription flagged

Haber L, DeFries T, Martin M. Things we do for no reason: discontinuing buprenorphine when treating acute pain. J Hosp Med. 2019 Oct 1; 14(10): 633-635.

2. How to safely provide alcohol withdrawal management (AWM) in a primary care setting ?

33 year old man with alcohol use disorder (AUD) experiencing mild-to-moderate withdrawal symptoms after last drink yesterday

- Returned to drinking few weeks ago: 1-2 bottles wine/day (≈5-10 standard drinks)
- Began naltrexone last week; starting new job and highly motivated

No h/o complicated withdrawal, otherwise healthy; supportive home environment

- Recently filled Rx for chlordiazepoxide and gabapentin (other prescribers)

PCP calling:

- ***Do I need to prescribe further benzodiazepines?***
- ***Doesn't know patient well, only able to offer phone visits currently; concerned about capacity to fully assess and monitor symptoms, medication response***

Assessing safety of ambulatory withdrawal management

Can the patient be safely monitored in an ambulatory care setting or at home?	Does the patient need inpatient care?
• Does the patient have safe housing and support? • Can the patient maintain telephone-based contact? • Can the patient follow medication instructions? Take orally? • Does your clinic have the capacity to provide remote monitoring and/or accessibility for patients with alcohol withdrawal syndrome?	• Are they at risk of severe or complicated withdrawal? • Does the patient have a history of seizures or delirium tremens? • How severe are their symptoms? • Does the patient have acute illness, medical co-morbidities or co-occurring substance use likely to complicate their withdrawal treatment? • Age 65 or over? • Pregnant?

American Society of Addiction Medicine, 2020

Consultant recommendations

Patient has previous experience and support through episodes of alcohol withdrawal: this is helpful when assessing appropriate level of care for ambulatory AWM.

Share Alcohol Withdrawal Scale: ask patient/support person to track signs & symptoms regularly and document scores → if symptoms worsen (e.g., CIWA-Ar $\geq$ 19), go to nearest ER.

Clarify what patient is taking of recently prescribed benzodiazepines, gabapentin and naltrexone: gabapentin can be used for AWM, then tapered down (dosing protocols available).

Benzodiazepines are an option for ambulatory AWM, but caller's preference is important: if withdrawal is worsening on benzodiazepines, patient is not safe at home.

ASAM Clinical Practice Guideline on Alcohol Withdrawal Management.
J Addict Med 14(5): Sept/Oct 2020.

3. How to transition to buprenorphine from multiple full agonists (including high potency)?

47 year old man with OUD and chronic pain. PCP has been prescribing fentanyl TD and hydromorphone 16mg daily for pain. Patient also injecting heroin. Patient's goal is to be on buprenorphine; agreeable to frequent follow-up.

Specialist at MOUD/MAT program calling:

- ***What is best option for transitioning to buprenorphine: stop full agonists completely, or cross taper?***

Consultant recommendations

1) Discontinue fentanyl patch

- Continuous, prolonged use may lead to increased systemic distribution/tissue storage: might increase risk of precipitated withdrawal when buprenorphine is initiated

2) Discuss various buprenorphine initiation strategies with patient

- Buprenorphine "micro-dosing" approach [lower dose, gradual start over 1 week] might be particularly useful for this scenario
- Offer patient options and control for how to manage heroin/hydromorphone (full agonist opioids) during buprenorphine initiation: stop all at once, taper over a week, keep using same amount until on full dose of buprenorphine

