24/7 Tele-Consultation Support for Clinicians: Expanding Access to Medications for Substance Use Disorder Treatment

The California Substance Use Line: a free, 24/7 tele-consultation service

Brenda Goldhammer, MPH | Jackie Tulsky, MD | Wasfa Jahangiri, MD | October 15, 2019

California **Substance Use Line**

(844) 326-2626

Webinar Reminders

1. Everyone is muted
    - Press * 7 to unmute and *6 to re-mute yourself
2. Remember to chat in questions!
3. This webinar is being recorded and will be sent out via email
4. Please fill out our evaluation at the end!

Today's goals

(1) Presenters will describe the California Substance Use Line (CSUL) and how this new, unique partnership can help deliver point-of-care guidance to any clinician in California

(2) Participants will hear about example cases that CSUL consultants have assisted with

(3) Participants will learn how callers to the California Substance Use Line have incorporated this resource into their work

Today's speakers

Brenda Goldhammer, MPH | Program Manager

Jacqueline Peterson Tulsky, MD | Professor of Medicine, Emeritus, UCSF

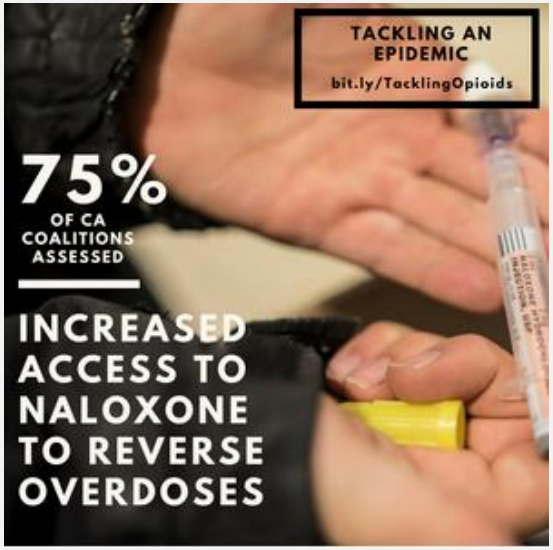
Addiction Consultant, California Substance Use Line

Wasfa Jahangiri, MD | Primary Care Provider, La Clinica De La Raza

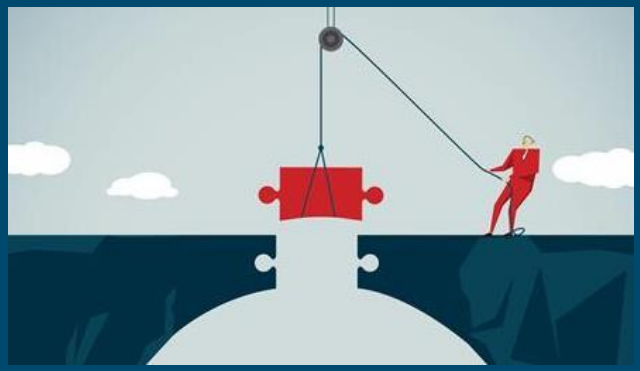
The ongoing public health crisis

California aims to continue expanding access to effective and evidence-based interventions, including medications for substance use disorder treatment.

Frontline clinicians without extensive experience providing substance use disorder treatment often benefit from guidance and support.



What if there were a resource that could help *any* clinician manage substance use disorders in *any* health care setting?



California **Substance Use Line**

(844) 326-2626

The California Substance Use Line

Free, confidential, 24/7 tele-consultation

Staffed by experienced physicians, clinical pharmacists, and nurses

Evidence-based guidance on substance use evaluation and management

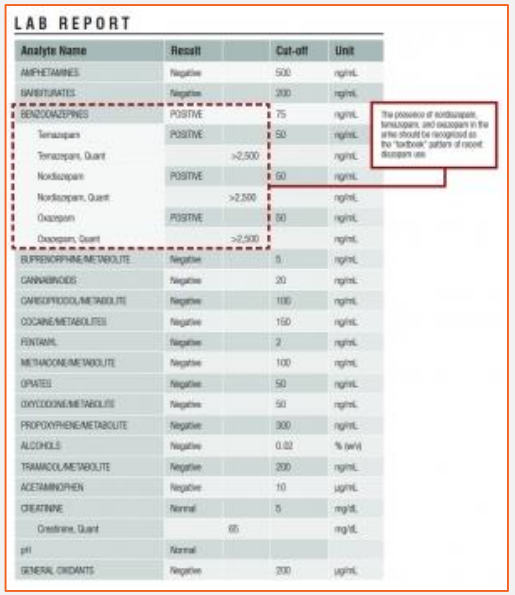
- For opioids, alcohol, sedatives, stimulants, and other substances
- Includes guidance on medications for substance use disorder treatment

Why call?

