



New York State
Office of Alcoholism & Substance Abuse Services
Addiction Services for Prevention, Treatment, Recovery

**GUIDELINES FOR DETOXIFICATION TRIAGE
USING THE 48 HOUR OBSERVATION BED**

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Detoxification is defined as a medical regimen, conducted under the supervision of a physician to systematically reduce the amount of the addictive substance in a patient's body, provide reasonable control of active withdrawal symptoms and/or avert life threatening medical crisis related to the addictive substance.

- There shall be a physician, nurse practitioner and/or physician's assistant under the supervision of a physician, on staff for sufficient hours to perform the initial medical examination of all patients and to prescribe any and all necessary pharmacological medications necessary to secure safe withdrawal.
- Substances that require detoxification include:
 - Ethyl alcohol
 - Opiates (heroin, codeine, methadone, etc)
 - Sedative – Hypnotics (barbiturates, benzodiazapines, etc)
 - Cannabinoids (marijuana, hash, etc)*
 - Stimulants (cocaine, amphetamines, etc)*
 - Hallucinogens (LSD, PCP, etc)*
 - Aromatic Petro-chemical inhalants*

*require alcohol, opiates or sedatives to be present for consideration of admission as the withdrawal does not require this level of medical intervention.

Principles of detoxification:

- Detoxification alone is rarely adequate treatment for AOD dependencies.
- When using medication regimens or other detoxification procedures, clinicians should use only protocols of established safety and efficacy.
- Clinicians must advise patients when procedures are used that have not been established as safe and effective.
- During detoxification, providers should control patients' access to medication to the greatest extent possible.
- Initiation of withdrawal should be individualized.
- Whenever possible, clinicians should substitute a long-acting medication for short-acting drugs of addiction.
- The intensity of withdrawal cannot always be predicted accurately.
- Every means possible should be used to ameliorate the patient's signs and symptoms of AOD withdrawal.
- Patients should begin participating as soon as possible in followup support therapy such as peer group therapy, family therapy, individual counseling or therapy, 12-step recovery meetings, and AOD recovery educational programs.
- Discharge planning should start at the time of admission.
- The medical team is responsible for a minimum of one note per day and should clearly delineate the state of the patient, the progress that the patient is showing and future medical plans.



Observation Bed – a unit of service bed which provides intensive assessment and treatment of withdrawal where the patient has continuous evaluation for up to 48 hours. At 24 and 48 hours, determinations are made as to the indicated level of care and the patient could be transferred to a lower level. The care given in the observation bed is equal to the medically managed level of care.

Medically Managed Withdrawal and Stabilization – Medically managed services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid condition. This level of care includes the 48 hour observation bed.

Medically Supervised Withdrawal and Stabilization Inpatient – Medically supervised inpatient services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications. Patients who have stabilized in a medically managed detoxification service may step-down to a medically supervised inpatient or outpatient services.

Medically Supervised Withdrawal and Stabilization Outpatient – Medically supervised outpatient services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with a stable environment and who are unable to abstain with an absence of past withdrawal complications. Patients who have stabilized in a medically managed or medically supervised inpatient detoxification service may step-down to a medically supervised outpatient service.

Medically Monitored - Medically Monitored Withdrawal and Stabilization Services – are appropriate for persons who are intoxicated by alcohol and/or others substances, who are suffering from mild withdrawal coupled with situational crisis, or who are unable to abstain with the absence of past withdrawal complications. Patients who have stabilized in medically managed or medically supervised inpatient withdrawal may step-down to this service.



Prior to Admission a determination is made as to outpatient vs inpatient detoxification and which level of inpatient service – the 48 hour Observation bed (medically managed level of care) or the medically supervised bed. An opiate dependent patient can be stabilized in the emergency department using buprenorphine and then admitted to an outpatient detoxification unit, a methadone program, or a private physician to complete the opiate detoxification program (tapering of buprenorphine and linkage to behavioral treatment). It is appropriate to consider buprenorphine or methadone maintenance in the chronically relapsing patient.

This determination should be made prior to admission and reviewed at the 24 hour and 48 hour period.

