ANCILLARY STABILIZATION AND WITHDRAWAL

The Why And How Of Stabilizing The Patient In A Comprehensive Treatment Setting
About CASAColumbia

• A science-based, multidisciplinary organization
• Focused on transforming society’s understanding of and responses to substance use and the disease of addiction
• Involved in MRT Reform Efforts (e.g., Evaluation for State Health Homes Program)

• Collaboration with OASAS:
  • $10 million SAMHSA SBIRT Grant
  • Co-Develop LOCADTR
  • MCTAC
What is MCTAC?

In partnership with the Community Technical Assistance Center of New York (CTAC), MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC’s Goal
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.
Who is MCTAC
MCTAC Partners
We know you’re busy!

- New regulations
- New billing procedures
- New business partners
- New outcome measures
- Justice Center

Day to Day Management Fiscal Constraints

Patient Centered Care
Should you? Can you?

Part I: Why Have Your Program Start An Ancillary Stabilization and Withdrawal Service?

Part II: What Medical Regimens Are Needed to Safely Carry Out Ancillary Stabilization and Withdrawal?

Part III: How Does My Program Implement An Ancillary Stabilization and Withdrawal Service?
Part I: Why Have Your Program Start An Ancillary Stabilization and Withdrawal Service?
Healthcare has and continues to change

- **The Affordable Care Act** - All health insurance sold on Health Insurance Exchanges or provided by Medicaid must include services for substance use disorders.

- **Mental Health Parity and Addiction Equality Act** - Services must be no more restrictive for substance abuse services than for medical/surgical services.

- **Accountable Care Organizations** - Independent but clinically-integrated health care providers that work together to manage and coordinate health care for a defined population.
Healthcare has and continues to change

- **National Quality Measure Clearinghouse**: Assess the percent of hospitalized patients 18 years of age and older identified with an alcohol or drug use disorder who received or refused at discharge a prescription for approved medication for treatment of alcohol or drug use disorder or received or refused a referral for addictions treatment and follow-up after hospitalization for substance use disorder.

- **Delivery System Reform Incentive Program**: CMS approved New York’s waiver funding ($6.4 billion) will be allocated to the overall goal of reducing avoidable hospitalizations in the State by 25 percent within its five-year lifespan.
Old 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, provide reasonable control of active withdrawal symptoms and/or avert life threatening medical crisis related to the addictive substance.
New Definition

• Detoxification is defined as a medical regimen, conducted under the supervision of a physician to stabilize the patient, 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.

• Improve the patient’s ability to engage in treatment and recovery
What it is and isn’t

• Ancillary Stabilization and Withdrawal is not taking a patient who requires an inpatient stay or the structure and support of residential care and treating them in an outpatient program.

• It is appropriate for the many, many patients who can benefit from outpatient medically supported recovery including those who require the support of residential services.
Pearls

• Do what is best for the patient

• Err on the side of safety

• Monitor Care!

• If at any time the patient develops symptoms of acute withdrawal, they must immediately be transferred to an emergency room and/or Part 816 stabilization and withdrawal 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.

• Document, document, document
Ponder these – Where are we now?

• What assumptions do we make about
  • Patients need to be withdrawn as quickly as is safely possible so that withdrawal medications can be discontinued.
  • Patients are likely to experience mild-to-moderate persistent withdrawal during their transition to the next level of care.
  • Patients are likely to sustain abstinence with this approach?
Ponder these – Where are we now?

• What assumptions do we make about:
  • Do our outcomes support our assumptions for all patients?
  • To what extent does our current system integrate withdrawal management with treatment and recovery?
  • Do you have to be detoxed to enter ongoing treatment?
Where to get withdrawn?

- Although SUD is a complex disorder, Stabilization and Withdrawal management is separate from treatment.
- Cost and Billing requires stabilization and withdrawal management and treatment be separated.
- Do we have the option to provide stabilization and withdrawal management in a setting designed to address ongoing needs, strengths, and recovery?
- What would it take to bring stabilization and withdrawal management to comprehensive service settings?
Why?

• One stop “shopping” – one door for all
• Expand patient centered care
• Better patient engagement right at the beginning and throughout the treatment experience
• Better patient outcomes
• Treating Protracted Withdrawal
• Support behavioral therapies
• Better business model in today’s Managed Care Environment
Why?

