Best Practices for EMR Configuration: Meeting New Quality Requirements

2020 Edition

Introduction

In 2019, the California Department of Healthcare Services (DHCS) initiated many changes to its quality measurement and quality oversight processes for MediCal Managed Care Plans. Many of these changes require changes in the way information is captured, processed and reported by our primary care provider network.

While many details of these new measures may be found in the Primary Care Provider Quality Incentive Program (PCP QIP) specifications, and in various state documents, they are not brought together in a way that targets those who configure PCP electronic health systems. This document is targeted to the needs of this group.

This document was created with input and advice from an advisory group with experience in using the three electronic health record systems with the greatest footprint in the Partnership HealthPlan of California (PHC) service area: eClinicalWorks, NextGen, and Epic. PHC thanks Dr. Danielle Oryn, Charles Kitzman, Linda D'Agati, and Susan Labbe for their contributions.

The document was updated in July 2020 to reflect changes due to COVID-19 and changes in HEDIS for 2020.

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Organization of Recommendations

The 36 individual recommendations are divided up as follows:

1. Top Ten Configuration Recommendations for All PCPs. These are either part of the PCP QIP or have other financial implications for the PCP.
2. Additional Recommended Configuration Recommendation for Non-PPS Providers. These are taking from the Proposition 56 Value Based Purchasing Program (VBPP).
3. Recommended Alerts and Workflows. These are more general recommended best practices for improving quality of care. The target interventions each can potentially improve one or more quality measures which have financial implications.
4. Recommended Templates and Order Sets: The first four relate to measures which have financial implications. The last two are best practices related to supporting patients with substance use disorder
5. Miscellaneous EMR and Billing Configuration Recommendations: Additional recommendations not covered above.
6. Appendix A: Template for screening for medical clearance for admission to Alcohol Use Disorder Detox or Treatment program.

The following color coded key is used to direct attention to additional categorizations of recommendations.

Key:

Type of Provider: L-large providers; P-PPS providers; All-All providers; NP-Non-pps providers

Type of Best Practice: T- Template, B- Billing, Ph- Pharmacy, A- Alert, R- Reporting, E- Education of providers, H- HIE, O- Other

Top Ten Configuration Recommendations for All PCPs

1. TELEPHONE AND VIDEO VISITS
    a. All, B: Set up codes for billable telephone and video visits, which will count as visits for 2020 in the PCP QIP. These visits are between patients out of the office and clinicians typically in the office, and would be documented in your EMR.
    b. Virtual visits: Since April 2020, through end of state of emergency, applies to phone and video visits, documented as progress notes.
        i. Usual visit CPT codes used, with a .95 modifier to indicate that the visit was done virtually.
    c. Minimal phone visits, not meeting standard for virtual visits: The codes depend on the provider type:
        i. For FQHCs and Rural Health Centers: G0071
        ii. For all other providers: G2012
2. WELL CHILD TEMPLATES: NOTE ELEMENTS
    a. All, T: Ensure all well-child templates follow the American Academy of Pediatrics standards as documented in the Bright Futures website. Specific elements of the DHCS Medical Record Review that are commonly missing are listed below. Templates should be double checked on these factors.
        i. All ages: Documentation of education on physical activity and healthy diet. This should be customized to be age appropriate for each template.
        ii. Newborns: documentation of review of newborn screening results
        iii. Two Blood lead test results between ages 1 and 3. Larger health centers may consider obtaining lead tests at the point of care to increase screening rates.
        iv. Lipid screening (at least once after age 8)
        v. Screening questions for risk of TB (all ages)
        vi. Skin cancer behavioral counselling starting at age 6 months.
        vii. Blood pressure screening starting at age 3.
        viii. Fluoride varnish application to teeth at the time of the well child visit (age 1 to 5)

ix. Prescription of Fluoride vitamin supplement (if living in location with non-fluoridated water).
x. Documented referral or recommendation for routine dental hygiene care (every visit, starting at age 6 months).