- **We offer point-of-care, free assistance** — no matter how complicated or where in the state you are practicing
- **Callers receive expert guidance** on developing a tailored treatment plan for any patient with (or at risk for) substance use disorders

Common consultation topics

- **Assessment and medical treatment** of opioid, alcohol, and other substance use disorders
- **Toxicology testing:** when to use it and what it means
- **Approaches** to adjusting opioid-based pain regimens to reduce risk of misuse and harms
- **Harm reduction** and overdose prevention strategies
- **Special populations** (pregnancy, kidney/liver disease, co-morbid opioid use disorder and pain, HIV)


LAB REPORT

Analyte Name	Result		Cut-off	Unit
AMPHETAMINES	Negative		500	ng/mL
BARBITURATES	Negative		200	ng/mL
BENZODIAZEPINES	POSITIVE		75	ng/mL
Temazepam	POSITIVE		50	ng/mL
Temazepam, Quant		>2,500		ng/mL
Nordiazepam	POSITIVE		50	ng/mL
Nordiazepam, Quant		>2,500		ng/mL
Oxazepam	POSITIVE		50	ng/mL
Oxazepam, Quant		>2,500		ng/mL
BUPRENORPHINE/METABOLITE	Negative		5	ng/mL
CANNABINOIDS	Negative		20	ng/mL
CARISOPRODOL/METABOLITE	Negative		100	ng/mL
COCAINE/METABOLITES	Negative		150	ng/mL
FENTANYL	Negative		2	ng/mL
METHADONE/METABOLITE	Negative		100	ng/mL
OPIATES	Negative		50	ng/mL
OXYCODONE/METABOLITE	Negative		50	ng/mL
PROPOXYPHENE/METABOLITE	Negative		300	ng/mL
ALCOHOLS	Negative		0.02	% (w/v)
TRAMADOL/METABOLITE	Negative		200	ng/mL
ACETAMINOPHEN	Negative		10	µg/mL
CREATININE	Normal		5	mg/dL
Creatinine, Quant		65		mg/dL
pH	Normal			
GENERAL OXIDANTS	Negative		200	µg/mL

The presence of nordiazepam, temazepam, and oxazepam in the urine should be recognized as the "textbook" pattern of recent diazepam use.

Leadership you can trust

Collaboration between California Poison Control System (CPCS) and the Clinician Consultation Center (CCC) of the University of California, San Francisco

- 25+ years helping clinicians of all experience levels provide evidence-based care

Expert clinical depth across multiple domains

- Polysubstance use
- Toxicology
- Behavioral health
- Harm reduction
- HIV
- Viral hepatitis
- Primary care

Extensive experience with opioid overdose/withdrawal management and its aftercare

California Poison Control System

UCSF-based program: Established in 1997

- 4 Divisions: San Francisco, San Diego, Sacramento, Fresno
- 24/7 hotline with expertise in managing acute poisonings and overdoses
- Supported through agreements/grants from state and federal governments
- Call volume: 250,000 cases per year

Principal Consultants

- Nurses and pharmacists with specialized training in poison information
- Board-certified medical toxicology physicians
- Health education coordinator with active community outreach program

Clinician Consultation Center

UCSF-based program: Call center at San Francisco General Hospital

- Operates National Substance Use Warmline, HIV Warmline, Hepatitis C Warmline, Perinatal HIV Hotline, PrEPline, and PEPline
- ~18,000 calls per year

Principal Consultants: Addiction Medicine-boarded physicians (IM, FM, OB), psychiatric/ substance use-boarded clinical pharmacists

Team also includes advanced practice nurses, other buprenorphine-experienced physicians

California Substance Use Line: Spring 2019 call data

1st quarter: 103 consultations
(66% calls from MD/DOs; ~12% NPs; ~9% pharmacists)