• Meeting regional needs

• Opening New Lines of Business

• Emergency Room Diversion

• Adolescent stabilization and withdrawal

• The Pregnant Patient (stabilization, taper off addiction medication is not suggested (Kaltenbach, et.al. OBGYN 1998, 25(1): pp 139-151)

• The Elderly Patient
Revised Clinical Guidance

• In December 2010, OASAS issued Clinical Practice Guidance: Chemical Dependence Outpatient Services Faced with a Patient Displaying Withdrawal Symptoms.

• The guidance document provides a more structured approach in response to concerns raised by Federal authorities in the use of addiction medications.
Ensuring Patient Safety

- The OASAS Part 822 regulations require and expect that Part 822-4 and 822-5 programs are addressing the need to use approved medications as part of treatment and these programs are authorized to provide or arrange for the provision of medication management services.

- There is clear regulatory authority for OASAS to allow Part 822-4 and Part 822-5 programs to provide ambulatory withdrawal services.

- OASAS must ensure that such services are provided in a safe and effective manner.
A Prescribers Decision

The decision to employ the practice in the case of a particular patient is left to the prescribing physician’s clinical judgment.
How is This Different than an 816.8 Medically Supervised Withdrawal Outpatient?

• An MSW-O/P generally has a specific focus and expertise in detoxification, managing withdrawal symptoms, establishing improved stability and referring the patient for ongoing care; presenting a stepped approach.

• An 822 generally has a specific focus and expertise in on-going care which can be supported by addressing mild to moderate withdrawal. Further, offering stabilization and withdrawal services in conjunction with ongoing care may facilitate greater patient engagement and recovery.
Part II: What Medical Regimens Are Needed to Safely Carry Out Stabilization and Ancillary Withdrawal?
It’s not just about the doctor

• While the following section is highly focused on prescribing, one cannot minimize the importance of the nurse and counselor and supporting staff in monitoring and furthering the process.
Within the context of the patient’s overall condition

- Alcohol, Opiates and Sedative dependence allows for successful, slow tapering of addiction medications once stabilization has occurred.

- Alcohol and Sedative dependence can be associated with fatal or near fatal consequences if not stabilized and treated.

- Opiate dependence while uncomfortable for the patient is not associated with fatal or near fatal outcomes even in untreated withdrawal states.
Within the context of the patient’s overall condition

- Cannabinoids (marijuana, hash, etc), Stimulants (cocaine, amphetamines, etc), Hallucinogens (LSD, PCP, etc) and Aromatic Petro-chemical inhalants can cause a level of withdrawal that does not warrant hospitalization; the withdrawal symptoms can be easily treated in the outpatient setting.
Principles of Stabilization and Withdrawal

• Detoxification alone is rarely adequate treatment for SUD dependencies.

• When using medication regimens or other detoxification procedures, clinicians should use only protocols of established safety and efficacy.

• Providers must advise patients when procedures are used that have not been established as safe and effective.

• During stabilization and withdrawal, providers should control patients' access to medication to the greatest extent possible.
Principles of Stabilization and Withdrawal

• Initiation of stabilization and withdrawal treatment 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.
Principles of Stabilization and Withdrawal

• Every means possible should be used to ameliorate the patient's signs and symptoms of SUD withdrawal.
  • Symptom driven PRNs

• 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 SUD recovery educational programs.
Severe Withdrawal or Recent Significant Use

• It is recommended that patients with a Clinical Institute Withdrawal Assessment [CIWA] score greater than 15* or similarly assessed be referred for Observation and/or Medically Managed Stabilization and Withdrawal.

*Who really needs to be in a Hospital? Don’t always go only by the score. Document your findings.
Severe Withdrawal or Recent Significant Use

• Patients clinical findings that are unclear, or give an indication of significant/complicated withdrawal can be evaluated in an observation bed (Observation and/or Medically Managed Stabilization and Withdrawal Service – hospital based).
Accurately Assess Level of Withdrawal

• Patients with co-morbid acute (necessitating immediate care and monitoring) medical or psychiatric disorders should not be considered for ancillary stabilization and withdrawal as an initial service.
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.

