
PARTNERSHIP
HEALTHPLAN
of CALIFORNIA
A Public Agency

Agenda

12:00 to 12:05 PM

Welcome/Housekeeping Rules

Liezel Lago, Continuing Education Program Coordinator

12:05 to 12:10 PM

Introduction

Robert L. Moore, MD, MPH, MBA
Chief Medical Officer, Partnership HealthPlan of California

12:10 to 1:15 PM

First Do No Harm:
Medical Clearance Exam for Alcohol Withdrawal

Robert Moore, MD MPH MBA & Jeffrey DeVido, MD MTS
Partnership HealthPlan

1:15 to 1:25 p.m.

Question & Answer Discussion

1:25 PM

Adjourn

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No Conflict of Interest

Presenters have signed the Conflict of Interest form and has declared there is no conflict of interest and nothing to disclose for this presentation.

*- Application for CME** credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.*

***CME is for physicians and physician assistants and other healthcare professionals whose continuing educational requirements can be met with elective CME.*

- Provider approved by the California Board of Registered Nursing, Provider #CEP16728 for 1 hours.

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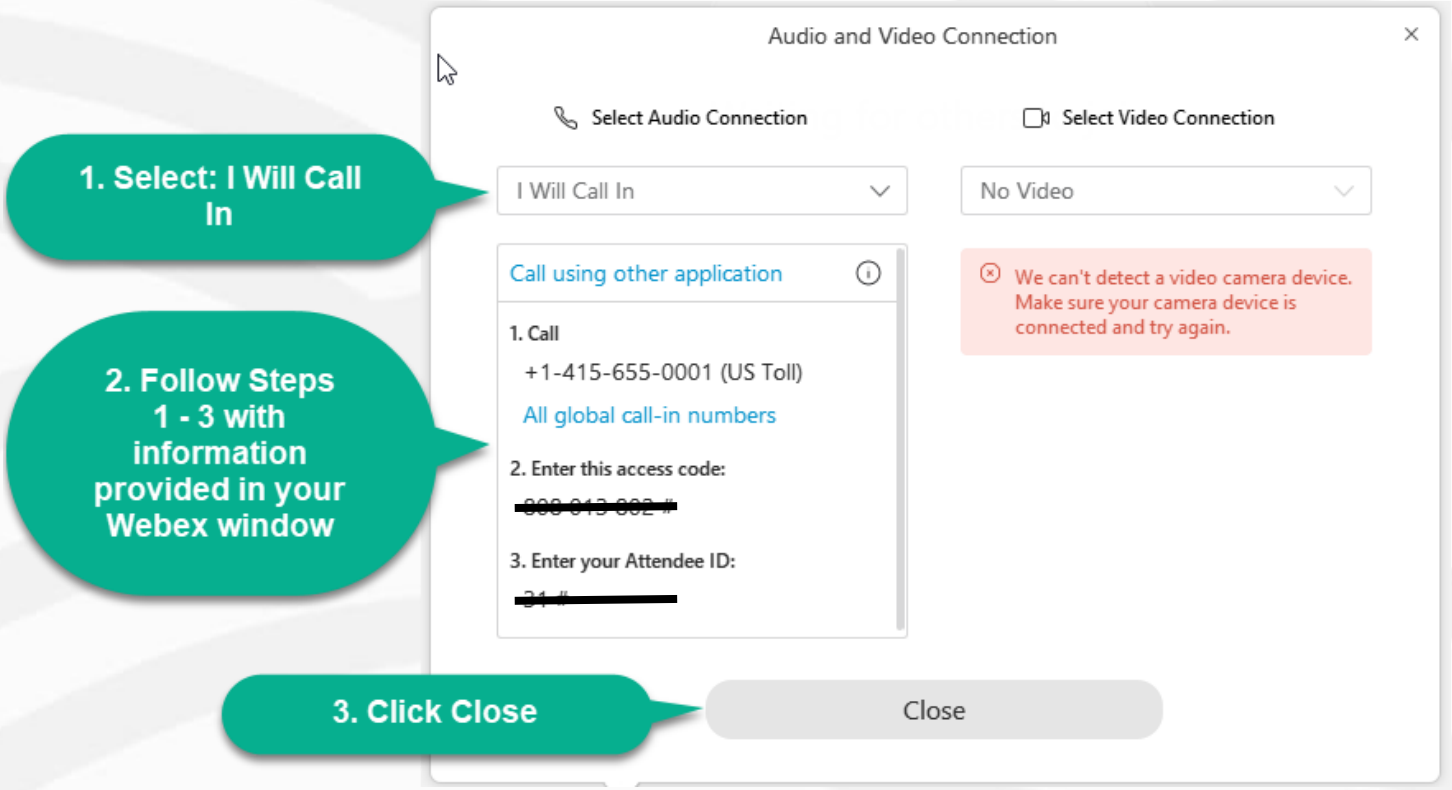
Housekeeping

To avoid echoes and feedback, we request that you use the telephone instead of your computer microphone for listening and talking during the webinar.