THE PATIENT SHOULD BE ADMITTED TO OUTPATIENT DETOXIFICATION SERVICES IF (ALL REQUIRED):

1. The patient is able to follow instructions
2. The patient has adequate support to help manage the outpatient detoxification process
3. The history of substance use is reliable
4. Risk of seizures, hallucinations, delirium tremens and severe psychiatric disorders are assessed as minimal
5. Withdrawal screening scores are mild to moderately elevated (CIWA less than 15, COWS, etc)
6. Mild withdrawal from sedatives that is not mixed with alcohol use.
7. For opiate withdrawal, buprenorphine, methadone or non-opiate medication is assessed as sufficient to adequately treat the withdrawal

THE PATIENT SHOULD BE ADMITTED DIRECTLY INTO A MEDICALLY SUPERVISED INPATIENT LEVEL OF SERVICE BED

Requires all of the following:

1. Principal diagnosis reflecting psychoactive substance use disorder.
2. Record must clearly substantiate the presence of psychoactive substance disorder.
3. Patient voluntarily accepts detoxification services.
4. Patient does not meet criteria for medically managed detoxification service or outpatient detoxification services
5. Risk of seizures, hallucinations, delirium tremens and severe psychiatric disorders are assessed as minimal
6. Evidence of acute intoxication or withdrawal symptoms, with no evidence of other changes in mental status
7. Withdrawal exhibits symptoms such as: tremors, irritability, sweating, change in vital signs (pulse>100, blood pressure higher than 160/100, temperature higher than 100.9F), anorexia, nausea, vomiting, diarrhea, cramping abdominal pain, goose flesh, tearing.
8. Vital signs are determined to be indicated for around the clock monitoring



Plus requires at least one of the following:

1. History of inability to comply with outpatient detoxification services
2. Mild psychiatric symptoms present which do not need an acute psychiatric intervention
3. Medical disorders do not require acute intervention
4. Home environment does not support outpatient detoxification

ADMISSION CRITERIA TO 48 HOUR BED

Admission requires 1, 2, 3, and 4 plus at least one other criterion (5 – 16):

1. Principal diagnosis reflecting psychoactive substance use disorder.
2. Record must clearly substantiate the presence of psychoactive substance disorder.
3. Patient voluntarily accepts detoxification services.
4. Nature of substance use requires inpatient supervised withdrawal services and there is documentation of the inability to utilize outpatient services.

Plus requires at least one of the following:

5. Evidence of acute intoxication or withdrawal symptoms.
 - a. As evidenced by at least one of the following
 - i. Exhibits at least two withdrawal symptoms such as: tremors, irritability, sweating, change in vital signs (pulse > 100, blood pressure higher than 160/110 or lower than 90/60, temperature higher than 100.9F), unstable vital signs, CIWA_r > 15, anorexia, nausea, persistent vomiting, persistent diarrhea, cramping abdominal pain, seizures, goose flesh, tearing.
 - ii. Changes in mental status/ confusion/ disorientation/ stupor
 - iii. Hallucinations – visual, auditory, tactile
 - iv. Severe psychomotor agitation which is expected to improve over the course of detoxification
6. Substance induced mood disorder with danger to self or others – must specify nature of danger other than continued substance use.
7. Inadequate nutrition that compromises bodily functions where family/community support cannot be relied on.
8. Patient is presently suffering from a significant medical disorder related to substance use that can be managed by the detoxification service.
9. Patient is presently suffering from a significant psychiatric or cognitive disorder (may or may not be related to the substance use) that can be managed by the detoxification service.
10. Patient has other medical disorders that are stated to be dangerous to the patient during detoxification if not monitored (insulin dependent diabetic, hypertension, COPD, etc).
11. Patient has a prior history of delirium tremens.
12. Patient has a prior history of withdrawal seizures under similar circumstances
13. Frequent vital sign monitoring every 1 - 2 hours needed to insure safe withdrawal (assessment and detox medication management)



14. Documented need for intravenous fluids to stabilize vital signs or correct electrolyte abnormalities
15. BAC > .30 with limited intoxication (absence of symptoms and signs of intoxication showing marked tolerance)
16. Parenteral medications for withdrawal with documentation that patient is unable to tolerate oral fluids and/or medications.