*ENGAGEMENT AT THE BEGINNING OF THE TREATMENT EXPERIENCE*
Accurately Assess Level of Withdrawal

• 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 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.)
An 822 can provide medication management

- The service may provide symptom relief and/or addiction medications for alcohol or opiate withdrawal, or a slow taper off of sedatives.

- Keep treating the symptoms, continue the engagement process.
An 822 can provide medication management

- The service must have a physician, registered physician’s assistant 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.
Patient Safety

- The service must ensure patient safety and institute and document vital sign monitoring commensurate with the level of withdrawal and the medication being used.
Drugs and Medications for Stabilization and the Treatment of Withdrawal

• For the Treatment of Withdrawal:
  
  • Alcohol withdrawal: Librium/Ativan/Anti-Convulsants (ex. Tegretol)
  
  • Opiate withdrawal: Methadone/ Buprenorphine/ Clonidine/ Naltrexone
  
  • Sedative withdrawal: Phenobarbital or Substitution
  
  • Nicotine withdrawal: NRT/ Varenicline/ Zyban
  
  • Cannabis: Gabapentin is under study (Barbara Mason, Int. Journal of Neuropsychopharm 2012)
    
    • Gabapentin 1200 mg /day as compared to placebo
    
    • Decrease use and withdrawal
    
    • Improved executive function
Drugs and Medications for Stabilization and the Treatment of Withdrawal

• For Stabilization:
  • Alcohol: Naltrexone/ Acamprosate
  • Opiates: Methadone/ Buprenorphine/Naltrexone
  • Nicotine: NRT/ Varenicline/ Zyban
  • Cannabis: Gabapentin is under study
## Opiate

### Medications
- Methadone ___ mg PO one dose (initial dose as per assessment)
- Methadone 5 mg PO QH PRN X 24 hours for score of 5-12 (MDD ~40mg a day) hold if FRP is less than 90/60
- Methadone 10 mg PO QH PRN X 24 hours for score of 13-24 (MDD ~40mg a day) hold if FRP is less than 90/60
- If the score is >25 contact LP

### Non-opioid agonists
- clonidine / CATAPRES 0.2 milligram orally every ___ hours
- clonidine / CATAPRES 0.1 milligram orally every ___ hours
- clonidine / CATAPRES 0.1 milligram orally every 4 hours PRN for COWS score ≥ 8 (hold if symptomatically hypertensive. Do not use if on fixed clonidine dosing)

### Anti-anxiety
- hydroxyzine / VISTARIL ___ mg orally every ___ hours as needed for agitation or anxiety (IMM = 300mg per day)

### Anti-emetic
- Tigan 300 mg orally every 6 hours as needed for nausea/vomiting
- Tigan 200 mg IM every 6 hours as needed for nausea/vomiting

### Anti-diarrheals
- loperamide / IMODIUM 4 mg new and 2 mg orally after each loose BM not to exceed 16 mg/day

### Analgesics/ Antispasmodics
- acetaminophen 650 mg tab / TYLENOL every 4 hours orally as needed for mild (1-3) pain
- ibuprofen / MOTRIN 600 mg tab orally every 6 hours as needed for mild (1-3) pain
- icosamide / BENYL 20 mg PO every 8 hours as needed for abdominal pain
- Mylanta 30 mL PO every 4 hours for indigestion
- cyclobenzaprine / FLEXERAL 10mg PO TID for muscle spasms

### Vitamins
- thiamine / VITAMIN B1 100 milligram orally or intramuscularly once a day
- neuc-recover 2 capsules tid
- multivitamin 1 po bid

### Laxatives
- magnesium hydroxide / MILK OF MAGNESIA 30 milliliter orally once a day as needed for constipation
- docusate sodium / COLACE 100 milligram orally 2 times a day
- bisacodyl / DULCOLAX 5 milligram orally once a day as needed for constipation
- bisacodyl / DULCOLAX 10 milligram suppository rectally once a day as needed for constipation

### PPD
- tuberculin ppd 5 unit/0.1 mL intradermal

### Admit to:__________________________

### Diet:______________________________

### Activity Level: OOB ad Lib

### Laboratory:

### Consults:
- Psychiatric consult
- Hospitalist consult
- Other__________________________
Opiate

Procedure:
Patients admitted to inpatient detoxification for opiate addiction should be started on the methadone detoxification protocol in accordance with the following guideline:

If daily use is 11 or more bags of heroin patient should be placed on Step 1
If daily use is 8 - 10 bags of heroin patient should be placed on Step 3
If daily use is 4 - 7 bags of heroin patient should be placed on Step 5
If daily use is 1 - 3 bags of heroin patient should be placed on Step 7

After the administration of the first dose, patient should be observed for withdrawal symptoms for a period of at least 30 minutes. If withdrawal symptoms are detected, an additional starting dose of 10 mg. may be provided.

