NEW YORK STATE | Office of Addiction Services and Supports

Guidance on Medical Protocols for Withdrawal Management for OASAS Certified Programs

To obtain and maintain a certification from OASAS to provide withdrawal management and stabilization services, programs must obtain and maintain approval of medical protocols from the Chief Medical Officer (CMO) of the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS). Effective immediately, the OASAS CMO will no longer routinely review all medical protocols. Rather, programs will attest that their protocols meet certain criteria when seeking new certification for or continued operation of withdrawal management and stabilization services, including ancillary withdrawal services (i.e., services to alleviate mild-to-moderate withdrawal symptoms and craving in ambulatory and residential settings). The OASAS CMO retains the right to review a program's medical protocols at any time, and if the protocols are found to be out of compliance with the below criteria and/or not to meet the standard of care for any reason, to request revisions to protocols and initiate regulatory action as necessary and appropriate. Example protocols from actual providers (names redacted) that meet the criteria below and represent an adequate standard of medical care are included with this guidance and are available upon request. These examples are not intended to represent perfect medical protocols or to be adopted verbatim, but rather to guide programs in creating protocols that work in their program's setting, align with local resources, and meet the needs of the population they serve. Questions should be directed to addictionmedicine@oasas.ny.gov.

Program medical directors should create and revise medical protocols to be consistent with the following criteria:

Objective monitoring:

- *Objective measures:* Protocols should specify that objective measures of withdrawal severity are utilized, including vital signs monitoring and validated withdrawal scales such as the Clinical Institute Withdrawal Assessment for Alcohol Scale (CIW-Ar), the Clinical Institute Withdrawal Assessment for Benzodiazepines Scale (CIWA-B), and the Clinical Opioid Withdrawal Scale (COWS). Which specific scales to use are at program medical director discretion, as long as they are objective and validated.
- *Toxicology screening:* Protocols should indicate the way in which toxicology screening is utilized to provide clinical information about the type (i.e., urine toxicology) and amount (i.e., blood alcohol content) of substances used, and how this information will inform treatment.

Safety:

- *Assessment:* Protocols should specify that patients are carefully assessed for risk factors for complicated and/or serious withdrawal. Domains of assessment include but are not

necessarily limited to: length and amount of recent use, poly-substance use including benzodiazepines, history of serious withdrawal complications (e.g., intensive care admissions, delirium tremens, seizures, suicidal ideation, self-harming or violent behaviors), unstable co-morbid medical and psychiatric conditions, and signs of withdrawal while still intoxicated.

- *Behavioral health risk:* Protocols should specify how patients are routinely screened for risk of self-harm/suicide and violence, and how this risk is assessed and mitigated for patients at potentially elevated risk. Protocols should also indicate how co-occurring psychiatric disorders are assessed and addressed by the program.
- *Contraindications:* Protocols should clearly state populations and conditions that cannot be safely managed at the designated level of care, and which should therefore be prioritized for transfer to a higher level of care or managed in the designated level of care with special safeguards in place. For instance, withdrawal from alcohol and/or opioids in pregnant women and persons with uncontrolled diabetes often cannot be safely managed with an ancillary withdrawal protocol in a residential or outpatient setting without specific considerations and/or additional clinical monitoring. Persons at risk for alcohol withdrawal and with a history of serious withdrawal episodes, such as delirium tremens or seizures, often need a medically managed withdrawal management and stabilization setting.
- *Preventive Care:* While the risk of intoxication and side effects from withdrawal management medications must be carefully balanced with the risk of acute withdrawal, protocols should generally emphasize prevention of withdrawal from alcohol and other sedative drugs such as benzodiazepines. This means that protocols should emphasize beginning medication treatment at mild-to-moderate levels of withdrawal (i.e., CIWA-Ar of 8-10; CIWA-B of 15-19), and/or changing treatment when withdrawal severity is rising despite treatment (e.g., CIWA-Ar rises from 6 to 9). Thiamine and folic acid must be provided for all patients with alcohol use disorder.
- *Emergency protocols:* Protocols should clearly indicate when and how patients are emergently assessed by a medical professional and transferred to a higher level of care (i.e., a hospital or intensive care if already in hospital).
- *Overdose prevention:* All protocols should specify that all patients receive overdose prevention education and are offered a naloxone kit or a prescription for naloxone prior to discharge. Given the increasing prevalence of high potency opioids (e.g., fentanyl) in many drugs, even individuals without identified opioid use disorder are at risk of overdose.

