



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

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# Definition

- 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
    - There shall be a physician, nurse practitioner and/or physician's assistant under the supervision of a physician, on staff 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.
  - Provide reasonable control of active withdrawal symptoms and/or avert life threatening medical crisis related to the addictive substance.



# 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.



# Principles of Detoxification:

- 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.
- 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.



# Principles of Detoxification:

- Patients should begin participating as soon as possible in follow-up support therapy such as peer group therapy, family therapy, individual counseling or therapy, 12-step recovery meetings and AOD recovery educational programs.



# Detoxification Today



# Detoxification (Crisis) Services in New York

- A. Medically Managed Detox: Services offered in acute inpatient hospital settings to patients requiring the most intensive level of service. For patients with medical or psychiatric complications.
- B. Medically Supervised Withdrawal – Inpatient: Services offered in an inpatient or residential setting to those requiring 24 hour supervision/support.
- C. Medically Supervised Withdrawal - Outpatient: General detoxification offered in an outpatient setting to those with stable social support.
- D. Medically Monitored Withdrawal : Detox for patients in mild withdrawal or situational crisis in residential setting. No Medicaid reimbursement.



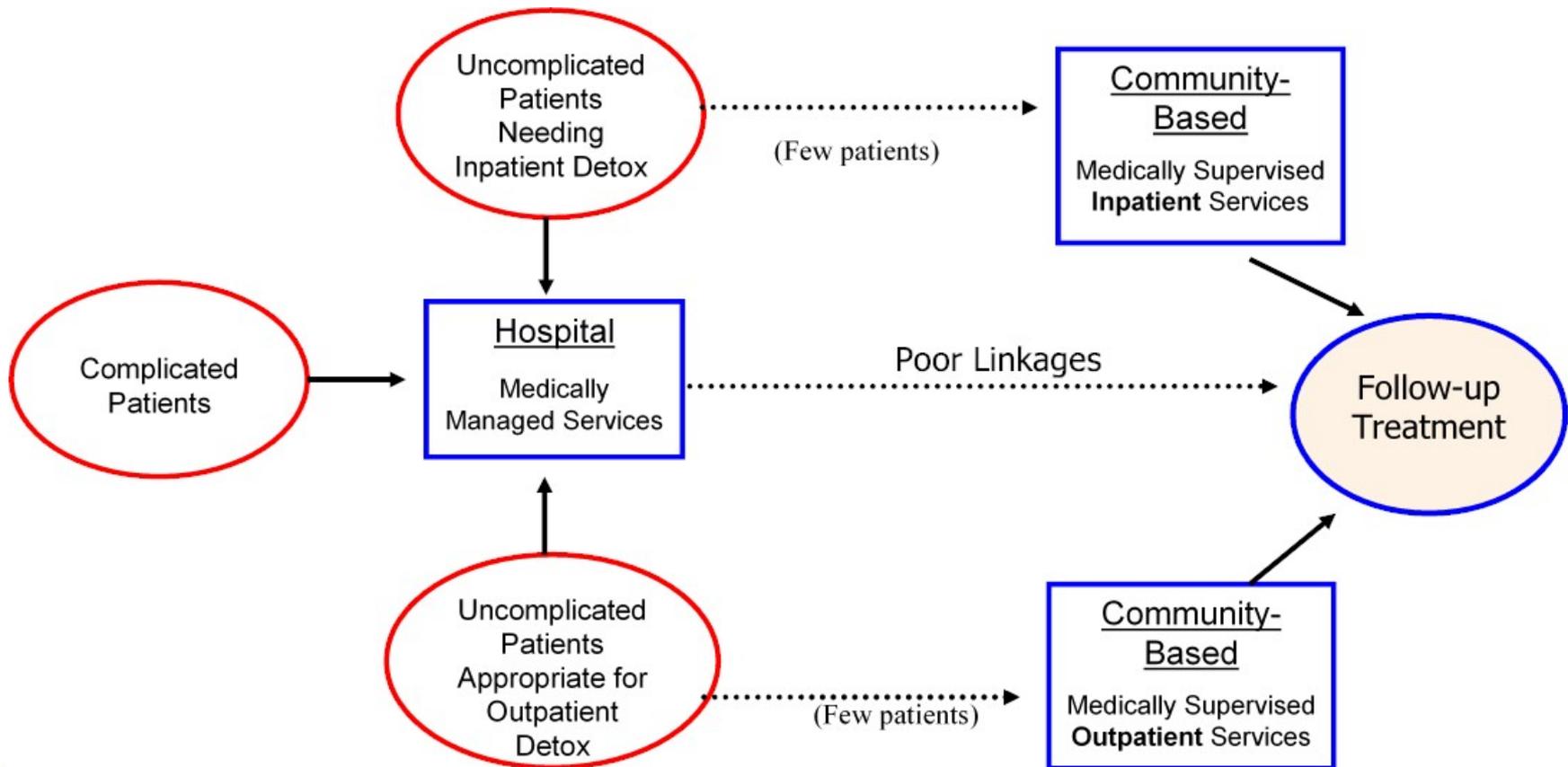
# Detoxification Providers in New York

(Fee for Service Medicaid)

Service Category	SFY 2004/2005		SFY 2005/2006	
	# of Providers	Total Medicaid	# of Providers	Total Medicaid
Medically Managed Detox (Hospital DRG Detox)	200	\$318,345,209	193	\$327,999,448
Medically Supervised Withdrawal - Inpatient (non-Hospital)	10	\$21,673,747	10	\$22,454,193
Medically Supervised Withdrawal - Outpatient (Hospital)	3	\$354,076	1	\$7,369
Medically Supervised Withdrawal - Outpatient (non- Hospital)	4	\$92,788	4	\$372,898
Total	217	\$340,465,820	208	\$350,833,908



# Detoxification Today



# NYS Detox Facts:

- 85% of Detox in NYS is done in Hospitals
  - Note: Other states use hospital-based detox primarily for medically or psychiatrically complicated cases.
- 60% - 80% of detox cases in NYS hospitals are billed to Medicaid as uncomplicated cases
- 80% of all hospital cases are not linked to follow-up treatment
- 44% of all hospital detox Medicaid cases end up back in detox



# The Opiate Patient Problem

- A significant percentage of the people who present for hospital-based detoxification in New York State are diagnosed as requiring “uncomplicated opiate detoxification”.