3. ACUTE VISIT TO WELL VISIT CONVERSION TEMPLATE
    a. All, T: Template for converting office visit to health maintenance visit. Epic: option 1: change visit type (front office), option 2: "dot phrase" or merge template which brings in entire well child template. Option 3: "dot phrase" or merge template which brings in an abbreviated template of factors that are part of a well-child template, but typically missing in an acute visit template:
        i. Age appropriate Physical developmental history
        ii. Age appropriate Mental developmental history
        iii. Age appropriate Anticipatory Guidance; common options for routine anticipatory guidance to add:
            1. Most ideal: Conducting the age appropriate Staying Healthy Assessment and counseling on findings (and documenting in chart)
            2. Documenting assessment of diet, weight and physical activity and counselling about physical activity and diet at every visit.
            3. Conducting other screening such as PRAPARE or PEARLS, again with actions taken depending on finding.
        iv. Review of vaccination status with ordering of age appropriate immunizations
        v. Add **ICD10 code** for well child visit: **Z00.121** for children over 28 days old. (Since child is coming in with other problem, Z00.122 would not be appropriate for an add-on code to an acute visit. Children with acute problems in first 28 days of life should have the visit completely converted to a well-child visit, which uses different codes.)
        vi. Use CPT code for well child templates for this converted visit. (see next item)
4. WELL CHILD TEMPLATES: BILLING CODES
    a. All, T: Ensure that all well child templates are linked to the age appropriate CPT code for preventive child visits (99381-99385 and 99391-99395).
    b. If these visits are conducted virtually, the .95 modifier must be added to the CPT code.
5. VACCINATION REGISTRY
    a. All, H: Build a two way interface between the EMR and CAIR.
6. HYSTERECTOMY DOCUMENTATION
    a. All, O: Change default choices for documenting a surgical history of hysterectomy to include the specific options needed to satisfy HEDIS denominator exclusion.
        i. Not acceptable: "Hysterectomy"
        ii. Acceptable: Total hysterectomy, Total Abdominal Hysterectomy (TAH), Total Vaginal Hysterectomy (TVH), Total Abdominal Hysterectomy with salpingo-oophorectomy (TAH-BSO), Radical Hysterectomy
        iii. Acceptable for medical record documentation, but will not allow patient to be excluded from cervical cancer screening denominator: Supracervical

(sometimes called “sub-total”) Hysterectomy, Supracervical Abdominal Hysterectomy (SAH)

7. GC/CHLAMYDIA SCREENING
    a. All, T: all women up to age 24 receiving cervical cancer screening or birth control should be tested annually for Chlamydia and Gonorrhea (GC). (Although only Chlamydia is in the HEDIS measure, USPSTF and the CDC recommend concurrent testing for GC, as the incidence is increasing). This can be done at the same time as cervical cancer screening, or can be done via a urine DNA amplification test if a cervical exam is not indicated. Family planning templates and well women templates should include these tests as defaults (under age 25) or as options (age 25 and older).
8. ASTHMA MEDICATIONS
    a. All, Ph: EMR medication defaults for AMR measure: controllers 3 months at a time with 3 refills; rescue one RX with one refill. Here is a current list of controller and rescue inhalers:
        i. **Inhaled Rescue Medications (Default in system: one device with one refill)**
            1. Albuterol
            2. Ventolin HF ProAir RespiClik
        ii. **Controller medications: (Default in system: 3 month supply with 3 refills)**
            1. **Oral Controllers**
                a. Montelukast (Singulair)
                b. Zafirlukast (Accolate)*
                c. Aminophylline
                d. Theophylline
            2. **Other Inhaled Controller Medications**
                a. Cromolyn Nebulized Solution
                b. Budesonide Nebulizer
            3. **Corticosteroid Controller Medications**
                a. Fluticasone Diskus and HFA (Flovent) or inhalation powder (Arnuity, ArmonAir Respi-click)
                b. Beclomethasone Dipropionate (Qvar)
                c. Flunisolide (Aerospan HFA)
                d. Ciclisone (Alvesco Inhalation Aerosole)
                e. Mometonsone Furoate (Asmanex HFA and Twisthaler)
            4. **Combination Medications (counts as controller)**
                a. Fluticasone & Salmeterol (AirDuo)
                b. Mometsosone Furoate & Formoterol Fumarate Dihydrate (Dulera)*
                c. Budesonide & Fomoterol Fumarate dehydrate (Symbicort)*
9. DEVELOPMENTAL SCREENING

a. All, T: Developmental screening (by January 1, 2020): Add developmental screening (CPT code 96110) billing to templates for 9 month, 18 month, 2 year old well child visits. Several screening acceptable:
    i. Ages and Stages Questionnaire (ASQ or ASQ-3) is most widely used
    ii. Other options can be found in the CMS specifications for this measure. Effective January 1, 2020, CPT code 96110 may only be used to bill one of the nine measures in these specifications, for children under age 3.
    iii. The M-CHAT (which only screens for autism) and the ASQ-SE (socio-emotional) are NOT acceptable for the incentive payment. If your clinical team decides to continue to use the MCHAT for screening for autism, it may be billed as 96110.KX, which will be paid as a fee for service, but not be eligible for the incentive payment. If your EMR templates use either of these measures, we recommend adding, the ASQ or ASQ-3.
    iv. Rate: $59.50 allowed; paid via claim (may consider setting rate 20% higher so don't have to change with Medi-Cal rate changes)

