The Wild West of Withdrawal Management

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Disclosure Information

- Presenter 1: Nadia Haddad, MD
  - No Disclosures
- Presenter 2: Michelle Gaffaney, PA-C
  - No Disclosures

Learning Objectives

1. Define opportunities and limitations of ASAM 3.2WM level of care
2. Describe real world challenges in applying medical standards to “social detox” to:
    a. Maximize safety
    b. Preserve access for the underserved - ASAM 3.2WM may be only option outside of emergency department
3. Review a practicing model to expand medical services in ASAM 3.2WM program
    a. Address gaps in detox continuum
    b. Reduce costly emergency department visits

Orientation

- Define & review detox
- ASAM withdrawal management history & levels of care
- Explore some cases
- Real world continuum, & the challenges in our community
- Particulars of our CMHC 3.2WM
  - Implementation of enhanced medical services
- A return to the cases
- Final Takeaways
- Discussion / Questions

Detox

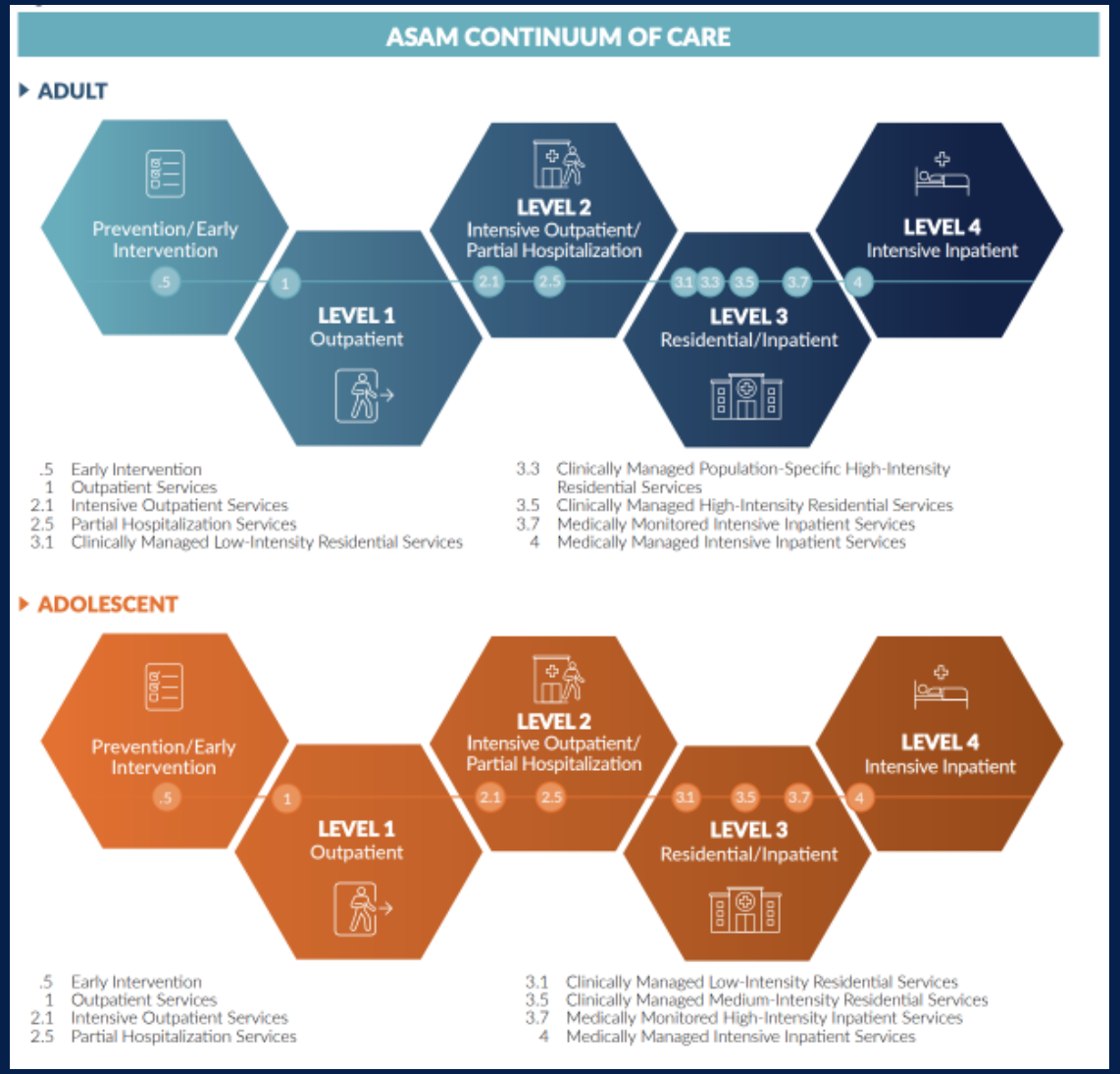
Withdrawal from tolerance inducing substances like alcohol, benzodiazepines and opioids

- Causes distressing symptoms and physiological signs including vital sign abnormalities
- Can be life threatening
- Acute manifestations and risk generally occur over the course of 2-4 days
- Signs and symptoms are rapidly evolving

History of Withdrawal Management

Development of ASAM Criteria

In the interest of individualizing care, Withdrawal management (WM) services became “a la carte”, unbundled from from other treatment services



https://www.asam.org/asam-criteria/about-the-asam-criteria

Review of WM Levels of Care

1.0	Ambulatory Detoxification Without Extended Onsite Monitoring	• Outpatient office, home health agency • Organized outpatient service • Monitoring at predetermined intervals
2.0	Ambulatory Detoxification With Extended Onsite Monitoring	• Day hospital • Monitored by licensed nurses
3.2	Clinically Managed Residential Detoxification	• Non-medical or social detoxification setting • Emphasizes peer and social support • Intended for patients whose intoxication and/or withdrawal warrants 24-hour support
3.7	Medically Monitored Inpatient Detoxification	• Freestanding detoxification center • Provides 24-hour medically supervised detoxification services
4.0	Medically Managed Intensive Inpatient Detoxification	• Hospital (Psychiatric or Medical)

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ASAM Level 3 WM: Non-Hospital Detox

3.2WM

- Non-medical staff (QMAPs, HS Diploma or bachelor's level)
- Licensed medical consultation available 24-7 by phone
- Physician approved protocols

No Medical Staff Required In House

3.7WM

- Assessment by medical provider within 24h of admit
- Licensed medical on-call 24h per day
- 24-7 RN to monitor & administer medications, stock medications in-house

What level would you triage to?

Case 1

JS, a 46yo male experiencing homelessness dropped off by police for alcohol intoxication. After admit, patient reports "end-stage cirrhosis" 2/2 alcohol use. ED diagnosed hepatic encephalopathy and sent him with lactulose. H/o TIPS, recent gastric bleed and hernia. H/o needing intensive care unit for detox. Recent reported history of alcohol use is unclear and changing, but possibly 750ml/day liquor. BAL 0.060 on arrival with CIWA of 38.