After 24 hours – the medical team reassesses the patient. Can the patient be discharged to methadone maintenance, buprenorphine maintenance, outpatient detox or medically supervised withdrawal. Use the outpatient detox service and the medical supervised detox service criteria to see if discharge to this level is indicated.

CONTINUED STAY AFTER 48 HOURS

Does the patient fit the medically supervised level at this time (for transfer to the MEDICALLY SUPERVISED LEVEL OF SERVICE – see previous med sup level of service criteria)? Does the patient still meet the medically managed (48 hour observation bed) criteria? Can the patient be discharged to an outpatient methadone clinic for continued opiate taper (buprenorphine or methadone)? Can the patient be admitted to an 822 outpatient program and have the buprenorphine slowly tapered (medication management protocols)? Can the patient be admitted to a methadone or 822 to be maintained on the buprenorphine dose?

AT THE MEDICALLY MANAGED LEVEL OF SERVICE

Requires all of the following:

1. Medical therapy which is supervised by a physician (carried out by the medical team) in order to stabilize the patient's medical condition is still indicated
2. Daily physician attendance is still indicated.
3. Vital signs at least every 6 hours or more often are still indicated
4. Implementation of individualized treatment plan is started
5. Medication administration (detoxification medications such as Librium) to prevent or modify withdrawal is still being adjusted and monitored

Requires at least one of the following:

1. CIWA greater than 12
2. Seizures within the past 24 hours
3. Delirium tremens within the past 24 hours
4. Hallucinations within the past 24 hours
5. Acute intervention needed for co – occurring medical disorder
6. Acute intervention needed for co – occurring psychiatric disorder
7. Severe withdrawal that cannot be handled at a lower level of care (continued vomiting, continued diarrhea, abnormal vital signs) requiring intravenous medication and/or fluids
8. Pregnancy



DISCHARGE CRITERIA FOR THE INPATIENT MEDICALLY MANAGED OR MEDICALLY SUPERVISED PATIENT

All are required:

1. Patient control and stability is acceptable for less restrictive treatment
2. Completion of prescribed treatment
3. Patient is off all medications that were used for detoxification EXCEPT if the plan is for the patient to be maintained on buprenorphine or methadone with appropriate referral; or the patient has been stabilized on a sedative with appropriate referral to an outpatient detox service or another OASAS level of care (inpatient rehab, 822) where the medication can be slowly tapered.
4. Discharge plan includes:
 - a. Withdrawal identified as reason for admission is resolved
 - b. Other co-occurring problems are stable/improved and follow up is arranged as necessary
 - c. Nursing and social work notes support discharge plans and instructions as outlined in physician's discharge note
5. Social and/or environmental support exists or can be provided
6. Vital signs have normalized
7. Withdrawal screening tool (CIWA, COWS, etc) is now in normal range
8. Patient is able to maintain oral nutritional intake
9. Linkage to the next appropriate level of care has been completed and documented in the chart