10. ALCOHOL SCREENING
    a. All, B: The following codes should be used to document screening for alcohol misuse and follow up counselling, for purposes of Value-Based Payment as well as the PCP QIP
        i. G0442 – Screening for Alcohol and or Drug Abuse,
        ii. G0443 – Brief intervention for individual who screens positive for alcohol misuse, with at least 15 minutes brief intervention

    Note that other codes for screening and brief intervention may be used by MediCare (G0396 and G0397) and Commercial insurers (99408 and 99409) but these are NOT covered by PHC or Medi-Cal, so your site will need to have insurance-specific templates set up.

Additional Recommended Configuration Recommendations for Non-PPS[1] Providers

I. CO-DOCUMENTATION OF SOCIAL RISK FACTORS
    a. NP, B &E: Documentation of Housing status. All VBP measures are eligible for enhanced payment for patients that have any one of the following: Homelessness/unstable housing, substance use disorder, and serious mental illness. While the final specifications are not yet available, it seems likely that these diagnoses will need to be on the same claim as the VBP service that is being provided.
        i. Since there are so many different VBP services potentially available, it would seem prudent to list these risk factors (when present) on every claim for

[1] PPS providers include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Tribal Health Centers (IHC). Non-PPS providers are all other provider types.

every visit. If this can be configured into the EMR, it would save the clinician or other staff member from remembering to add these codes, when present. See the last page of the VBP specifications for details of which codes apply.

ii. For documenting homelessness or unstable housing, the following ICD10 codes were selected:
    1. Z59.0 – Homeless
    2. Z59.1 – Inadequate Housing

II. BLOOD PRESSURE CONTROL
- a. NP, B&E: Prop 56 VBP for blood pressure control requires documentation of control using CPT-2 codes (also require for MediCare supplemental payments).
    i. Controlled Systolic:
        – CPT 3074F (systolic blood pressure less than 130)
        – CPT 3075F (systolic blood pressure less than 130-39)
    ii. Controlled Diastolic:
        – CPT 3078F (diastolic blood pressure less than 80)
        – CPT 3079F (diastolic blood pressure less than 80-89)

    Hypertension must be documented using the ICD-10 code: I10 (essential hypertension) to count

III. DIABETES CONTROL:
- a. NP, B&E: For the Prop 56 Value Based Payment measure for diabetes control, the results of the most recent Glycohemoglobin (HBA1c) must be documented in the claim using the following CPT-2 codes:
    i. CPT 3044F most recent HbA1c < 7.0%
    ii. CPT 3045F most recent HbA1c 7.0-9.0%
    iii. CPT 3046F most recent HbA1c > 9.0%

IV. TOBACCO USE SCREENING
- a. NP, T: For Prop 56 VBP, one of the following CPT codes should be associated with tobacco use/nicotine use screening templates: 99406, 99407, G0436, G0437, 4004F, or 1036F

V. DEPRESSION SCREENING
- a. NP, T &E: For Prop 56 VBP, one of the following codes should be submitted in a claim to document screening:
    i. G8431 – Positive screen with plan
    ii. G8510 – Negative screen

Recommended Alerts and Workflows

I. PREVENTIVE REMINDERS
- a. All, A: Develop system to push out preventive gaps whenever a chart is opened. As an example, this is called the Care Gap list in OCHIN EPIC.

II. BLOOD PRESSURE CONTROL
- a. All, A: Elevated Blood pressures documented at visits by medical assistants are commonly ignored by the clinician: they are not repeated and not addressed in the

assessment or plan. Consider if any configuration or audit mechanism is available for one or more of the following:

i. Alerting the provider and MA at the time of the visit (highlighting the abnormal blood pressure)
ii. Forcing selection of a diagnosis when the measure is elevated, either bringing over HTN from the problem list or selecting "elevated blood pressure" as an ICD10 diagnosis, requiring explanation.
iii. Generating a weekly report of elevated blood pressures for staff to follow up on, with a nurse or pharmacy-only visit, for example.
iv. Quality measure of repeat blood pressure done when initial BP out of range.

