El Dorado – Q&A Document

El Dorado Community Health Centers Site Visit	
Question	Answer
Can you address the really challenging/complex patients you sometimes see? How do you address those who continually cross boundaries?	Dr. Reina: We have our QIRC Interdisciplinary committee which is helpful for the entire team to be on the same page. Boundary setting is a challenge for patients who try to split staff (front office vs MA vs providers vs RN Case managers vs BH vs psychiatry)...For some patients if it's a question of safety or there is concern for diversion, we offer the choice of weekly in office visits with 1 week of medication or sublocade or referral to methadone clinic. Consistency and communication are key. • Our front office staff, MAs, all need to feel confident that they won't be undermined by providers as this helps the entire treatment team maintain boundaries. • This may ultimately get to the issue of a personality disorder (narcissistic vs borderline) vs patient truly needing a higher level of care/more intensive care. • All patients have a standard treatment agreement, though. When patients continually cross boundaries, we update the treatment agreement with clear patient/provider expectations, ie your treatment team has decided your treatment options for MAT at our clinic are weekly visits, sublocade or we can arrange referral to methadone program. Johannah Maggetti, RN: We discuss challenging patients during our daily huddle before we see patients
How do you manage patients with SUD: Such as meth or alcohol with patients who need opioids for chronic pain?	Dr. Reina: If OUD treat out with SL bup/sublocade. We are seeing high rate of patients who use meth and are unknowingly using fentanyl, this presents an elevated risk for development of OUD and or higher risk of death/overdose. • For chronic pain and opioid dependence, we feel that suboxone/butrans is safer alternative than full agonist opioids. So we can use a partial agonist as we try to work on the other underlying issues with AUD our SUD (meth). We try to treat the underlying anxiety/depression/mood/bipolar issue as well. • For AUD: If on suboxone would recommend acamprosate or gabapentin for alcohol cravings or antabuse as deterrent. Shorter duration refills (weekly or every 2 weeks) is another option we employ. Some patients will never progress beyond 1 week refills if they present ongoing elevated risks. For patients who have chronic pain (not OUD) we do have honest conversation about need to switch gears by tapering off opioids/bup and or consider transition to vivitrol if indicated. ○ All these patients are getting fentanyl test kits and narcan. • For SUD: We use our contingency management group, wellbutrin and mirtazepine to decrease cravings for stimulants. ○ All these patients are getting fentanyl test kits and narcan. Susan Scott, MS, LAADC: For chronic pain, as a counselor, I try and determine if they have any use disorder or just chronic pain. Most patients sent to our clinic with chronic pain have some behaviors of OUD but may not see themselves this way. I usually explain the difference between OUD and Opioid dependence, and what addiction behaviors look like. If the patient discloses OUD behaviors, I explain why

	treating them with this in mind is better, than just treating pain and letting them deal with the recovery process on their own. It is up to the patient if they are interested in any support programs. For AUD: We generally focus on OUD and getting patient on Buprenorphine to decrease risk of overdose and then focus on the AUD. We work hard to keep patients involved when they are on Bup and drinking alcohol with weekly refills, Utox, and counseling. We also educate on the risks of this behavior. We work on patients willingness to quit the AUD in hopes that they will see that this is increasing their danger. Offer services like group, individual counseling, and therapy as needed. For SUD: We focus on the OUD and getting patients on Buprenorphine to decrease risk of overdose and then focus on the SUD. We are currently running a Contingency Management Program to support these patients if they are ready to work on this issue.
How often are you drug testing people? What test are you using? Point of Care, Breathalyzer, Send outs? Are you testing for Fentanyl?	Dr. Reina: We are seeing a high number of methamphetamines being cut with fentanyl the same with illicit opioids (oxycodone, M30s) and benzodiazepines. We do POCT testing that checks for Amphetamines, Barbituates, Benzos (not clonazepam), Buprenorphine, Cocaine, Methamphetamines, Methadone, Opioids (not fentanyl), PCP, oxycodone, and PCP. • Fentanyl is a sent out to Quest (return time is 1-3 days). Some people will report a different "high" on methamphetamines that are cut with fentanyl. So going by history provides some insight. • We use a breathalyzer for our alcohol withdrawal patients. • For all new patients we do send out confirmatory tests including fentanyl. • For stable patients we tend to do UDS. • We hand out fentanyl testing kits and ask patients to test their supply to help us determine if they are unknowingly using fentanyl. Johannah Maggetti, RN: We try to drug test each time patient has an appointment with a MAT provider.
Do you know if your clinics fall under 42CFR since your provider is only a MAT provider?	Our clinics do fall under 42 CFR Part 2 because we provide Substance Use Treatment. This means that we have special provisions in our EMR system that does not allow other clinic employees to see our notes on patients who are under the STEPS Program. We do communicate with other staff, such as primary care physicians, psychiatry, and behavioral health therapists when we have a difficult patient to ensure appropriate coordinated care throughout our clinics.
What labs do you use for UDS?	Quest - PCOT UDS Clia Waved Instant Drug Test Cup II - Oral Swab: ORal-Eze, send out to Quest.... Has long turn around time, 5-10 business days.

What EMR do you use?	Dr. Reina: ECW (Eclinical Works), its... less than ideal.
What determines the prescribing QD buprenorphine or divided dose? Is there a benefit for QD dose? Benefit for divided dose?	Dr. Reina: I think daily dosing is sufficient if a patient's cravings/urges have abated in afternoon/evening. If patients have persistent craving despite daily dosing, then I would consider moving to BID (twice daily dosing). If they have persistent cravings, then would move to TID (three times daily) and/or QID (four times daily). There is a group of people that do better with larger am dose (12-16mg) and often that dose is sufficient for 24-hour coverage.
Can you share a program brochure and if you guys have steps or tiers that patients progress through?	Johannah Maggetti, RN: We have a brochure we give to patients; it talks about our outpatient program. There are 3 phases, Phase 1, 2, and 3. Phase 1 we see patient on a weekly basis, phase 2 and 3 will depend on how patient is doing, but we closely monitor patients the first 4-6 weeks. Dr. Reina: We use the ASAM Assessment to "get the lay of the land" figure out all use disorders and see if they would need/benefit from a higher level of care. But in terms of practical day to day management, we follow above.