

Clinical Practice Guidance

Medication Management in Part 822 Programs Chemical Dependence Outpatient Services Faced with a Patient Displaying Withdrawal Symptoms

While it is the practice for medical staff of Chemical Dependence Outpatient Services (Part 822) to administer medication to treat an array of physical and psychiatric conditions which are judged to be safely and effectively managed within the resources of the service, there have been questions raised as to whether it is permissible to address the symptoms associated with mild to moderate or persistent withdrawal. It is OASAS' determination that similar to treating psychiatric conditions, mild to moderate or persistent withdrawal can be addressed in support of continued Outpatient Services if applied within the following guideline.

Guidance for Part 822 Chemical Dependence Outpatient Services Faced with a Patient Displaying Withdrawal Symptoms

OASAS recommends that patients with a CIWA score greater than 15 or similarly assessed be referred for Observation and or Medically Managed Stabilization and Withdrawal

Severe Withdrawal

A patient is admitted from another level of care or from home and/or has used substances within the last 24 hours requiring acute detoxification services

- This patient should be transferred to a Part 816 service for acute management of withdrawal.

Mild to Moderate or Persistent Withdrawal (symptoms that can last for months after acute detoxification)

The service can provide medication management for symptom relief of mild to moderate or persistent withdrawal as differentiated from acute detoxification services.

- A patient is admitted directly from a detox service (Part 816) (mild to moderate or persistent withdrawal symptoms are present).
- A patient is admitted from another level of care or from home and has used substances several days earlier and it appears that he/she is not in need of acute detoxification services, but does require a degree of medical care to alleviate mild to moderate or persistent withdrawal symptoms and become engaged in treatment.
- A patient is admitted and is exhibiting mild to moderate or persistent withdrawal symptoms as can be seen in alcohol dependence, sedative dependence and opiate dependence.

The service can provide symptom relief and/or addiction medications for the patient in mild to moderate or persistent withdrawal only after an accurate assessment of the level

of withdrawal, which includes the use of a standardized assessment instrument. Providers should be familiar with Part 816.5 (C)(1) - Procedures for the clinical evaluation and management of alcohol and/or other substance specific withdrawal syndromes, to include the use of standardized withdrawal evaluation instruments, (including, but not limited to, Clinical Institute Withdrawal Assessment [CIWA] or Clinical Opiate Withdrawal Scale [COWS], if available.)

The service may provide symptom relief and/or addiction medications for alcohol or opiate withdrawal, or a slow taper of sedatives with the following conditions:

- The service must ensure patient safety and institute and document vital sign monitoring commensurate with the level of withdrawal and the medication being used.
- The service must have a physician or nurse practitioner readily available on site or by phone for problems and medication management decisions. A registered nurse or physician's assistant may take the initial call but must have a physician or nurse practitioner available for consultation.
- The physician, if utilizing buprenorphine, should do so using prescriptions that can be filled at an outside pharmacy and the program should not dispense buprenorphine unless they have an Opioid Treatment Program (OTP) certification.

The service must attempt to have the patient complete the medication/medications used for symptom control for the patient to be stabilized prior to discharge. However, OASAS recommends that patients who are doing well on buprenorphine should not be tapered off the medication against their wishes, or if maintenance is medically and clinically indicated. In such cases the clinic is responsible for ensuring that the patient is linked successfully to a community buprenorphine physician at the time of discharge and should have established relationships with them if possible. If no community practitioner is available, the patient should continue in the service as an active patient until such time as a community practitioner becomes available.

Medical orders should be documented at the start of medication and be followed and adjusted as clinically relevant for patients who are medically treated in a Part 822 clinic. The note must document

- the initial withdrawal symptoms,
- medication prescribed, and a
- schedule for monitoring vital signs and other withdrawal symptoms,
- behavioral issues, and
- signed by the prescribing professional within 24 hours.

The admission assessment and subsequent Treatment Plans should incorporate the withdrawal plan as indicated.

Long-term treatment utilizing buprenorphine with limited outpatient services is allowable in Part 822 clinics as medically and clinically indicated and in compliance with Part 822

regulations. Should a patient request a referral to methadone treatment (OTP services), every effort must be made to refer the patient to an OASAS provider certified and accredited to provide such services.

For patients receiving addiction medicine (e.g., buprenorphine) for an extended period of time, who may have met all other treatment plan goals, their treatment plan should continue to address such issues as medication management and monitoring along with ongoing assessment for post acute or post sub-acute withdrawal. Treatment plan goals might include continued abstinence and/or relapse prevention. These goals would be appropriate under the medical and/or substance abuse functional areas. Such patients would require treatment plan reviews and utilization reviews as specified in the Part 822 regulations. In addition, per Section 822.7(e), patients who are seen once per month (which might be the case for long-term buprenorphine patients) do not have to be factored into the one full-time equivalent primary counselor for every 35 patients ratio requirement. Active patients must be seen face-to-face at least once every thirty days by medical and/or clinical staff to appropriately monitor and document progress on remaining treatment plan goal(s).

If at any time the patient develops symptoms of acute withdrawal, they must immediately be transferred to an emergency room and/or Part 816 withdrawal and stabilization service. Programs that provide medication management should have specific linkages with inpatient withdrawal services and/or emergency rooms and have detailed policies regarding safe transportation of clients in need of these services.

If you have any questions please contact: NYS OASAS Treatment Bureau – 518 485-2123.