Topics Discussed	N	%
Total	**84**	**100.0%**
Prescription Opioids	59	72.0%
Nonprescription Opioids	34	41.5%
Alcohol	12	14.6%
Cocaine	4	4.9%
Amphetamine/ methamphetamine	10	12.2%
Cannabis	2	2.4%
Hallucinogen(s)	0	--
Sedatives/Hypnotics/Anxiolytics	7	8.5%
Other	4	4.9%
Unknown	1	1.2%
None Reported	2	2.4%

Topics Discussed	N	%
Total	**84**	**100.0%**
Screening and Diagnosis of SUD	16	19.3%
Medication Assisted Treatment of SUD	63	75.9%
Behavioral Interventions	7	8.4%
Clinical Complications of Substance Use	7	8.4%
Co-morbid Conditions	20	24.1%
Harm Reduction	4	4.8%
Opioid Safety and Overdose Prevention	12	14.5%
Opioid Dosing, Titration and Tapering	27	32.5%
Patient Monitoring incl. Urine Toxicology	17	20.5%
Withdrawal Management	14	16.9%
Protocol/References	6	7.2%
Referral to Treatment	1	1.2%
DATA 2000 Waiver Training	1	1.2%
Insurance Coverage/Billing	2	2.4%
Legal/regulatory	4	4.8%
Other topic(s)	5	6.0%

Case vignettes

Call 1: Methadone to buprenorphine/naloxone

Setting: Rural county, few accessible treatment resources

Caller: PCP at local FQHC

Population: Mostly heroin use

Reason for call: Last methadone induction did not go well, would like to plan for this next one

- 45 year old woman new to the area; on methadone for OUD x ~9 months
- Pt had asked OTP to initiate taper due to “intolerable side effects”; down to 45mg daily
- Left OTP 10 days ago and reports no exposure to opioids since then
- Also, history of daily EtOH in the past, but rare use over the last 9 months
- PMH includes chronic psychiatric disorder (specifics unknown to caller, but medication list includes asenapine, benztropine, and possibly an antidepressant)

Call 1: Methadone to buprenorphine/naloxone

Other information available today:

- In-office COWS = 12
- Point-of-care urine tox screen = positive for methadone and EtG
- Pharmacy down the street stocks buprenorphine
- Patient's insurance is active in county

Audience:

What considerations would you raise with this caller?

Questions/concerns discussed on the call

(1) What were the “intolerable side effects” ?

(2) Is the patient really eligible for buprenorphine/naloxone? If not, why? If yes, why?

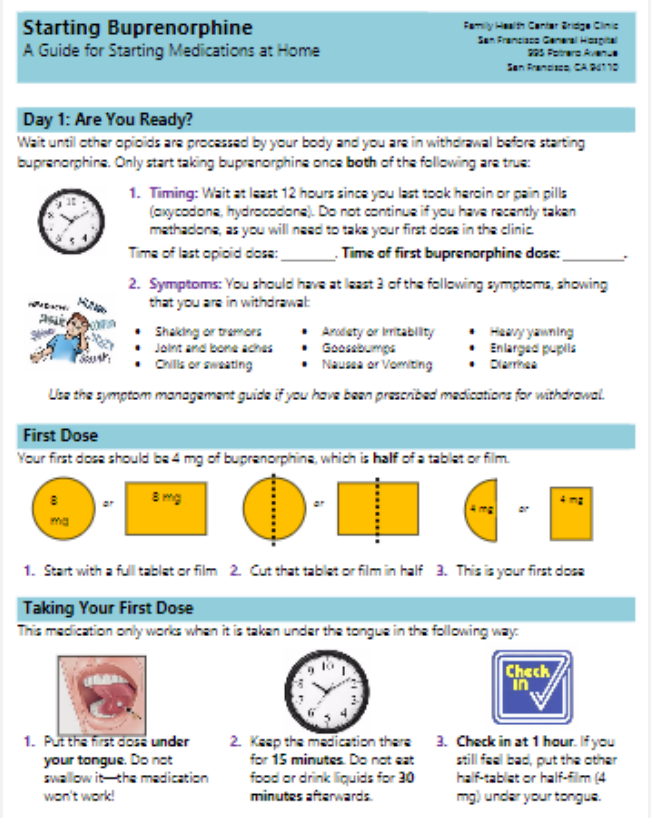
(3) Would you go ahead with an induction today?

(4) How would you approach this scenario?

(5) What other information might be useful for planning this transition?