III. WELL CHILD VISITS

a. All, A: Alert systems for well child visits starting at age 2 or 3, for annual well child visits, starting alerts about 9 months after the last visit. Note that here is no minimum interval for well child visits from a billing or HEDIS perspective for PHC Members; State MediCal (which may still require the old PM160 form) still follows the old minimal intervals established by CHDP. Thus the time to the next visit may vary, depending if the child has PHC or state Medi-Cal; education of providers may be needed.

IV. CHILD IMMUNIZATION

a. All, E: Ensure a robust system for having vaccines for adults and children given outside the clinic setting are entered into the patient record as structured data (not merely scanned) and that they are also entered into CAIR.

V. ADULT IMMUNIZATION

a. All, A: Since children older than age 6 months and adults require annual flu vaccination, set up an alert system to remind all staff (front office, medical assistants and providers that a patient has not yet had an annual flu vaccination, starting when influenza vaccines arrive in mid-September, through the end of March.

VI. CERVICAL CANCER SCREENING

a. All, A: Set up reminders for front office staff, medical assistants and clinicians if cervical cancer screening is due, to offer patients option to do the screening while they are there (separate from a well woman exam), instead of risking a no show for a well woman exam in the future.

Additional Recommended Templates and Order Sets

I. SCREENING FOR PSYCHOLOGICAL TRAUMA

a. All, T: Template for PEARLS and ACES. (by January 1, 2020)
i. Two codes: Probably need to conduct screening before visit an select a template based on the results (a bit like PHQ2 screening).
1. G9919 for positive screen and provision of recommendations (score 4 or greater)
2. G9920 for screening performed and results negative (score 0-3)
3. Set rate for these at least at $29 as this may turn out to be paid via claims, but this is not certain. It may be prudent to build in a rate about 20% higher to lessen changes of changes to Medi-Cal rates.

4. Adults age 18 to 65: Build questionnaire with scoring capability into EMR. Use original ACEs tool: frequency of screening once in a lifetime with any given provider (configure alerts/reminders similar to other once in a lifetime tests: (Hep C, HIV)
5. Children: Build questionnaire with scoring capability within EMR. Frequency rules: screen up to once every year with PEARLS tool, which includes a few questions on social determinants of health, so overlaps a little with the Staying Healthy Assessment and PRAPARE. We recommend it be added to the templates for well child visits for age 12 month, 24 months, and each annual visit from age 3-19.

II. POST-PARTUM VISITS
   a. All, T: Post-partum visits: Now that ACOG, DHCS and PHC recommend two post-partum visits (one before 21 days and one 21 days to 84 days after delivery). Consider having two slightly different post-partum templates (one early and one late). Both should use the ICD10 code for a post-partum visit: (Z39.2).
      i. We recommend review of the HEDIS specifications for what must be included in a post-partum visit for it to count; note that NCQA/HEDIS only require one post-partum visit, so the minimum specification for this visit must be in both post-partum template.
      ii. In particular, HEDIS requires reference to abdominal exam, which is not required by ACOG. One minimum option for documenting abdominal exam: three choices: normal /abnormal/ not clinically indicated.
      iii. All post partum notes should address family planning, lactation status, and include depression screening.
      iv. If the post-partum visit is conducted virtually, the .95 modifier should be used.

III. WELL CHILD VISIT (ASTHMA)
   a. All, T: Since visits for asthma alone are infrequent, ask at every well child visit if the child has asthma. If the answer is yes, merge an asthma template with the well child visit.

IV. ASTHMA ORDER SET
   a. All, T: Adapt Asthma Order Set to align with Asthma Medication Ratio best practices. Set up alerts for patients with asthma. Embed provider best practice summary into chart (best practice alert), triggered by medication or diagnosis.

V. MEDICATION ASSISTED THERAPY
   a. All, T & B: Create a template for a clinician Medication Assisted Therapy visit attached to the Dx Code: F11.2x, which allows the visit to be paid fee for service, even if the patient is not assigned as a primary care patient. If a similar arrangement is in place for conducting physical exams for clearance for alcohol detox or initiation of home detox, a template with the code F10.2x would be used to pay fee for service even if the patient is not assigned as a primary care patient.

VI. ELEMENTS OF TEMPLATE FOR CLEARANCE FOR ALCOHOL WITHDRAWAL MANAGEMENT
   a. All, T &E: See Appendix A for example.

Miscellaneous EMR and Billing Configuration Recommendations

I. L, O: Those who customize EHR for HEDIS: Buy the NCQA Specifications and Value Set. Note that if you are part of a health center consortium, they may have a mechanism for sharing these with their members. We recommend checking with them before independently purchasing the specifications.