BP 198/104
K 3.0 BUN 36 Cr 1.23 Ca 7.7 TBili 2.8
MCV 103.4 H/H 10.9/33.3
Lipase 374

Case 2

DC, 48yo female experiencing homelessness, previously well-functioning without psychosis in early 30s, presenting for methamphetamine use. Reporting significant paranoia, believes she's being stalked and poisoned. Hands and feet have 4+ pitting edema and face has many lesions in various states of healing. Patient's interpretation is that she had chemicals thrown on her face and extremities. Face looks like skin picking. She consistently elopes from WM and residential services 2/2 paranoia.

Patient is escalating usage of withdrawal management services, presenting 5x in the past month.

Case 3

JW, 52yo male experiencing homelessness, self-presented to WM reporting 1L of vodka daily x 1 month. H/o withdrawal seizures. No history of ICU admissions. No medical conditions. No substance use.

BAL on admission was 0.192

BP 142/97, pulse 100

Who are we?

Mental Health Partners is a **community mental health center** serving Boulder & Broomfield Counties in the state of Colorado

We take Medicaid & uninsured

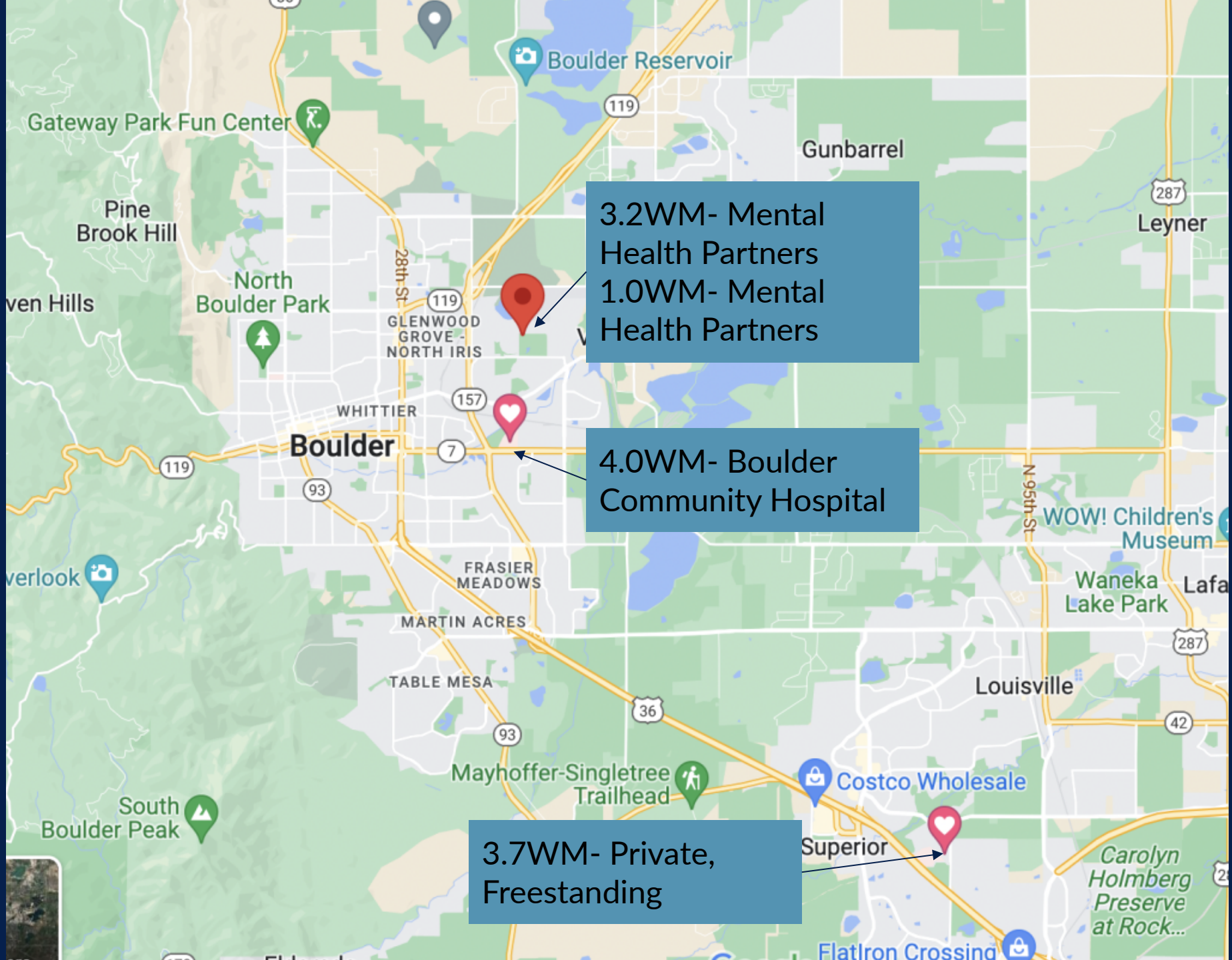
Alcohol, fentanyl & methamphetamine are most common substances people present with for detox

NEWS › COLORADO NEWS • News

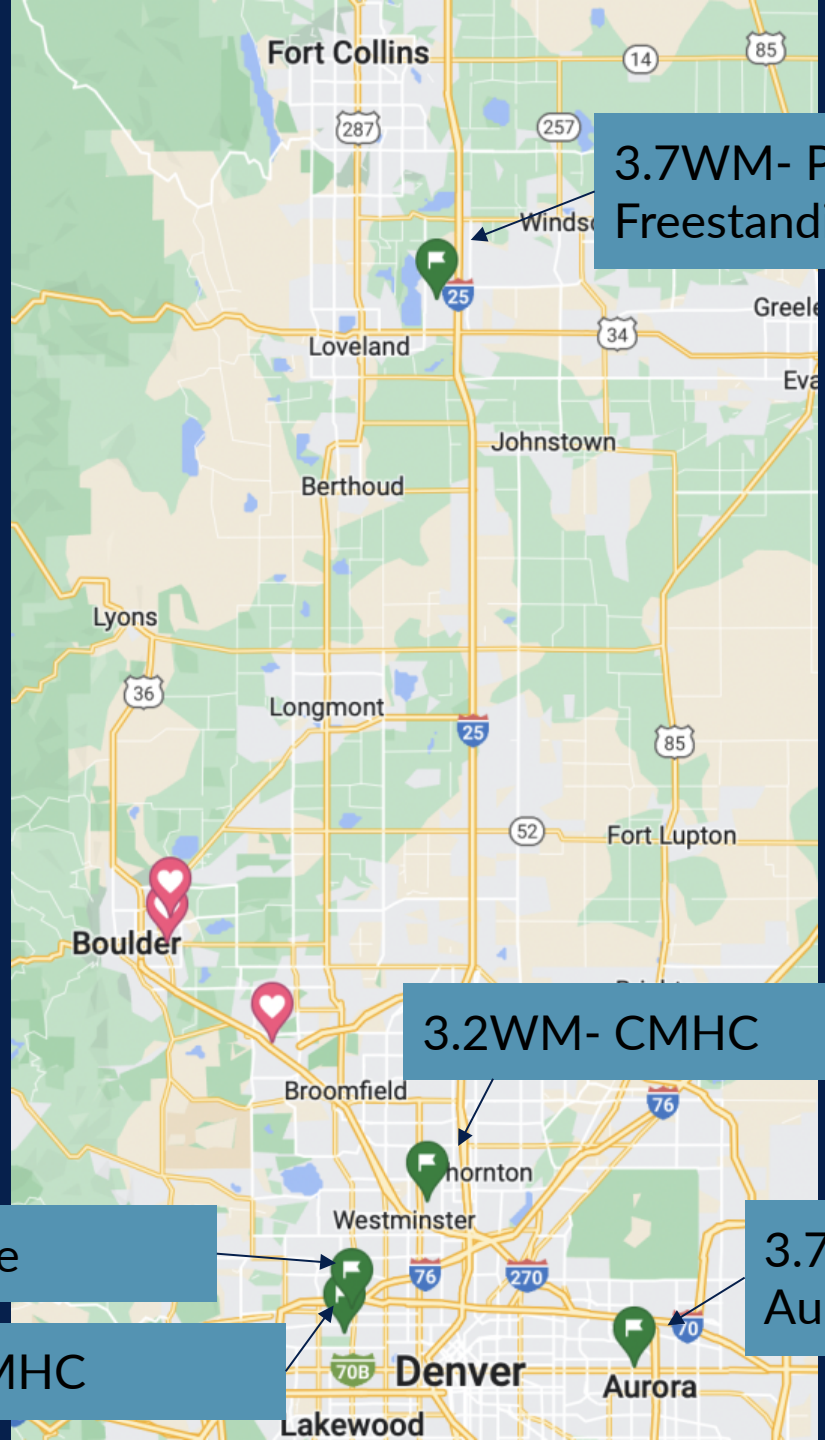
Boulder's main library closed indefinitely after tests find high meth levels in restroom exhaust vents