Housekeeping

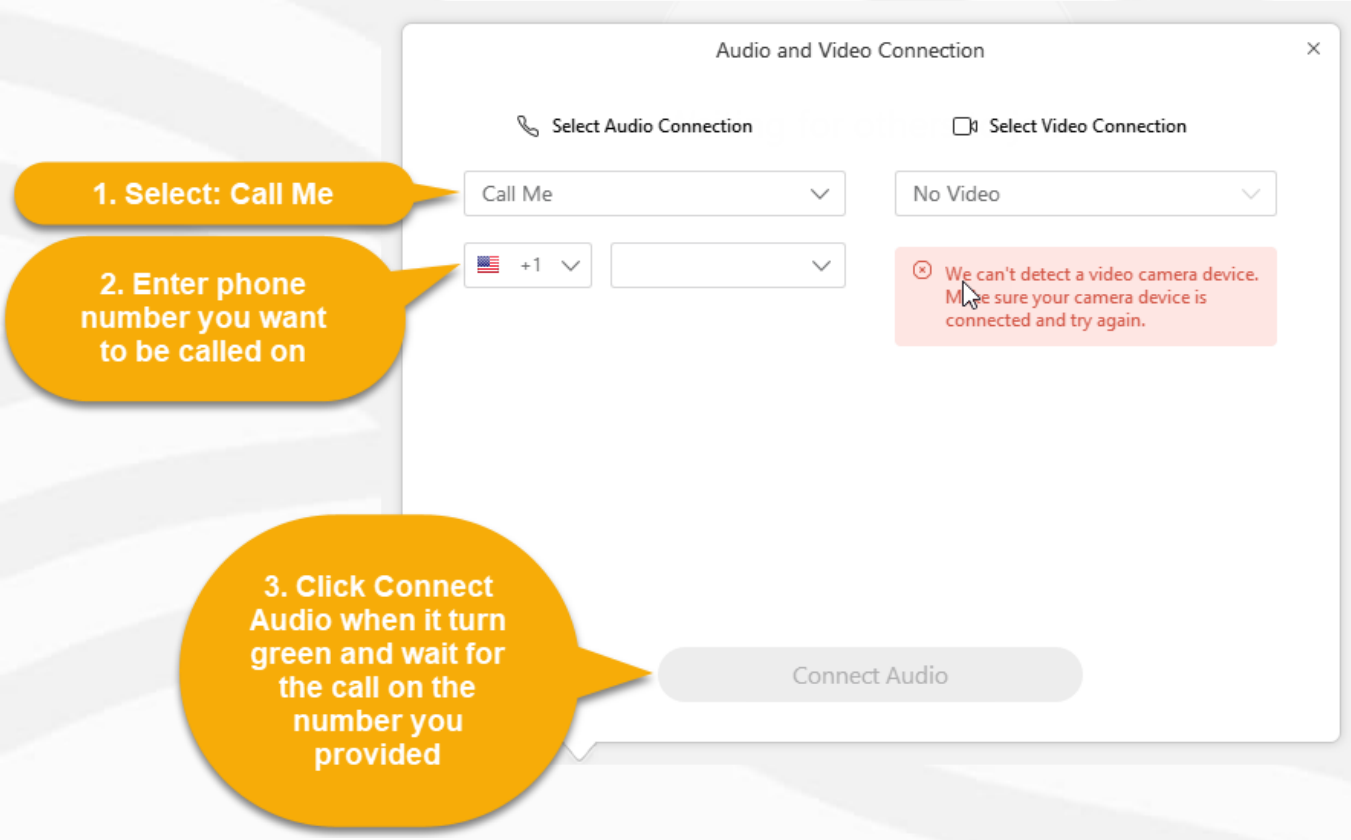
1.) I Will Call In -
Participant to call event number, enter access code and attendee ID.