Once stabilized with a starting dose, patients should be tapered in accordance with their placement on the following chart. Single doses are typically utilized and given in the morning. Split doses may be utilized, however, if medically indicated.

<table>
<thead>
<tr>
<th>Step</th>
<th>Single Dose</th>
<th>If Split Dose Is Utilized</th>
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<td>8</td>
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<td>9</td>
<td>15 mg.</td>
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Clinical decision rests with prescriber.
*HHC algorithm as a model. However clinical decision rests with prescriber.
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Alcohol

ALCOHOL DETOXIFICATION

Librium is the medication utilized for treating alcohol detoxification. Degree of withdrawal is defined as CIWA-AR:

Mild withdrawal: scores between 10-19
Moderate withdrawal: scores between 20 and 29.
Severe withdrawal: scores of 30 or above.

Below are the dosing regimens and specific dosages utilized.

<table>
<thead>
<tr>
<th>Mild Withdrawal</th>
<th>Time: 0600</th>
<th>1200</th>
<th>1800</th>
<th>2400</th>
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<tbody>
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<td>Day 1:</td>
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<td>Day 2:</td>
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<td>Day 4:</td>
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<th>1200</th>
<th>1800</th>
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<td>Day 1:</td>
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<td>Day 2:</td>
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<th>1800</th>
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<td>Day 2:</td>
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<td>Day 3:</td>
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<td>Day 6:</td>
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Ativan 2 mg, Im every 2 hours prn. If severe withdrawal maximum 4 doses in 24 hrs. for 3 days.

Clinical decision rests with prescriber
*HHC algorithm as a model. However clinical decision rests with prescriber.
Anticonvulsants

- Carbamazepine (Tegretol®)
  - Alcohol Withdrawal Protocols
    - 600 - 800 MG Per Day in Divided Doses
    - Continue for 2 days then decrease by 200 MG per day
      - Be aware of adverse effects of Tegretol
      - Clinical decision rests with prescriber
*HHC algorithm as a model. However clinical decision rests with prescriber.
Adolescent

- Opiate epidemic has produced a vast, largely untreated group of individuals that with social supports could be treated in an outpatient program very well, provided there is stabilization.
Buprenorphine

• Pharmacologic Uses

• Doses used for opioid addiction treatment is 1-2 MG up tp 16-32 MG

• Short-term Treatment in Adolescents?
  
  • JAMA article by G. Woody et al, (2008) adolescents aged 15 to 21 did better with long term Suboxone than a short (2 week) detox protocol using Suboxone
The Elderly

• Improved buy-in if able to be treated with outpatient and not inpatient services with less disruption to their lives.

• Allows for slower taper of medication.

• Allows for peer treatment.
Do all patients experience protracted withdrawal?

- No. Some clients experience no symptoms after the acute withdrawal stage, whereas others have lingering symptoms. Still others experience an initial clearing of symptoms for the first month or two of abstinence and then develop unpleasant symptoms again. The intensity of symptoms also differs among clients.
Symptoms of Protracted Withdrawal

Treatment of protracted withdrawal can help the patient achieve a successful recovery.