City tested vents after receiving 15 reports of people smoking in library restrooms in past month

https://www.denverpost.com/2022/12/20/boulder-public-library-meth-smoking-restrooms/


3.2WM- Mental Health Partners
1.0WM- Mental Health Partners
4.0WM- Boulder Community Hospital
3.7WM- Private, Freestanding
Boulder Reservoir
Gateway Park Fun Center
Gunbarrel
Pine Brook Hill
Leyner
North Boulder Park
28th St
GLENWOOD GROVE - NORTH IRIS
WHITTIER
Boulder
N 95th St
WOW! Children's Museum
Waneka Lake Park
FRASIER MEADOWS
MARTIN ACRES
TABLE MESA
Louisville
Mayhoffer-Singletree Trailhead
Costco Wholesale
South Boulder Peak
Superior
Carolyn Holmberg Preserve at Rock...
FlatIron Crossing
119
157
7
93
36
42
287

Google Maps



3.7WM- Private, Freestanding

3.2WM- CMHC

3.7WM- Private

3.2WM- CMHC

3.7WM- Hospital-Based Aurora

Google Maps

Colorado WM Landscape

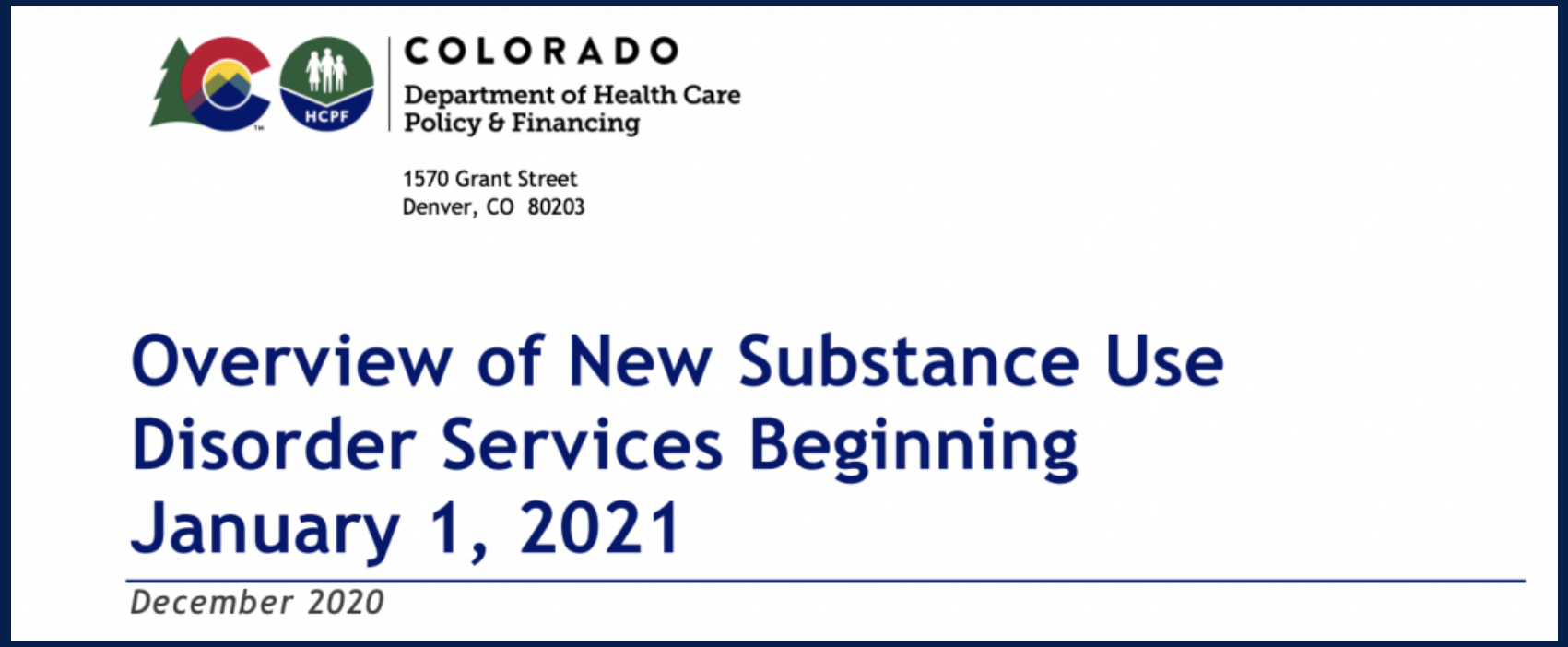
- 3.7 WM is rarely affiliated with community mental health programs
  - Costly, as it requires 24-7 nursing
  - **3.7 WM was NOT a Medicaid covered service until Jan 2021**

https://hcpf.colorado.gov/sites/hcpf/files/Provider%20Manual%20for%20Resident%20and%20Inpatient%20Substance%20Use%20Disorder%20%28SUD%29%20Services%20April%202022.pd

Colorado WM Landscape

- Community mental health centers cannot typically afford to run 3.7WM but still want to offer WM services, so tend to develop 3.2WM
  - BUT, reimbursement rates are very low for 3.2 WM services
  - To cover costs, grant funding & state supplemental funds are necessary