Housekeeping

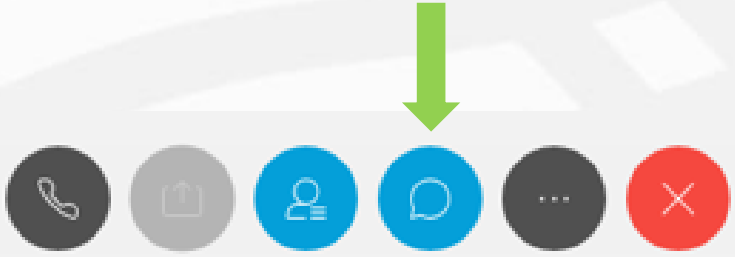
2.) Call Me -

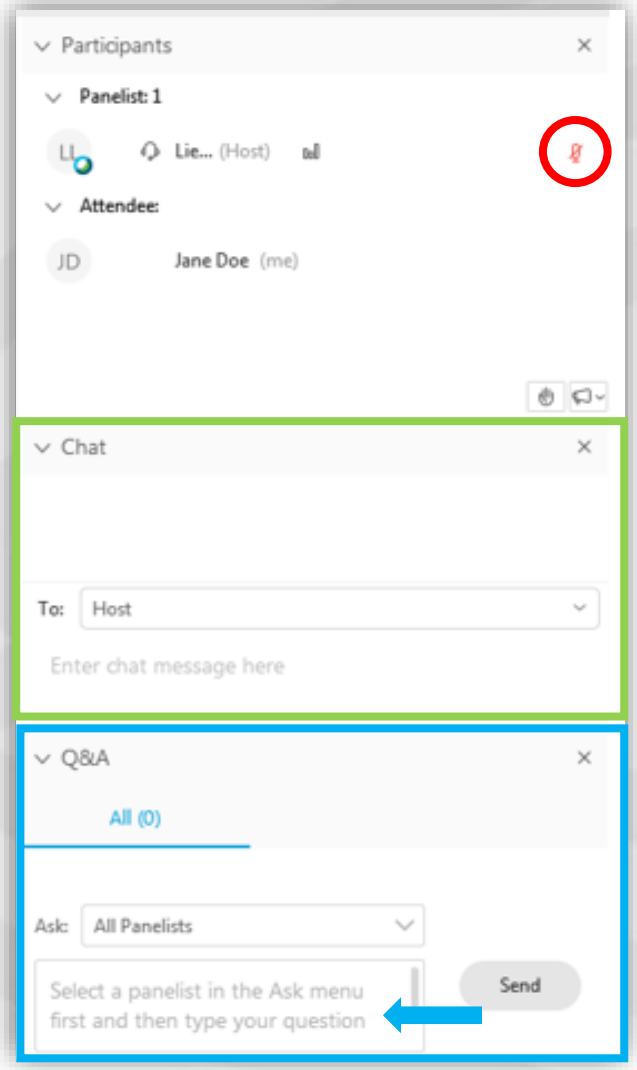
Participant enters a number to call, Webex will call number, participant answers the phone and follows voice instructions.



Housekeeping

- All participants have been muted to eliminate any possible noise interference/distraction.
- If you have a question or would like to share your comments during the webinar, **please type your comment in the Chat box or your question in the "Q&A" box.**