- Many of these individuals receive multiple detox episodes without connecting with appropriate post-detoxification treatment.
- The majority of individuals who receive opiate detoxification services in hospitals relapse to the use of illicit opiates rather quickly.
  - Gruber et al, Drug Alcohol Depend 2008;94(1-3):199-206
    - 6 month methadone maintenance with counseling was more effective than 21 day methadone detoxification in reducing heroin and alcohol use.
- When a long-term opiate addicted patient relapses and uses illicit opiates after a detox episode, he/she is at increased risk for accidental overdose death, since the detox experience can reduce the individual’s opiate tolerance.



# Detoxification Tomorrow



# The Right:

- Service
- Setting
- Linkage



# Principles of Detoxification Reform

- Patient Centered
- Integrate Best Practices
- Develop and Support Linkages
- Services are Adequately and Appropriately Funded
- Collaboration and Cooperation among Stakeholders



# 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

- 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 and have not experienced withdrawal complications in the past.
- Patients who have stabilized in a medically managed detoxification service should be considered for medically supervised inpatient or outpatient services.



# FORMULATION OF NEW GUIDELINES

- St. Luke's – Roosevelt model
- IPRO models
- ASAM Patient Placement Criteria
- OASAS Medical Advisory Panel
- Outpatient Detox providers
- OASAS Internal Workgroup



# Old Way

- The patient comes into the emergency room.
- From the emergency room the patient is admitted directly to the Detoxification / DRG unit.
- The patient stays, on average, 3 – 5 days.
- Linkage to the next level of treatment is inconsistent.



# New Way

- If an indicated level does not exist in the local area, the patient should be placed in the next higher 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.



# Prior to Admission

## A Determination is Made:

- Outpatient vs Inpatient Detoxification
  - An opiate dependent patient can be stabilized in the emergency department using buprenorphine and then admitted to:
    - an outpatient detoxification unit
    - a methadone program
    - a private physician to complete the opiate detoxification program (tapering of buprenorphine and linkage to behavioral treatment)
  - An opiate dependent patient can be stabilized in the emergency department and then referred to a methadone program for either methadone or buprenorphine stabilization and then detoxification or maintenance.
- Which level of inpatient service – the 48 hour Observation bed, Medically Managed level of care or the Medically Supervised bed.