CO Medicaid makes a distinction between primary MH and primary SUD



COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Overview of New Substance Use Disorder Services Beginning January 1, 2021

December 2020

https://hcpf.colorado.gov/sites/hcpf/files/Substance%20Use%20Disorder%20New%20Benefit%20Overview%20December%202020_0.pdf

Ideal vs Reality in Colorado

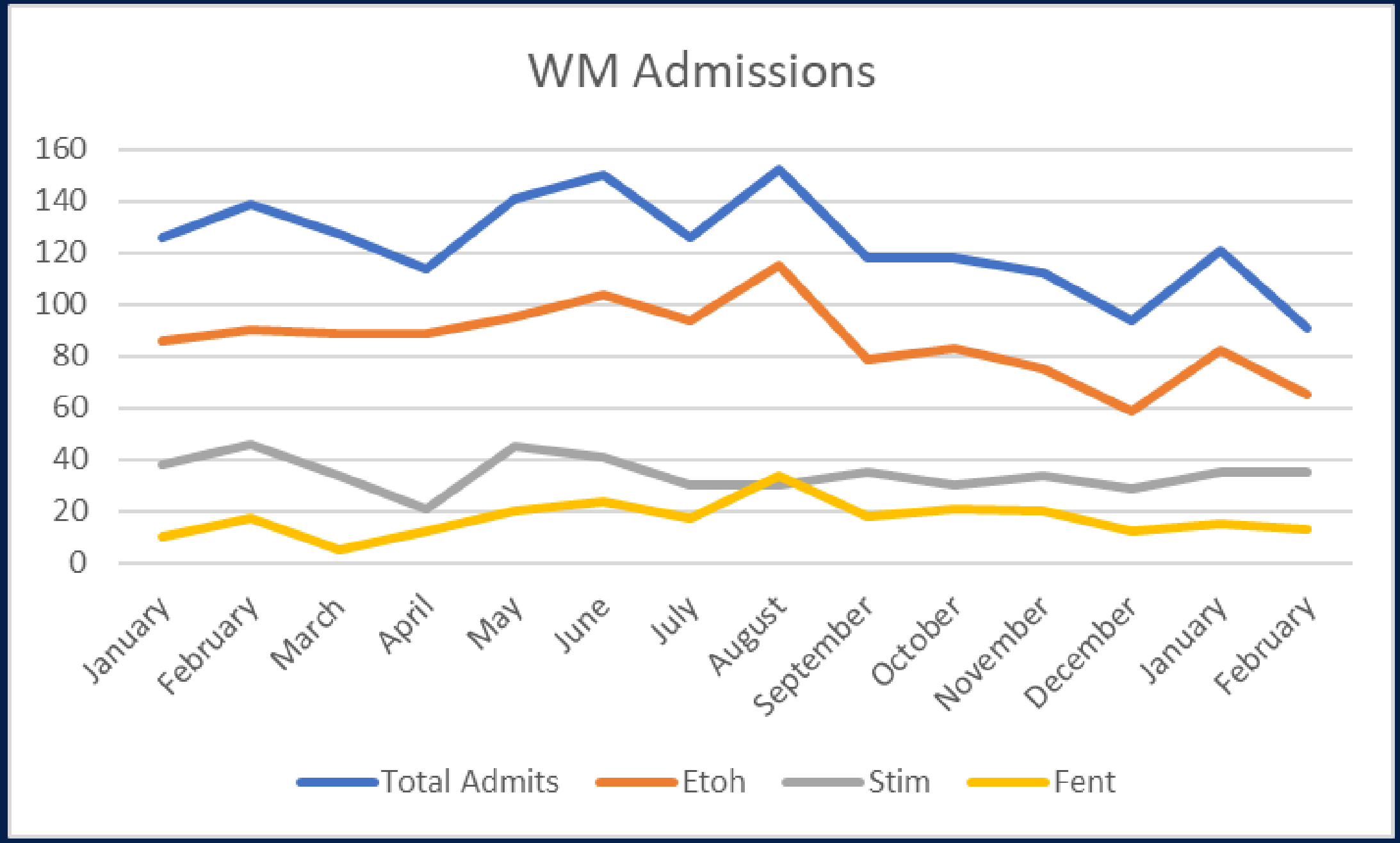
The intention of having different levels of care is presumably to triage people into the right level of care.

The reality is more complicated due to:

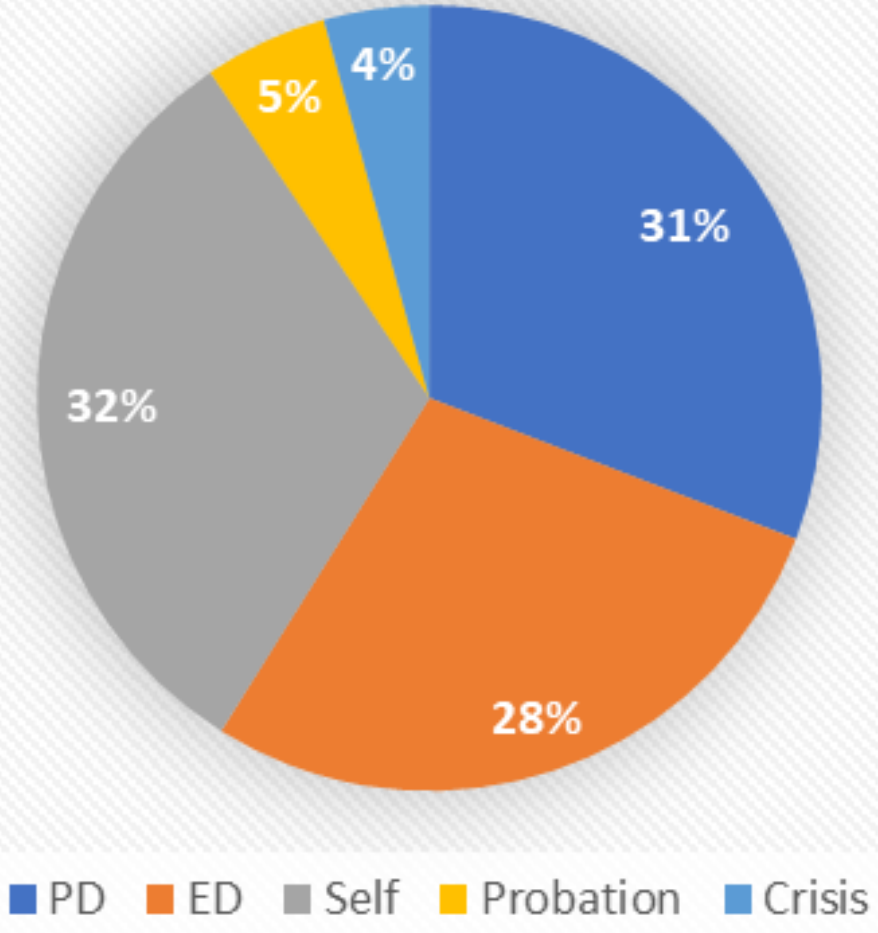
- Fragmented system
- No centralized triage
- Cost of 3.7 WM
- Complexity of funding streams and history of not funding, then limited payment for 3.7 WM meant that most 3.7 WM are private

Practical Considerations

- Who triages & where does this happen?
- What resources to transport if they are not at the right level?
- What is procedure for acceptance at new facility if someone needs transfer between levels of care?
- Who is appropriate for “social” detox?