II. All, O: Ensure all electronic signatures give the title of the person, for example: MD, RN, DO, DC, RN, MA, MFT, LCSW, PsychD etc. One method of doing this for some EMRs is to include the title as part of the last name, for example: Last name: "Smith RN"

III. All, B: Change modifiers for other telemedicine visits: all telemedicine visits require use of 95 modifier to the CPT code, except for Transmission Cost Codes.

IV. REFERRAL TRACKING

a. All, O: Set up referral tracking in the EMR to include the following:

i. Referral status (for each referral)

1. Specialty of specialist ordered by clinician
2. Referral ordered by clinician (include date)
3. Referral processed (information sent to specialists; on-line RAF completed if needed)-- Include date
4. Appointment made (include date)
5. Appointment confirmed to be completed (include date), no records received.
6. Appointment confirmed to be completed, records received from specialist (date of receipt of records/letter
7. Appointment canceled by patient, date and reason; list of reasons below
    a. Problem resolved
    b. Appointment rescheduled
    c. Loss of insurance coverage
    d. Lack of transportation
    e. Specialist canceled
8. Unable to schedule referral; date; list of reasons below:
    a. No specialist available
    b. Specialist refused referral

ii. EMR can generate summary report which consolidates the above information by insurance type of the patient.

V. L, E: Special issue of elevated BP measured at a dental visit. HEDIS rules currently require the blood pressures measured in a dental office that shares an EMR with a medical practice be counted as a potential BP for purposes of control. In other words, blood pressures measured by a dental office are not excluded if they are integrated within an overall medical record shared with medical care. Since such patients are commonly anxious, the blood pressures may be higher than general for the patient. As this is discriminatory against integrated medical-dental practices, PHC is petitioning NCQA to change this. In the meantime, if you have an integrated medical and dental record, consider an alternative way of documenting BP, that will not integrate it with the blood pressures of the medical record.

VI. All, O: Documenting BMI percentile in children: ensure your EMR documents the BMI percentile as a number, not just allowing access to a graph generated by the computer. Note: documenting a numerical value for BMI is a meaningful use measure.

VII. All, O: Ensure a system for capturing prior cervical cancer results allows capture of type of study done (with or without HPV), the month it was done and a summary of results. Results reported by patient and signed off on by a clinician are sufficient for HEDIS, although not for HRSA/UDS, which requires a copy of the actual report. Be sure your system can differentiate measurement for these two standards, or (as a best practice) set up the system to adhere to the more stringent specifications, to ensure both standards are met.

VIII. All, E: Adjust refill protocol used by nurse/pharmacist, with no auto refills of rescue inhalers; additional action required.

IX. All, O: Add to prescription module: equipment that can be filled at a pharmacy: Glucometers, BP cuffs, humidifier, vaporizer, nebulizer. After January 1, 2021, this system will be changing due to the impending carve out of the pharmacy benefit by the state. More information coming.

Appendix A: Screening for medical clearance for admission to an alcohol use disorder detox or treatment program

Patient Name:_____ DOB:_____
MR#_____

Treatment program being considered

Facility Name: _____ASAM level: _____

KEY to ASAM Levels

1: Outpatient

2: Intensive outpatient

3: Residential

3.1 or 3.2: Residential with clinical supervision

3.7 or 4.0: Inpatient, medically supervised

History:

Alcohol/Drug/Psycho-active substance use in past week:

Drug name	Specific Name/Form	Recent use/day	Last Used
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Benzodiazepine(s)	_____	_____	_____
Marijuana	_____	_____	_____
Opioids	_____	_____	_____

Methamphetamine _____ _____ _____

Cocaine _____ _____ _____

Other _____ _____ _____

Medical Risk factors that would affect the management of the withdrawal:

___pregnancy

___Chronic kidney failure

___Cirrhosis/liver insufficiency

___Angina requiring nitrates

___Class III or IV CHF

___Severe HTN (chronic, poorly controlled at baseline)

___Acute medical condition requiring inpatient treatment (e.g. sepsis, surgical problem)

Current Medications:

Medication Allergies:_____

Psychiatric History:

____Schizophrenia: Psychosis present?_____

____Bipolar disorder: Psychosis present?_____

Prior SUD treatment History:

History of _____ alcohol withdrawal delirium (give details)

History of _____ alcohol withdrawal seizure (give details)