- The patient who is admitted to the hospital is assessed by a member of the detox medical team:
  - Prior to admission,
  - At 24 hours; and again
  - At 48 hours



# Example #1

- 28-year-old man comes into the emergency room and requests detox.
  - Alcohol use of 2 to 3 six packs per day.
  - He denies other drug use.
  - He denies significant withdrawal in the past.
- At present he is in mild withdrawal.
  - He comes in with his significant other and lives with her in a safe environment.



- The patient should be admitted to Outpatient Detoxification Services if (all required):
  - The patient is able to follow instructions.
  - The patient has adequate support to help manage the outpatient detoxification process.
  - The history of substance use is reliable.
  - Risk of seizures, hallucinations, delirium tremens and severe psychiatric disorders are assessed as minimal.
  - Withdrawal screening scores are mildly to moderately elevated (CIWA less than 15, COWS, etc).
  - Mild withdrawal from sedatives that are not mixed with alcohol.
  - For opiate withdrawal, buprenorphine, methadone or non-opiate medication is assessed as sufficient to adequately treat the withdrawal.
- If outpatient withdrawal is **not available**, then patient can be admitted into a medically supervised bed.



## Example #2

- 28-year-old man comes into the emergency room and requests detox.
  - Heroin use: 4 – 6 bags per day.
  - He denies other drug use.
- At present he is in mild withdrawal after not using for 24 hours.
  - He comes in with his significant other and lives with her in a safe environment.



- Admit to an outpatient detoxification service.
- Admit to a methadone program for stabilization and taper or maintenance.
- Start buprenorphine and hand off to a:
  - Private physician;
  - Methadone program;
  - 822 OASAS outpatient program; or
  - Hospital Medical clinic:
    - If appointment available next day;
    - If medication can be used; and
    - If linkage can be set up.



# Example #3

- 28-year-old man comes into the emergency room and requests detox.
  - Heroin use: 4 – 6 bags per day.
  - He uses occasional sedatives
  - He drinks less than a 6 pack per day.
  - He denies significant withdrawal from all drugs other than the opiates.
- At present he is in mild withdrawal after not using for 24 hours.
  - He comes in alone.
  - He lives by himself in a motel.
  - He does not work.
  - He has no available transportation.
  - He has no family in the area.



- The patient should be admitted to Outpatient Detoxification Services if (all required): **NO**
  - The patient is able to follow instructions.
  - The patient has adequate support to help manage the outpatient detoxification process. **NO**
  - The history of substance use is reliable.
  - Risk of seizures, hallucinations, delirium tremens and severe psychiatric disorders are assessed as minimal.
  - Withdrawal screening scores are mild to moderately elevated (CIWA less than 15, COWS, etc).
  - Mild withdrawal from sedatives that is not mixed with alcohol or other drugs.
  - For opiate withdrawal, buprenorphine 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 (all required):
  - Principal diagnosis reflecting psychoactive substance use disorder.
  - Record must clearly substantiate the presence of psychoactive substance disorder.
  - Patient voluntarily accepts detoxification services.
  - Patient does not meet criteria for medically managed detoxification service or outpatient detoxification services.
  - Risk of seizures, hallucinations, delirium tremens and severe psychiatric disorders are assessed as minimal.
  - Evidence of acute intoxication or withdrawal symptoms, with no evidence of other changes in mental status.



- The patient should be admitted directly into a Medically Supervised Inpatient Level of Service bed (all required):
  - 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 or tearing.
  - Vital signs are determined to be indicated for around the clock monitoring.
  - Plus requires at least one of the following:
    - History of inability to comply with outpatient detoxification services;
    - Mild psychiatric symptoms present which do not need an acute psychiatric intervention;
    - Medical disorders do not require acute intervention; and
    - Home environment does not support outpatient detoxification.



# Example #4

- 28-year-old man comes into the emergency room and requests detox.
  - His heroin use: 4 – 6 bags per day.
  - He uses occasional sedatives.
  - He drinks 3 6- packs per day.
  - He denies significant withdrawal from the opiates, but is not sure about alcohol.
  - There is a question of a seizure in the past.