WM Admissions
160
140
120
100
80
60
40
20
0
January
February
March
April
May
June
July
August
September
October
November
December
January
February
Total Admits
Etoh
Stim
Fent

Referral Types



June 18, 2022- February 28, 2023

3.2WM at MHP

Social detox

- Requirements of staff
  - Bachelor's in psychology OR
  - High school diploma + CAT (certified addiction technician)
    - CAT = 1000 hours of supervised work experience
  - Training received - 2 Shadow shifts

- Staff members are "QMAPs"

Section 2 CCR 502-1-21.210.914 - Level 3.2-WM Staff Requirements, 2 Colo. Code Regs. § 502-1-21.210.914 | Casetext Search + Citator

QMAP

QMAP = Qualified Medication Administration Personnel

- Can follow simple written medication orders
  - Cannot take or follow verbal orders
  - Cannot complete assessments
- No standardized training
  - Our QMAPs go through ~6 hours of pre-recorded online training then take a test
  - 2022- implemented additional required CMHC training overseen by nursing leadership

Medication administration/QMAP | Department of Public Health & Environment (colorado.gov)

3.2WM + Benzo Waiver

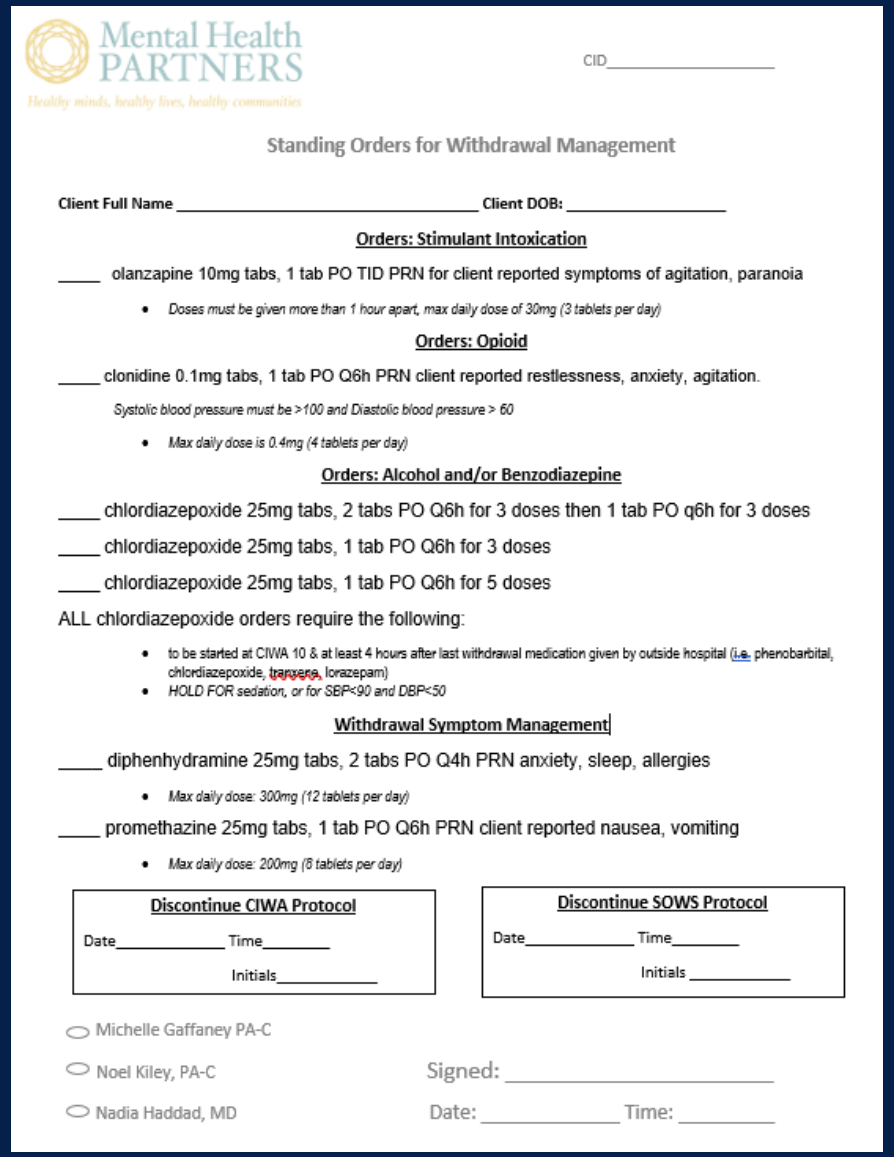
In addition, we've been granted a benzodiazepine waiver

- Allows stock benzodiazepines in-house and their administration with a medical order
  - Chlordiazepoxide (Librium)
- Requires E/M note & consent if written in-house
  - In-house medical provider

3.2WM + Benzo Waiver

With medical provider already in-house→ opportunity for stock medications for other detox related symptoms with medical order:

1. Clonidine - opioid withdrawal
2. Promethazine - anti-nausea
3. Olanzapine - psychosis/agitation generally associated with stimulant intoxication or SIPD
4. Naltrexone - initiation of MAT for transition to Vivitrol
5. Buprenorphine (by pharmacy pick-up)



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CID_____

Standing Orders for Withdrawal Management

Client Full Name _____ **Client DOB:** _____

Orders: Stimulant Intoxication

____ olanzapine 10mg tabs, 1 tab PO TID PRN for client reported symptoms of agitation, paranoia

- *Doses must be given more than 1 hour apart, max daily dose of 30mg (3 tablets per day)*

Orders: Opioid

____ clonidine 0.1mg tabs, 1 tab PO Q6h PRN client reported restlessness, anxiety, agitation.

Systolic blood pressure must be >100 and Diastolic blood pressure > 60

- *Max daily dose is 0.4mg (4 tablets per day)*

Orders: Alcohol and/or Benzodiazepine

____ chlordiazepoxide 25mg tabs, 2 tabs PO Q6h for 3 doses then 1 tab PO q6h for 3 doses

____ chlordiazepoxide 25mg tabs, 1 tab PO Q6h for 3 doses

____ chlordiazepoxide 25mg tabs, 1 tab PO Q6h for 5 doses

ALL chlordiazepoxide orders require the following:

- to be started at CIWA 10 & at least 4 hours after last withdrawal medication given by outside hospital (i.e. phenobarbital, chlordiazepoxide, tranxene, lorazepam)
- *HOLD FOR sedation, or for SBP<90 and DBP<50*