Call 1, continued

- The caller and patient are both highly motivated to start buprenorphine today.
- Patient agrees to daily phone check-ins through the weekend; daughter lives with patient and is supportive of plan.
- Started bup/nx 2/0.5mg SL and another 2/0.5mg SL an hour later. At home that night took additional 4/1mg SL and did well with no precipitated withdrawal.
- Follow-up call: patient took 12/3.0mg SL through days 2 and 3.



Starting Buprenorphine
A Guide for Starting Medications at Home

Family Health Center Bridge Clinic
San Francisco General Hospital
995 Potrero Avenue
San Francisco, CA 94110

Day 1: Are You Ready?

Wait until other opioids are processed by your body and you are in withdrawal before starting buprenorphine. Only start taking buprenorphine once **both** of the following are true:

1. **Timing:** Wait at least 12 hours since you last took heroin or pain pills (oxycodone, hydrocodone). Do not continue if you have recently taken methadone, as you will need to take your first dose in the clinic.

Time of last opioid dose: _____. **Time of first buprenorphine dose:** _____.

2. **Symptoms:** You should have at least 3 of the following symptoms, showing that you are in withdrawal:

- Shaking or tremors
- Joint and bone aches
- Chills or sweating
- Anxiety or irritability
- Goosebumps
- Nausea or Vomiting
- Heavy yawning
- Enlarged pupils
- Diarrhea

Use the symptom management guide if you have been prescribed medications for withdrawal.

First Dose

Your first dose should be 4 mg of buprenorphine, which is **half** of a tablet or film.

8 mg or 8 mg | or | 4 mg or 4 mg

1. Start with a full tablet or film
2. Cut that tablet or film in half
3. This is your first dose

Taking Your First Dose

This medication only works when it is taken under the tongue in the following way:

1. Put the first dose **under your tongue.** Do not swallow it—the medication won't work!
2. Keep the medication there for **15 minutes.** Do not eat food or drink liquids for **30 minutes** afterwards.
3. **Check in at 1 hour.** If you still feel bad, put the other half-tablet or half-film (4 mg) under your tongue.

Call 1: CSUL role

(1) Provided collegial consult for unfamiliar/uncomfortable clinical scenario for this caller

(2) Reviewed options for the approach: absolute vs. relative contraindications

(3) Anticipatory guidance for “worst case scenario” (PW)

(4) Shared clinical tools/resources (patient home induction sheet)

(5) ”Planted seed” with suggested approaches to addressing alcohol when able to talk more

Call 2: Peri- and post-operative management and buprenorphine

Caller: Experienced provider, but first time involved in elective peri- and post-operative plan

Reason for call: Guide me through this decision-making?

1. Patient on bup/nal 12/3mg SL and doing well for 2 months; scheduled for oral surgery
2. Oral surgeon sends note to caller requesting that patient be tapered off bup/nal
3. Patient is worried, really doesn't want to stop or decrease the medication

Audience:

- **Have you had experiences like this?**
- **How would you respond to the surgeon's request?**
- **How would you manage patient's buprenorphine in the perioperative period?**

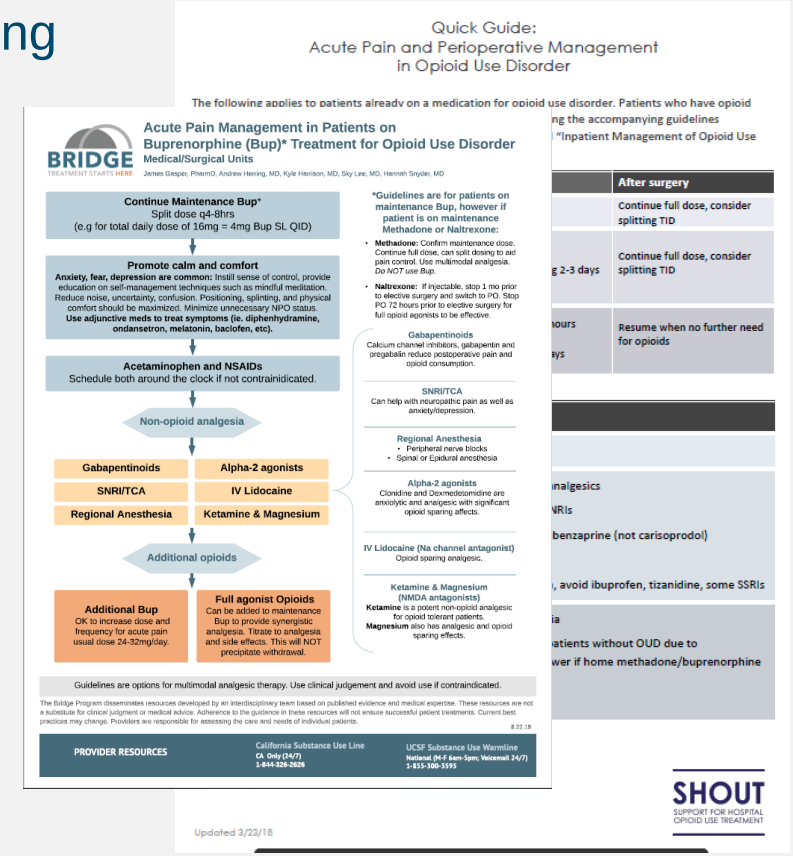
Call 2: Peri- and post-operative management and buprenorphine