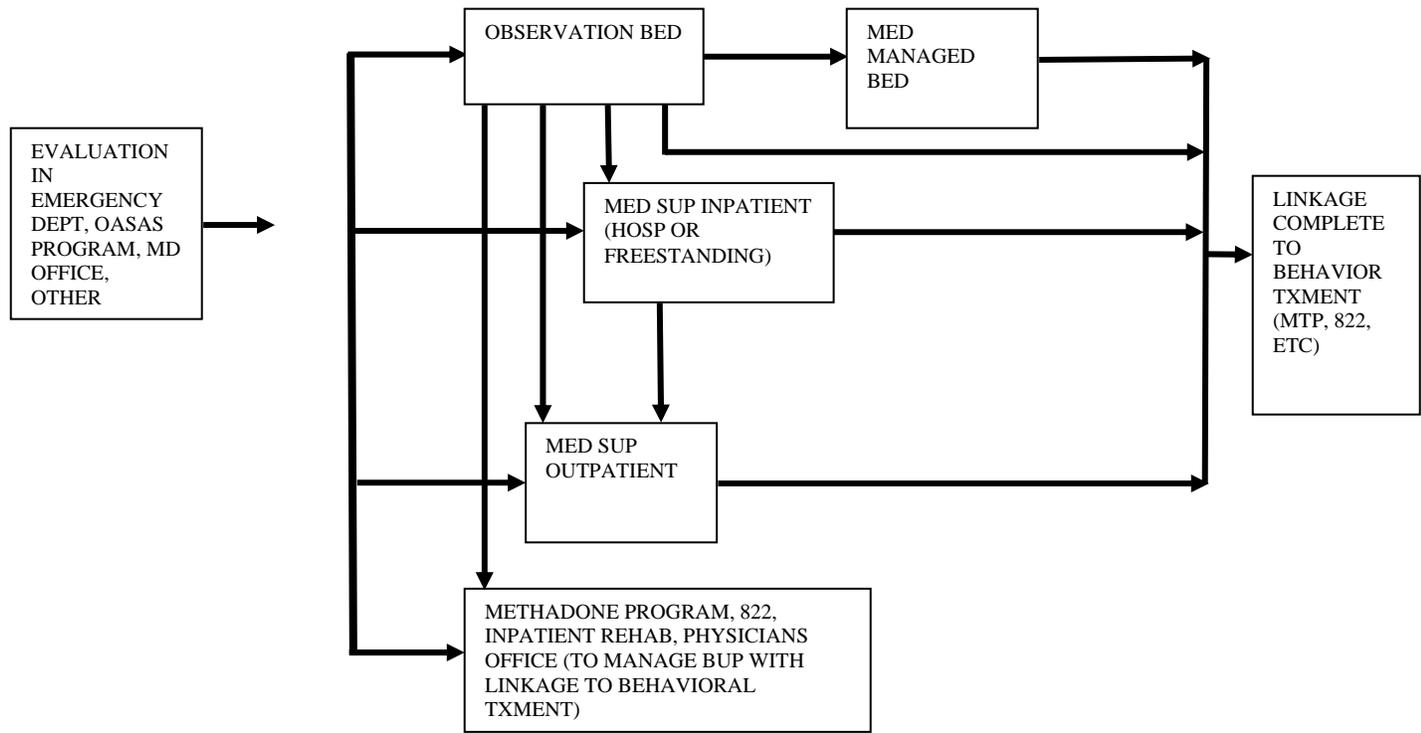
ADDENDUM A

CRISIS SYSTEM OVERVIEW COMPARISON OF LEVEL OF CARE

Level of Care	Setting	Site	Purpose	Intoxication/ Withdrawal	Co-Morbidity	Sober Supports
Observation Bed	Inpatient	Hospital	Initial extensive medical observation and treatment of withdrawal and co-morbidity	Severe or risk of severe	unstable	Doesn't effect
Medically Managed	Inpatient	Hospital	Ongoing medical management of withdrawal and co-morbidity	Severe	Unstable	Doesn't effect
Medically Supervised	Inpatient	Hospital or Freestanding	Treatment without co-morbidity	Mild to moderate	Stable	Unstable
Medically Supervised	Outpatient	Clinic	Stabilization of early moderate withdrawal	Mild to moderate	If present, stable	Good



ADDENDUM B



- If an indicated level does not exist in the local area, the patient should be placed in the next higher level of care
- Once a patient's level of care is determined either initially or after an observation bed stay, they will complete their detoxification at that level of care.
- Medically monitored programs can be used as a linkage program for patients that are stabilized and do not require medication adjustment (other than following a taper schedule) or a high degree of medical supervision



ADDENDUM C

The Medical Note:

- The 816 regulation states:
 - o The frequency of progress notes shall be based on the condition of the patient. In an medically supervised outpatient withdrawal and stabilization service, progress notes shall be documented no less often than once per visit; in medically managed once per shift and in all other withdrawal and stabilization services, progress notes shall be documented no less often than once per shift for the first five days and no less often than once per day thereafter.
 - Interpretation:
 - o Applies to nursing and/or counseling
 - o Medical team notes should be at a minimum once per day
- What are we looking for in the note?
 - o Subjective findings
 - o Objective findings (vital signs, evidence or lack of withdrawal signs and symptoms)
 - o Interpretation of the above
 - o The plan of action





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