Treatment Dates Drug Treatment Modality

_____ _____ _____

Social History:

____Unstable Housing status

Physical exam,

Vital signs: Weight, Height, Pulse, Respiration, Blood Pressure, O2 Saturation

Mental status exam: (See attachment)

Neuro exam:

____Gait

____Coordination

____Focal findings: _____

Depression screen: PHQ9 score: ____ Suicidal? _____

Examination directed on history:

Lab work:

CBC with differential,

CMP

Magnesium, Phosphorus

Blood alcohol level

Screen for other drugs in system

Qualitative HCG (urine or serum pregnancy test) if woman of reproductive age

If liver disease: PT/INR, Lipid profile or Cholesterol

If residential program: Quantiferon TB test or other TB screening test.

If not recorded previously, screening for HIV and Hep C is indicated for all adults

Imaging:

If cough: CXR to R/O TB/pneumonia: _____

If suspected head trauma or unexplained altered LOC: Head CT: _____

Modified CIWA scale[2] score _____

[2] While the CIWA scale is intended for inpatient use, this is the tool specified by DHCS for assessing for potential hospitalization and for justification of inpatient hospitalization. Other options intended for outpatient screening are the Brief Alcohol Withdrawal Scale (BAWS), the Newcastle Alcohol Withdrawal Scale (AWS) and the Short Alcohol Withdrawal Scale (SAWS).

Assessment:

_____Acute Alcohol Intoxication

_____Chronic Alcohol use (Blood alcohol level: _____)

_____Alcohol Use Disorder

_____Other substance use: _____

_____ Alcohol Withdrawal: Low Risk (CIWA score less than 8)

_____ Alcohol Withdrawal: Medium Risk (CIWA-Ar score of 8 or lower, with the co-morbidities noted below, or a CIWA-Ar score of 9-15 without co-morbidities.)

_____ Alcohol Withdrawal: High Risk

Co-morbidities:

_____

Plan:

_____Observe in Emergency Department

_____Admit to hospital

_____Medically stable for outpatient sobering (non-medically supervised)

_____Medically stable for medically supervised sobering

_____Medically stable for outpatient withdrawal management

Medication Regimens Options:

Moderate withdrawal symptoms and risk for serious withdrawal symptoms (C1WA score between 10 and 18). Maximum prescribed medication: sufficient for 4 days according to one of the following regimens; may direct to use extra doses earlier for severe symptoms, but refills should only be done after clinical re-evaluation.

1. Long acting benzodiazepine protocol (chlordiazepoxide; brand name Librium; best for normal liver function)
    a. Loading dose: 100 mg (give in ED), plus 15 tablets of 25 mg prescribed with these instructions:
    b. Day one: 50 mg every 6 to 12 hours
    c. Day two: 25 mg every 6 hours
    d. Day three: 25 mg twice a day

e. Day four: 25 mg at night

2. Shorter acting benzodiazepine protocol (oxazepam; brand name Serax; best if impaired liver function as demonstrated by elevated PT)
    a. Loading dose: 30 mg (given in ED), plus 10 tablets of 30mg prescribed with these instructions:
    b. Day one: 30 mg every 6 hours
    c. Day two: 30 mg every 8 hours
    d. Day three: 30 mg every 12 hours
    e. Day four: 30 mg at night

Mild withdrawal symptoms-symptom triggered (for supervised settings).

1. If withdrawal symptoms are not present or are mild (C1WA score less than 10), then one of the following protocols applies:
    a. Non-benzodiazepine option: Gabapentin 300mg #28 tablets. 1 in the am, 1 mid-day, 2 at bedtime for 7 days.
    b. Long acting benzodiazepine protocol (chlordiazepoxide; brand name Librium; best for normal liver function) (15 tablets of 25 mg)
        i. Day one: 50 mg every 6 to 12 hours as needed
        ii. Days two to five: 25 mg every 6 hours as needed
    c. Shorter acting benzodiazepine protocol (oxazepam; brand name Serax; best if impaired liver function as demonstrated by elevated PT) (15 tablets of 15mg)
        i. Day one: 30 mg every 6 hours as needed
        ii. Days two to five: 15 mg every 6 hours as needed

All patients who may experience withdrawal:

thiamine 100 mg for 3 days
multivitamins with minerals daily
ondansetron, 4mg PO or SL q4 hours prn nausea
loperamide 2mg: 1-2 prn loose stools
acetaminophen 500mg q 6 hr prn pain
hydroxyzine 25-50mg po q6 hrs. prn anxiety