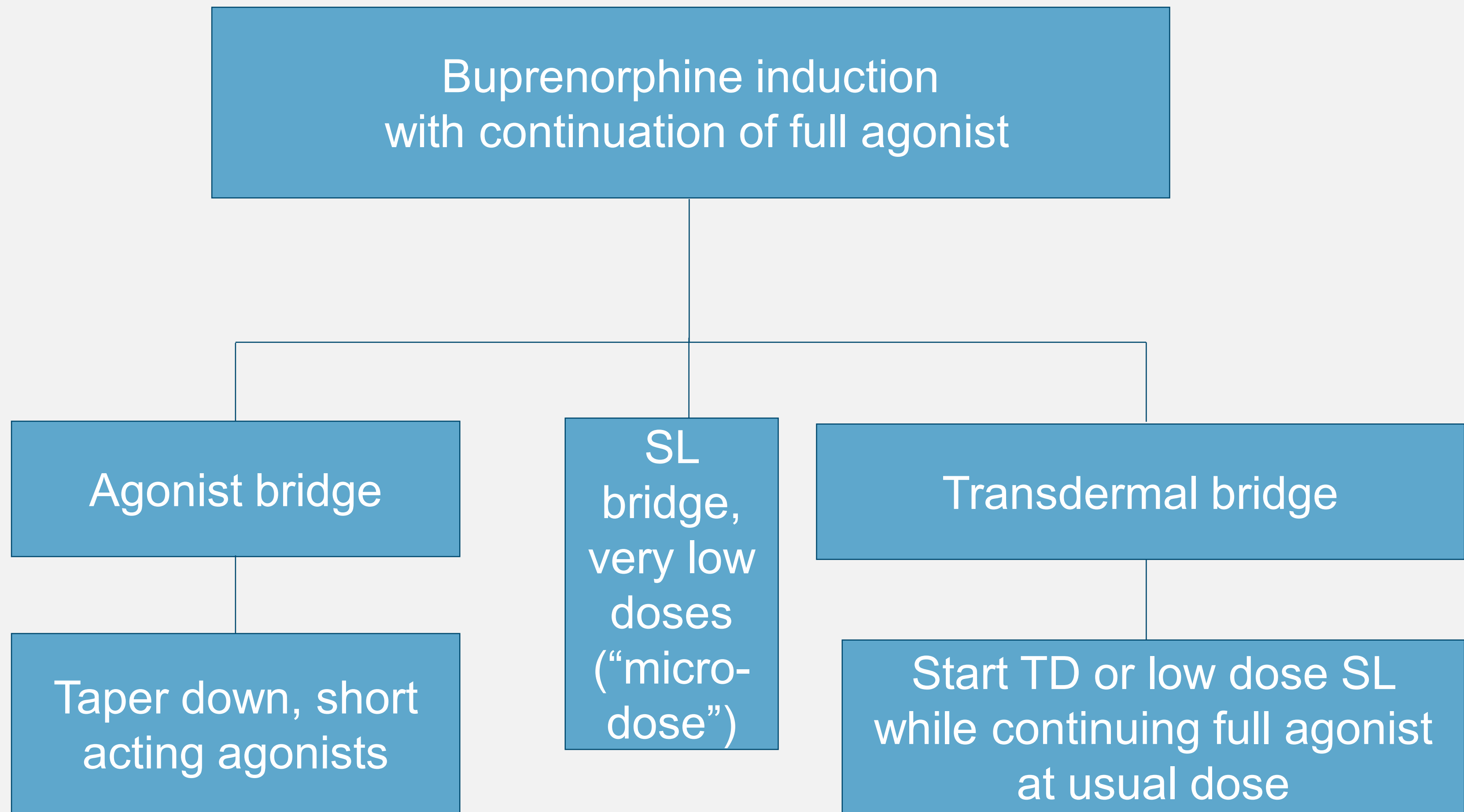
Consultant recommendations

3) Adjunct medications (e.g., clonidine, etc.) can be prescribed to address potential withdrawal symptoms.

4) Anticipate split dosing of buprenorphine once stabilized to help address chronic pain (expect total daily dose: ~16-32 mg/day given over 2-4 times per day)

5) Clear communications between specialty medication for opioid use disorder (MOUD) provider, PCP, and patient regarding buprenorphine prescribing and overall plan for pain management

Varying approaches



Ghosh SM, Klaire S, Tanguay R, et al. A review of novel methods to support the transition from methadone and other full agonist opioids to buprenorphine/naloxone sublingual in both community and acute care settings. Can J Addiction. Dec 2019.

Patient instructions for "microdosing" induction (sample)

Patient Guidelines for Buprenorphine "Micro-Dosing" Induction

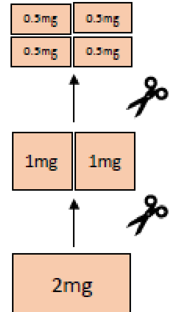
To reduce the risk of precipitated withdrawal when starting buprenorphine/naloxone, we would like you to start at very low doses and increase slowly. Please follow the schedule below and call us at ______________________ if there are any problems.

PREPARING YOUR DOSES:

On Days 1-5, we will use 2mg buprenorphine/naloxone films:

- **Days 1-2:** Cut ONE 2mg film into four equal pieces to achieve the lowest dose needed (0.5mg or 1/4th of a 2mg film).
- **Day 3:** Cut ONE 2mg film into two equal pieces to achieve the lowest dose needed (1mg or ½ of a 2mg film).
- **Days 4-5:** Use full 2mg films. You do NOT need to further prepare the films.

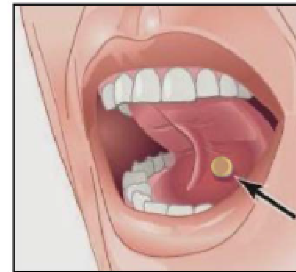
On Days 6-7, we will use 8mg buprenorphine/naloxone films. You do NOT need to cut or further prepare these films.



DAILY DOSING INSTRUCTIONS:

On each day, take your 1st dose of buprenorphine/naloxone about 10-15 minutes ***BEFORE*** using any other opioid-based substances (i.e. heroin, fentanyl, methadone, prescription pills, etc.)

Place the film ***under your tongue*** and let it melt completely.



Day	Instructions
Day 1: ______	Take ¼ of a 2mg film (0.5 mg) ONCE
Day 2: ______	Take ¼ of a 2mg film (0.5 mg) TWICE daily
Day 3: ______	Take ½ of a 2mg film (1 mg) TWICE daily
Day 4: ______	Take one full 2mg film (2mg) TWICE daily
Day 5: ______	Take two full 2mg films (4mg) TWICE daily
Day 6: ______	Take one full 8mg film (8mg) TWICE daily
Day 7: ______	STOP using any non-buprenorphine opioid-based substances. Continue taking buprenorphine/naloxone 8mg films TWICE or THREE TIMES daily (as advised by your medical provider).

PLEASE RETURN TO CLINIC ON:

____

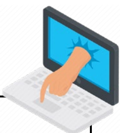
Electronic copies of this sample patient instruction sheet available from the Substance Use Warmline

Questions?

NATIONAL CLINICIAN CONSULTATION CENTER
Translating science into care

Please spread the word to your networks

Substance Use Warmline	HIV/AIDS Warmline
(855) 300-3595	(800) 933-3413
Perinatal HIV Hotline	**PrEPline**
(888) 448-8765	(855) HIV-PrEP
Hepatitis C Warmline	**PEPline**
(844) HEP-INFO	(888) 448-4911



Clinical questions can also be submitted securely: nccc.ucsf.edu

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Looking for more information, or materials to distribute to clinicians?

- Contacts
  - David.Monticalvo@ucsf.edu, Project Manager
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Thank you!

To learn more, please visit www.nccc.ucsf.edu

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