# Example #5

- 28-year-old man comes into the emergency room and requests detox.
  - At present he is in withdrawal after not using for 24 hours.
    - Pulse 110, significant tremor, BP 170/110 with mild orthostatic changes.
  - He has not eaten in 2 days due to diarrhea and vomiting.
  - He comes in alone, lives by himself in a motel, does not work and has no family in the area.
  - He has been through inpatient and outpatient detox and rehab over the last year.
  - Medically he thinks he may have had a “high sugar” in the past (ER – 310 glucose).



# Admission Criteria to the 48 Hour Bed

**Admission requires 1, 2, 3, and 4 plus at least one other criterion from 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.



# Admission Criteria to the 48 Hour Bed

5. Evidence of acute intoxication or withdrawal symptoms.
  - A. As evidenced by at least one of the following:
    1. 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<sub>r</sub> > 15, anorexia, nausea, persistent vomiting, persistent diarrhea, cramping abdominal pain, seizures, goose flesh or tearing.
    2. Changes in mental status/ confusion/ disorientation/ stupor
    3. Hallucinations – visual, auditory, tactile
    4. 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.



# Admission Criteria to the 48 Hour Bed

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.



# Admission Criteria to the 48 Hour Bed

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.



# 24 Hours Later

- The Medical Team member reassesses the patient:
  - Buprenorphine and librium protocols
  - Intravenous fluids required
  - Vital signs stabilizing
  - Mildly elevated CIWA and COWS
  - Potassium 3, Glucose 190
- Continue in 48 hour bed



# At 48 Hours

- Does the patient fit the medically supervised level at this time?
- 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:
  - Medical therapy which is supervised by a physician (can be carried out by the medical team) in order to stabilize the patient's medical condition is still indicated;
  - Daily physician attendance is still indicated;
  - Vital signs at least every 6 hours or more often are still indicated;
  - Implementation of individualized treatment plan is started; and
  - Medication administration (detoxification medications such as Librium) to prevent or modify withdrawal is still being adjusted and monitored.



# AT THE MEDICALLY MANAGED LEVEL OF SERVICE

- Requires at least one of the following:
  - CIWA greater than 12;
  - Seizures within the past 24 hours;
  - Delirium tremens within the past 24 hours;
  - Hallucinations within the past 24 hours;
  - Acute intervention needed for co-occurring medical disorder;
  - Acute intervention needed for co-occurring psychiatric disorder;
  - 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; or
  - Pregnancy.



- Once the patient's level of care determination is made, the patient stays at that level until discharge
  - Realistically patient could move from MMW to MSW and back to MMW
    - Billing and coding nightmare
    - Fair



# Discharge Criteria for the Inpatient Medically Managed or Medically Supervised Patient

All are required:

- Patient control and stability is acceptable for less restrictive treatment.
- Completion of prescribed treatment.
- 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
  - if 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.



# Discharge Criteria for the Inpatient Medically Managed or Medically Supervised Patient

- Discharge plan includes:
  - Withdrawal identified as reason for admission is resolved.
  - Other co-occurring problems are stable/improved and follow up is arranged as necessary.
  - Nursing and social work notes support discharge plans and instructions as outlined in physician's discharge note.
- Social and/or environmental support exists or can be provided.
- Vital signs have normalized.
- Withdrawal screening tool (CIWA, COWS, etc) is now in normal range.
- Patient is able to maintain oral nutritional intake.
- Linkage to the next appropriate level of care has been completed and documented in the chart.



# The Warm Hand-Off

- The transfer of care from one service to another has been recognized as key to breaking the cycle of *Detox, Detox, Detox*.
- We should seek to establish a personal contact between our patient and the next caregiver. A name of who to ask for is a minimum and direct communication should be used if possible. **THINK CONNECTION.**



# The Medical Note

- The 816 regulation states:
  - The frequency of progress notes shall be based on the condition of the patient. In a 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:
      - Applies to nursing and/or counseling
      - Medical team notes should be at a minimum once per day



# The Medical Note

- What are we looking for in the note?
  - IPRO looks at quality and utilization:
    - Quality issues look at the provision of safe, effective medical treatment.
    - Utilization issues occur when there is poor documentation of what is being done (what services are being delivered to justify the present level of care).
  - A note should include:
    - Subjective findings;
    - Objective findings (vital signs, evidence or lack of withdrawal signs and symptoms);
    - Interpretation of the above; and
    - The plan of action



# Pearls

- Do what is best for the patient.
- Err on the side of safety.
- Document, document, document.