We suggested resources to support continuing bup/nal throughout the operative period

- California Bridge, Project SHOUT
- Lembke A, et al. Pain Med. 2019 – *Pts Maintained on Bup for OUD Should Continue Through the Perioperative Period*

…and…

- Encouraged caller to have the Oral Surgeon and/or Anesthesia team call us with any concerns/questions



Quick Guide:
Acute Pain and Perioperative Management
in Opioid Use Disorder

The following applies to patients already on a medication for opioid use disorder. Patients who have opioid
ng the accompanying guidelines
"Inpatient Management of Opioid Use

	After surgery
	Continue full dose, consider splitting TID
g 2-3 days	Continue full dose, consider splitting TID
hours ays	Resume when no further need for opioids

nalgesics
NRIs
benzaprine (not carisoprodol)
, avoid ibuprofen, tizanidine, some SSRIs
atients without OUD due to
wer if home methadone/buprenorphine

BRIDGE
TREATMENT STARTS HERE

Acute Pain Management in Patients on Buprenorphine (Bup)* Treatment for Opioid Use Disorder
Medical/Surgical Units

James Gasper, PharmD, Andrew Herring, MD, Kyle Harrison, MD, Sky Lee, MD, Hannah Snyder, MD

Continue Maintenance Bup*
Split dose q4-8hrs
(e.g for total daily dose of 16mg = 4mg Bup SL QID)

Promote calm and comfort
Anxiety, fear, depression are common: Instill sense of control, provide education on self-management techniques such as mindful meditation. Reduce noise, uncertainty, confusion. Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status.
Use adjunctive meds to treat symptoms (ie. diphenhydramine, ondansetron, melatonin, baclofen, etc).

Acetaminophen and NSAIDs
Schedule both around the clock if not contrainidicated.

Non-opioid analgesia

Gabapentinoids	Alpha-2 agonists
SNRI/TCA	IV Lidocaine
Regional Anesthesia	Ketamine & Magnesium

Additional opioids

Additional Bup
OK to increase dose and frequency for acute pain usual dose 24-32mg/day.

Full agonist Opioids
Can be added to maintenance Bup to provide synergistic analgesia. Titrate to analgesia and side effects. This will NOT precipitate withdrawal.

*Guidelines are for patients on maintenance Bup, however if patient is on maintenance Methadone or Naltrexone:

- **Methadone:** Confirm maintenance dose. Continue full dose, can split dosing to aid pain control. Use multimodal analgesia. *Do NOT use Bup.*
- **Naltrexone:** If injectable, stop 1 mo prior to elective surgery and switch to PO. Stop PO 72 hours prior to elective surgery for full opioid agonists to be effective.

Gabapentinoids
Calcium channel inhibitors, gabapentin and pregabalin reduce postoperative pain and opioid consumption.

SNRI/TCA
Can help with neuropathic pain as well as anxiety/depression.

Regional Anesthesia
- Peripheral nerve blocks
- Spinal or Epidural anesthesia

Alpha-2 agonists
Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing affects.

IV Lidocaine (Na channel antagonist)
Opioid sparing analgesic.

Ketamine & Magnesium (NMDA antagonists)
Ketamine is a potent non-opioid analgesic for opioid tolerant patients.
Magnesium also has analgesic and opioid sparing effects.

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

The 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.