Withdrawal Symptom Management

____ diphenhydramine 25mg tabs, 2 tabs PO Q4h PRN anxiety, sleep, allergies

- *Max daily dose: 300mg (12 tablets per day)*

____ promethazine 25mg tabs, 1 tab PO Q6h PRN client reported nausea, vomiting

- *Max daily dose: 200mg (8 tablets per day)*

Discontinue CIWA Protocol
Date_____ Time_____
Initials_____

Discontinue SOWS Protocol
Date_____ Time_____
Initials _____

○ Michelle Gaffaney PA-C
○ Noel Kiley, PA-C
○ Nadia Haddad, MD

Signed: _____
Date: _____ Time: _____

Standing Orders - PRN MEDS

- Acetaminophen
- Ibuprofen
- Calcium carbonate
- Loperamide
- Nicotine patch 21mg
- Nicotine gum 4mg
- Cough drops (Halls)

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Standing Orders for Withdrawal Management at Mental Health Partners

- Acetaminophen 500mg caps, 2 caps (1000mg) q8h PRN for pain, *Max daily dose is 6 caps (3000mg)*
- Ibuprofen 200mg tabs, 3 tabs (600mg) q6h PRN for pain, *Max daily dose is 12 tabs (2400mg)*
- Calcium carbonate (Tums) 1000mg tabs, 2 tabs (2000mg) q4h PRN for acid reflux, *Max daily dose is 8 tablets (8000mg)*
- Loperamide 2mg tabs, 2 tabs (4mg) q6h PRN for diarrhea, *Max daily dose is 8 tablets (16mg)*
- Nicotine patch 21mg, 1 patch q24h PRN for nicotine cravings
- Nicotine gum 4mg, 1 gum q2h PRN for nicotine cravings
- Cough drops (Halls), 1 drop q30 minutes PRN for cough or sore throat

- Vital signs q4 hours for the first 8 hours, and then qShift thereafter
- Self-reported CIWA q4 hours is to be started on every client who reports alcohol or benzodiazepine use, or who has a positive BAL or UDS for benzodiazepines.
- SOWS q12 hours to be started on every client who reports opioid use, or who has positive UDS for opioids, including methadone, buprenorphine, oxycodone and fentanyl.
- Valid home medications that are not controlled substances in their original bottle with full prescription details in client's name can be given according to instructions on bottle until reviewed by medical provider with the exception of **bupropion** for those clients here for alcohol or benzodiazepine withdrawal.

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Partnership with ED for orders

We allow benzodiazepines brought in from the emergency department to be given per bottle directions IF:

- Written within 12 hours of admission for alcohol or benzodiazepine withdrawal
- Given for CIWA 10 or higher
- AND is at least 4 hours out from last hospital administered dose of benzodiazepine or barbiturate

Rounding Process

Purpose: Identify with staff's help clients who need to be seen for benzodiazepines or those who may benefit from other detox protocols

- 1x per day at any point in the 24h, 7 days per week
  - If pt's are too acute to wait for medical provider in-house, they are too acute for 3.2WM and are sent out to ED

- In an ideal world we could send them up to 3.7 WM, but system is fragmented and this is infrequently possible

Admission Criteria

Difficult to implement, but wish list is the following:

Ambulate
Attend to ADLs
A&O x 4
SBP <210, DBP <105
Pulse <120
Temp <101
O2 Sat >90%
Safe on room air or have a concentrator (consistently satting >88% on RA/concentrator)

Able to urinate/defecate without issue or need for assistance
No violent or threatening behavior
Able to follow direction

No h/o violence/aggression in ED
No major medical condition that could interfere with detox
-*Cirrhosis*
-active cardiovascular disease (MI in past 1 month, angina)
-h/o CVA (stroke) within 1 month
-DM type I, or uncontrolled/without medications DM II
-pregnancy for alcohol withdrawal

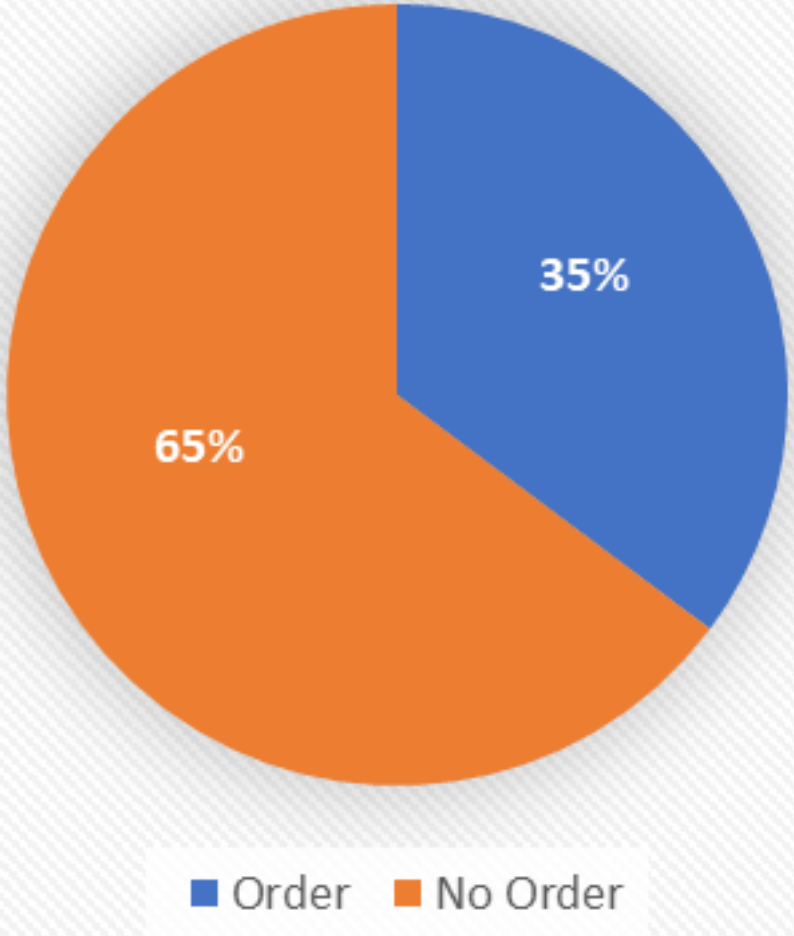
Meds - if they are prescribed anti-seizure medications, blood thinners, arrhythmia medications, insulin, they have these medications with them.