Involvement of medical professionals:

- Protocols should establish clear and objective criteria for when a medical professional (i.e., a physician or nurse practitioner) is re-consulted after initiation of withdrawal treatment. These criteria should include but are not necessarily limited to when vital signs are unstable, when acute medical problems or adverse drug effects are suspected, when withdrawal severity is increasing despite treatment (even if still mild-to-moderate), and when withdrawal severity is assessed to be high-moderate-to-severe (e.g., CIWA-Ar of 13 or greater; CIWA-B of 30 or greater; COWS of 20 or greater).

Stabilization on medication-assisted treatment:

- ***Opioids: For patients with opioid use disorder and in opioid withdrawal, transition to and stabilization on medication-assisted treatment (MAT) rather than tapering withdrawal management medications is the safest and most evidence-based standard of care.*** Not only does MAT increase rates of continued follow-up in the community and enhance chances for recovery, but the risk of overdose death is high after detoxification from opioids, and MAT is protective. ***All protocols should emphasize stabilization on MAT as routine practice, with rare exceptions for patient refusal or significant contraindications.*** Protocols should generally begin with using buprenorphine to treat symptoms of opioid withdrawal, followed by presenting MAT options to patients once they are comfortable (i.e., remaining on buprenorphine, transitioning to methadone, or transitioning to long-acting naltrexone injection). When a program has the ability to perform a methadone induction, protocols can include starting with methadone as an option for appropriate patients, as indicated. For patients who choose long-acting naltrexone injection upon admission, protocols can include an opioid-free detoxification option prior to naltrexone induction. To accommodate patients who refuse all MAT options once comfortable on buprenorphine, protocols can include a buprenorphine taper option, though discharging patients without any MAT should be the exception.
- *Alcohol:* MAT for alcohol use disorder can be very helpful for many patients, is an evidence-based practice, and is under-utilized. Therefore, protocols should include routinely offering naltrexone and/or acamprosate to patients with alcohol use disorder and starting them on their choice of MAT prior to discharge.

Patient comfort:

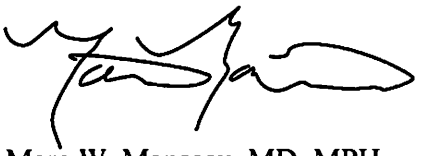
- *Timing:* When medically safe and appropriate, protocols should begin treatment of opioid withdrawal at mild-to-moderate ranges (e.g., COWS 8-12).
- *Ancillary medications:* Protocols should make ample use of ancillary medications for withdrawal management, such as clonidine (but with a maximum daily dose of 1-1.2mg and with blood pressure and heart rate cut-offs), sleep medications, anti-nausea medications, anti-diarrheal medications, pain medications (but with precautions for acetaminophen with alcohol withdrawal and gastric protection for non-steroidal anti-inflammatory medications), and anti-anxiety medications. Especially for inpatient and residential programs, these ancillary medications can include the judicious use of benzodiazepines for opioid withdrawal, with appropriate, careful monitoring and plans to discontinue benzodiazepines started at the program prior to discharge.
- *Tobacco:* Patients with tobacco use disorder or nicotine dependence should be offered nicotine replacement therapy to prevent nicotine withdrawal while they are at the program and unable to use tobacco products, even if they are not willing to consider tobacco cessation.

Level of care assessment:

- *LOCADTR:* Protocols should specify that the LOCADTR 3.0 is performed upon admission and that the Concurrent Review Module of the LOCADTR is performed at least once during the program admission, with the frequency and timing of subsequent Concurrent Review Modules determined as clinically appropriate given the care setting.

Transition to continued care:

- *Overdose prevention:* Protocols should specify that all patients are discharged with a naloxone kit in-hand or a prescription for one, as well as education about overdose prevention and other relevant harm reduction education.
- *Continuity support:* Protocols should indicate how engagement with continued care at the next level of care will be enhanced (e.g., a warm handoff, peer engagement, check-in phone calls, a next-day appointment, etc.), or should reference related program policies and protocols that describe this.



Marc W. Manseau, MD, MPH
Chief of Medical Services
New York State Office of Alcoholism and Substance Abuse Services