8.22.19

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

SHOUT
SUPPORT FOR HOSPITAL OPIOID USE TREATMENT

Updated 3/23/18

https://bridgetotreatment.org

Call 2: CSUL role

1. Guidance and suggestion of clinical management options

    -- For patient

    -- For surgical and anesthesia colleagues

2. Tools and references (evidence-based when available)

3. Offer to be a resource to share with other providers

Call 3: Mixed opioids, atypical induction

Caller: Experienced provider in urban area

- 55 year old male w/ OUD, injecting fentanyl for ~2 years
- Self-titrated down to 0.5 grams 2-3x/day and highly motivated for treatment
- History of “rocky” trial of self-induction onto bup/nal due to street methadone (patient was eager, but worried)
- Last fentanyl ~66 hrs ago, however COWS 2 days in a row < 8 and patient felt no withdrawal symptoms
- This morning patient called provider reporting sudden onset of withdrawal symptoms

Call 3: Mixed opioids, atypical induction

Information available today:

- COWS in office: 10-11 (mainly anxiety and restlessness, pupils midline and smallish, not sweating, yawning, runny nose)
- Results just back from send-out urine tox: Positive for fentanyl (expected), oxycodone, methadone, benzodiazepines (expected), cannabinoids
- Patient reports no methadone use and was feeling badly so caller started induction with 2/0.5mg bup/nal. After 60 min, COWS still 10+ and patient reports feeling continued withdrawal → given 4/1.0mg bup/nal
- It's 20 minutes later, patient still in office and about the same. Caller is trying to plan for the remainder of the afternoon and over the weekend.
- Detailed methadone report came back: methadone 929ng/mL and metabolite 599ng/mL

Call 3: Mixed opioid/substance induction

Questions to address:

- Why is patient *feeling* worse than he *looks* after 6/1.5mg bup/nal?
- What does the urine drug test tell us, and how do we use the information?
- Caller really asking if the patient is in precipitated withdrawal. **What do you think?**
- It's about 1pm on a Friday, what about the rest of the afternoon/day plan?

Follow-up: about an hour after the last check-in with consultant, COWS now 12, with diaphoresis, yawning, BP up, coherent and got additional 6/1.5mg for total of 12/3mg. Fell asleep in clinic after a total of 16/2mg.

- What is the weekend plan now? Would you go over 16/4mg bup/nal in 24 hours?

Call 3: CSUL discussion and role

CSUL Toxicology specialist: *"Some experienced ERs are moving towards 8 + 8mg dosing strategy, with doses administered within an hour. So far, have been finding that some patients need 16mg+ on day 1 (some as high as 24, 32mg)…*

…In terms of determining what total 1st day dose should look like, some ERs stop once COWS < 8. Possible benefit of going above 16mg is being able to extend duration of coverage re: withdrawal symptoms. This could potentially help space out the time to next follow-up visit, which may be desirable for settings with limited outpatient follow-up resources. Each 8mg/day roughly correlates to an extra day out."

- CSUL team was able to partner w/ caller for ongoing assessments in real-time during in office induction that had unanticipated challenges
- Offered options from clinical experience of multi-disciplinary consultant team for current and next steps
- Assisted with literature search for atypical inductions with fentanyl (few case reports)

Caller experience and testimony

Q & A

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We are ready to support you and your patients.

For more information: Call **(844) 326-2626** and **press 3,** or visit http://nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line/

The California Substance Use Line is generously funded by the California Department of Health Care Services.

Upcoming ATSH Webinars

November 21: (12 – 1PM) *How Peer Recovery Can Improve MAT for Your Patients.* Cherokee Health Systems in Tennessee will lead a webinar on how to use peer recovery support specialists on your MAT core team. They'll share their job descriptions, a training guide, and policies and procedures to operationalize this role. Register here: https://zoom.us/meeting/register/e546925447772102d746f627e8486654

December 11: (12 – 1PM) MAT Training for Your Staff: Katie Bell, SUD Nurse Case Manager at Chapa De Indian Health Program, will lead the webinar. The training is geared to provide the basics of MAT for those who want to learn more about opioid use disorder, medications, etc. Note: Any staff member from your clinic can register, they do not need to be part of your MAT core team. Registration information coming soon!

Thank you!

For program/administrative questions about the California Substance Use Line, please email Brenda.Goldhammer@ucsf.edu (Program Manager, CCC)

If you'd like us to send you hard copies of outreach materials (tri-fold brochures, small palm cards, flyers), please email Zebulin.Kessler@ucsf.edu (Project Coordinator).

If you are a local expert and frequent presenter, please feel free to reach out for slides/materials highlighting the California Substance Use Line that may be included in your trainings.