Send out Parameters

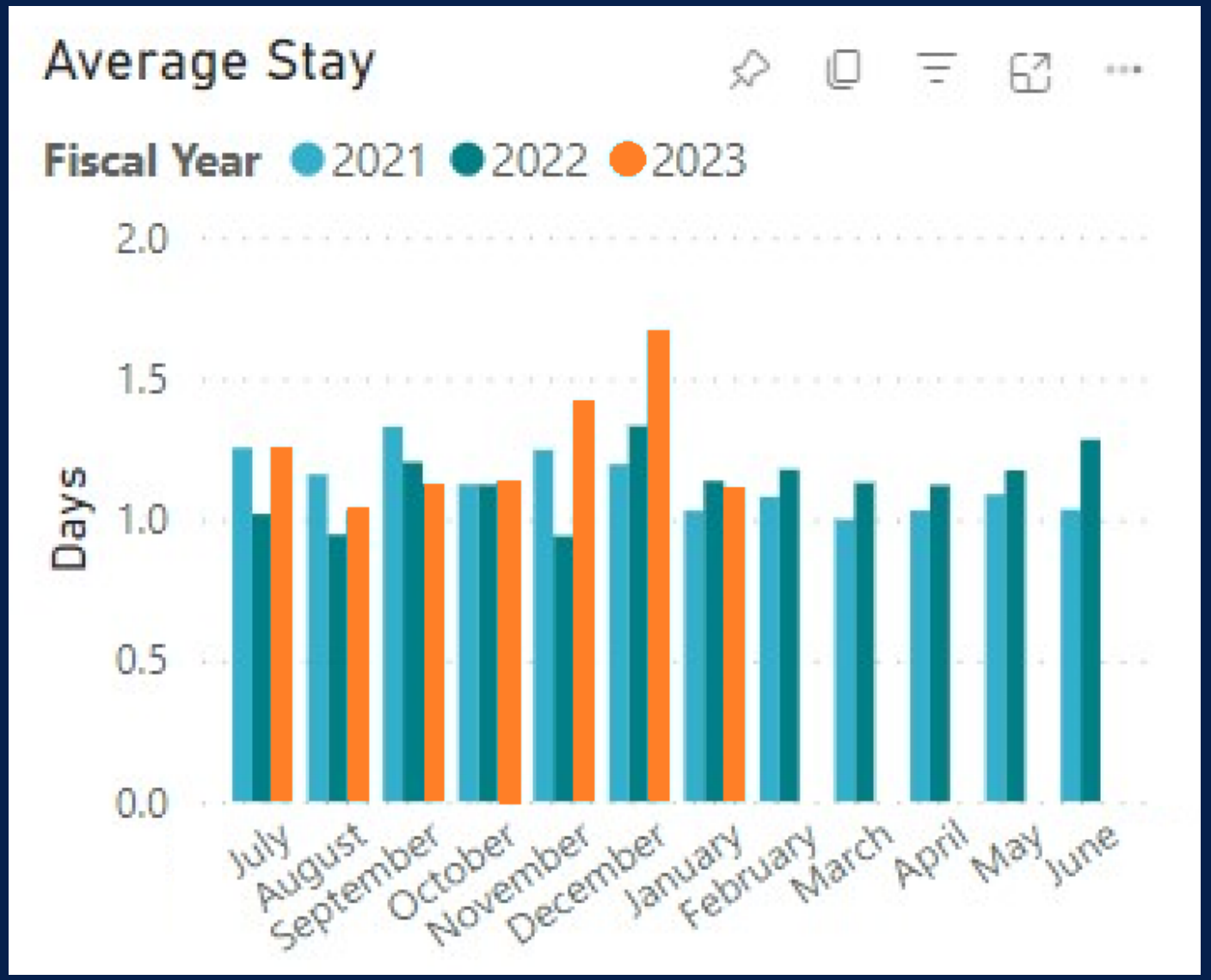
By agreement with local EDs:

Systolic BP >200 or <80
Diastolic BP >120 or <50
Pulse >120 or <45
Confusion
Seizure
Self-reported CIWA >25

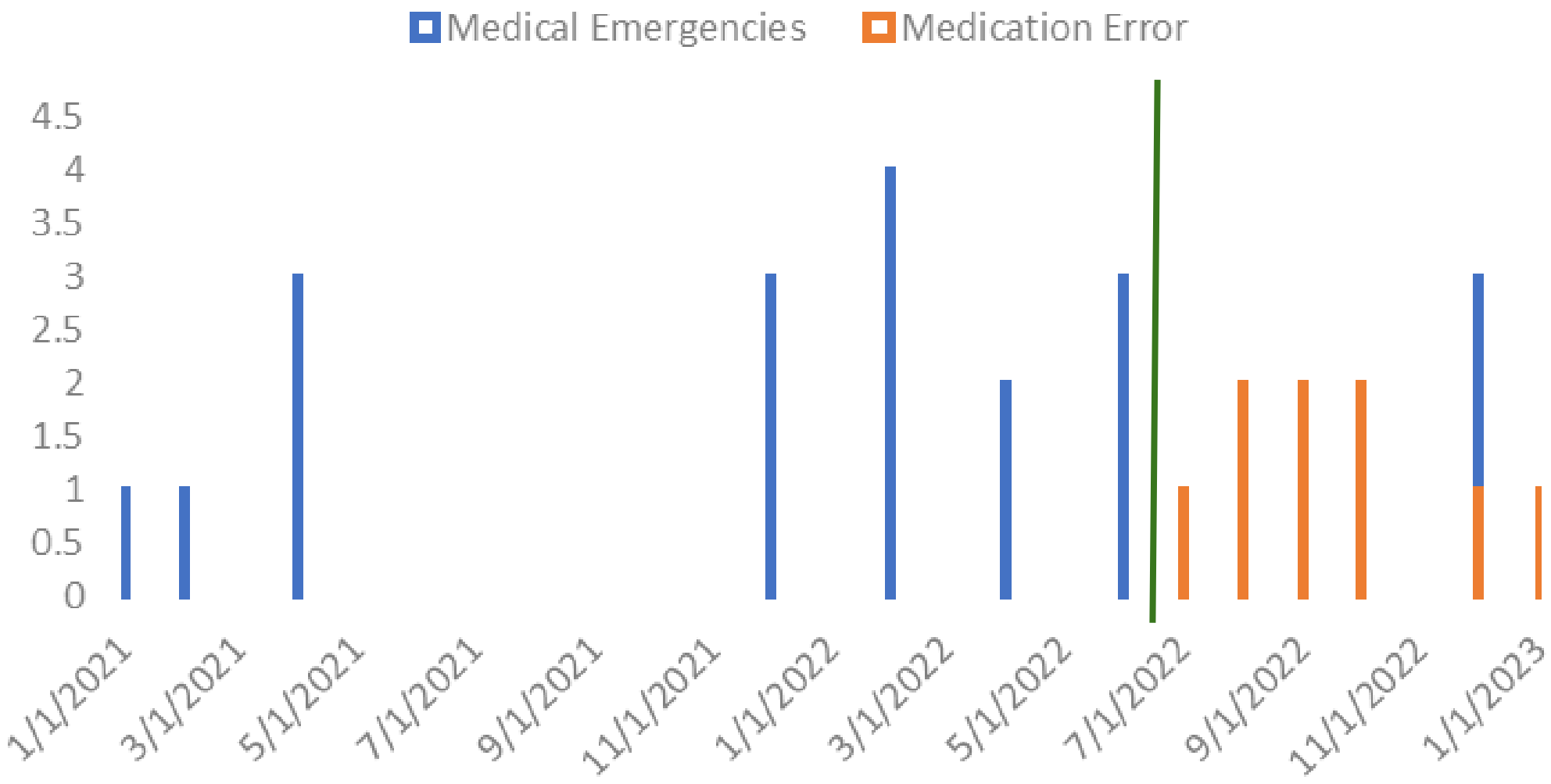
Withdrawal Medication Orders



Average Length of Stay



Critical Events



Case 1

JS, a 46yo male experiencing homelessness dropped off by police for alcohol intoxication. After admit, patient reports "end-stage cirrhosis" 2/2 alcohol use. ED diagnosed hepatic encephalopathy and sent him with lactulose. H/o TIPS, recent gastric bleed and hernia. H/o needing intensive care unit for detox. Recent reported history of alcohol use is unclear and changing, but possibly 750ml/day liquor. BAL 60 on arrival with CIWA of 38.