- Anxiety
- Sleep difficulties
- Problems with short-term memory
- Persistent fatigue
- Difficulty concentrating and making decisions
- Alcohol or drug cravings
- Impaired executive control
- Anhedonia
- Difficulty focusing on tasks
- Depression
- Irritability
- Unexplained physical complaints
- Reduced interest in sex
Recognize and treat protracted withdrawal

- The difficult patient who is not engaging in treatment, may be in protracted withdrawal

- Behavioral and medical interventions for Protracted Withdrawal
  - Insomnia
  - Anxiety
  - Depression
  - Craving
Only OTPs Can Dispense Medications

• The physician, when prescribing withdrawal medications (including buprenorphine), should do so using prescriptions that can be filled at an outside pharmacy and the program should not dispense any medication unless they have an Opioid Treatment Program (OTP) certification.
The Prescribing Professional

• 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
  • the medication prescribed
  • a schedule for monitoring vital signs and other withdrawal symptoms
  • behavioral issues
  • must be signed by the prescribing professional within 24 hours.
Treatment Planning

- 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.
Buprenorphine

- 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.
Continuing Care

• 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.
Face-to-Face

• In addition, in a Part 822-4 program, as per Section 822-4.8(e), if patients are seen once per month (which might be the case for long-term buprenorphine patients), they 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).
Pearls

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• Monitor Care!

• If at any time the patient develops symptoms of acute withdrawal, they must immediately be transferred to an emergency room and/or Part 816 stabilization and withdrawal 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.

• Document, document, document
Part III: How Does My Program Implement An Ancillary Stabilization and Withdrawal Service?
A team effort

- Physical space needs
- Equipment needs
- Staff needs/training/retraining
- How to monitor
- Learning Community
Preparing for System Change

- Have discussions of treatment philosophy.
- Explore patient need and interest
- Examine impact on current policies and procedures
- Develop a viable business model
Preparing for System Change

- Establish a change team
- Plan, Do, Check, Act
- Work as a team
- Expect new learning
Preparing Patients and Yourself

- Work to establish a relationship of watchful trust
- Give examples from your experience to help establish a common language
- Encourage and open dialogue
- Acknowledge challenges
- Provide clear choices
Preparing Patients and Yourself

- Help establish expectations
- Share and work in coordination with other staff
- Expect experimentation
- Run confirmatory tests
- Be prepared to reassess
How to obtain authorization to provide ambulatory detoxification services in a certified, Part 822 program:

• This is a voluntary service and is not mandated.
How to obtain authorization to provide Ancillary Stabilization and Withdrawal in a certified Part 822 program:

- Providers must submit a request to the Certification Bureau for authorization to provide Ancillary Stabilization and Withdrawal and approval of protocols by the OASAS Medical Director’s Office.
How to obtain authorization to provide Ancillary Stabilization and Withdrawal in a certified Part 822 program:

• All submissions must be in an electronic format to: CertificationBureau@oasas.ny.gov
Components of the Application

1. Policy on vital sign monitoring to be commensurate with the level of withdrawal and the medication being used.

2. Medical protocol to be used for withdrawal treatment

3. Use of medications post- withdrawal, i.e. naltrexone used once withdrawal has ceased
How to obtain authorization to provide Ancillary Stabilization and Withdrawal in a certified Part 822 program:

4. Adjunct Services:
   • Transportation
   • Hours
   • Telephone coverage
How to obtain authorization to provide Ancillary Stabilization and Withdrawal in a certified Part 822 program:

5. How toxicology testing will be used (i.e., number of tests, intervals, etc.)
How to obtain authorization to provide Ancillary Stabilization and Withdrawal in a certified, Part 822 program:

6. How determinations are made as to which behavioral treatment services the patient receives (part of the normal group structure or specialized withdrawal groups)
How to obtain authorization to provide Ancillary Stabilization and Withdrawal in a certified, Part 822 program:

7. Q.A Plan (How outcomes will be measured; for example: log of untoward events, compliance with monitoring/ staff follow-up, patient retention in 822 v/s detox and discharge)

8. A plan for 24 hour access for emergencies

9. Copy of the Operating Certificate for each PRU where the services may be provided
How to obtain authorization to provide Ancillary Stabilization and Withdrawal certified, Part 822 program:

• OASAS will approve this service as long as it meets the standards set forth above and as necessary and appropriate to meet the service delivery needs of the geographic areas of the State as determined by OASAS.
Service Capacity Limits

• All providers of 822-4 services are eligible with no capacity of patient limits.

• 822-5 services are eligible with a 10% of total capacity limit (capacity is 100 patients, 90 methadone patients and 10 patients on withdrawal treatment status)
Rethinking DETOX

• Stabilization, engagement and then Managed Withdrawal

• We may never get to zero medications

Questions & Comments

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THANK YOU

www.casacolumbia.org