BP 198/104
K 3.0 BUN 36 Cr 1.23 Ca 7.7 TBili 2.8
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Lipase 374

Ideal: 4.0 WM
Reality: 3.2 WM

Case 2

DC, 48yo female experiencing homelessness, previously well-functioning without psychosis in early 30s, presenting for methamphetamine use. Reporting significant paranoia, believes she's being stalked and poisoned. Hands and feet have 4+ pitting edema and face has many lesions in various states of healing. Patient's interpretation is that she had chemicals thrown on her face and extremities. Face looks like skin picking. She consistently elopes from WM and residential services 2/2 paranoia.

Patient is escalating usage of withdrawal management services, presenting 5x in the past month.

Ideal: 3.7 WM

Reality: 3.2 WM

Case 3

JW, 52yo male experiencing homelessness, self-presented to WM reporting 1L of vodka daily x 1 month. H/o withdrawal seizures. No history of ICU admissions. No medical conditions. No substance use.

BAL on admission was 0.192

BP 142/97, pulse 100

Ideal: 3.7 WM if symptomatic

Reality: 3.2 WM

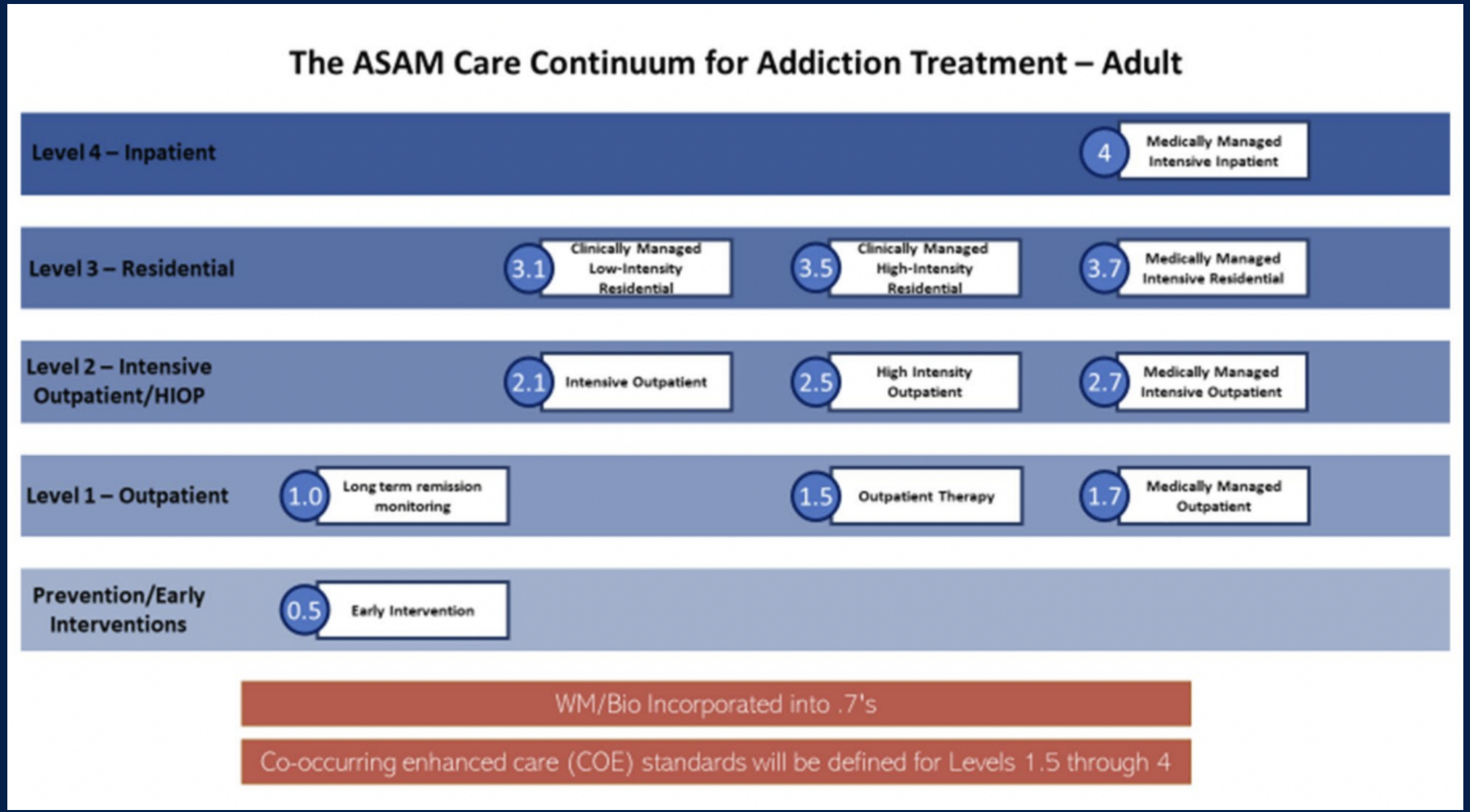
Final Takeaways/Summary

- Detox is a medical condition
- Large gap between 3.2WM and 3.7WM already exists
  - Without triage, transport, or easy admit process into the right level of care → gap becomes even larger
- Within fragmented system, CMHCs need to be able to provide some amount of medical detox services because
  - Homeless, uninsured & Medicaid populations get shunted primarily through community mental health services

Our Solution

By integrating limited medical services into 3.2 WM, we:

- Narrow the gap between standard 3.2 WM and 3.7 WM models
- Avoid costly ED visits
- Agency can avoid the cost of running a 3.7 WM, which we could not afford (as 2 of our sister agencies have found out)
- Provide safer alternative to standard 3.2 WM



https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/publications/criteria-4th-edition/asam-criteria-4th-ed-standards-public-comment-final-(1).pdf?sfvrsn=593c955a_3

Real World Considerations for ASAM

- New proposed ASAM Criteria will encourage transition from WM into other treatment services
  - BUT level of WM does not directly correlate with needed level of treatment service
- What happens to 3.2WM?
- Does not address the need for triage and transitions within the same type of treatment service
  - 3.2WM ↔ 3.7WM

Discussion

- What do you think about the new proposed integration of WM into ASAM treatment levels of care?
- How do your communities manage the large gap between 3.7WM and 3.2WM?
- Other thoughts?
- Questions?

References

1. About the ASAM Criteria, https://www.asam.org/asam-criteria/about-the-asam-criteria
2. Treatment Improvement Protocol (TIP) SEries No. 45. Overview, Essential Concepts and Definitions in Detoxification. Substance Abuse and Mental health Services Administration; Rockville, MD; 2006. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64119/
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