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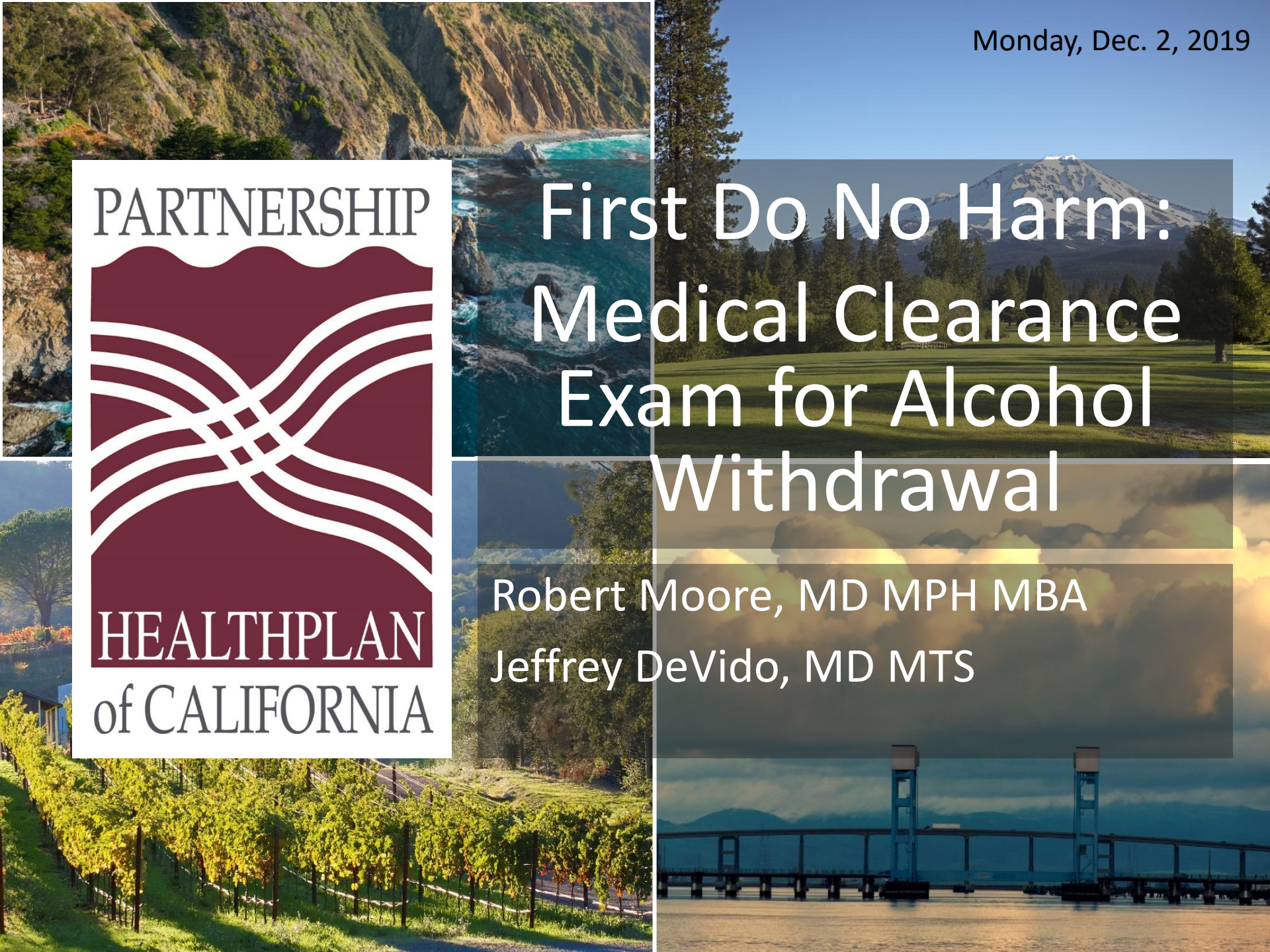
Monday, Dec. 2, 2019



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First Do No Harm: Medical Clearance Exam for Alcohol Withdrawal

Robert Moore, MD MPH MBA

Jeffrey DeVido, MD MTS

Medical Clearance Exam

- Required for placement in residential detox, residential SUD treatment program, county jail, and sobering centers.
- Landscape changing: Changing delivery system for SUD for Medi-Cal will increase need for clearance exams.
- Same overarching process anytime addressing a patient with chronic alcohol consumption who is contemplating abstinence.
- High risk of morbidity and mortality if clearance given and patient sent to an inappropriately low level of care.

Medi-Cal and SUD Treatment

- SUD treatment parity mandated with Affordable Care Act
- State has been slow in achieving this for Medi-Cal
- PHC region: who pays for Medi-Cal SUD services
  - County run systems: Marin, Napa, Yolo
  - PHC Regional Delivery System scheduled to start February 2020: Humboldt, Shasta, Siskiyou, Modoc, Lassen, Trinity, Mendocino, Solano counties
  - Counties with Medi-Cal SUD services paid by state (counties provide some services): Del Norte, Lake, Sonoma

Case Presentation Vallejo

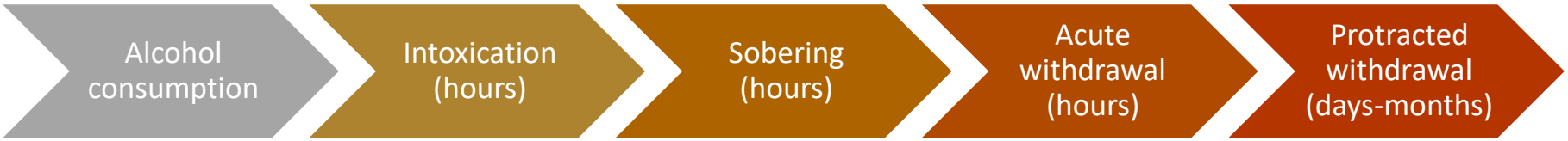
- 45 year old man arrested for disorderly conduct
- Brought to the Emergency Department
- Seeking Medical Clearance for direct admission into a non-medical residential sobering center, with subsequent plan to abstain from alcohol
- How do you decide it is safe to clear him?

What Could Happen to Him?

Case I, continued

- Sleepy but rousable easily
- Able to answer simple questions with slight slurring of speech
- Oriented to person, place, month, year
- Reports consuming one 750 ml bottle of Whisky per day for the past month
- Lives alone in apartment
- Has a mild chronic cough

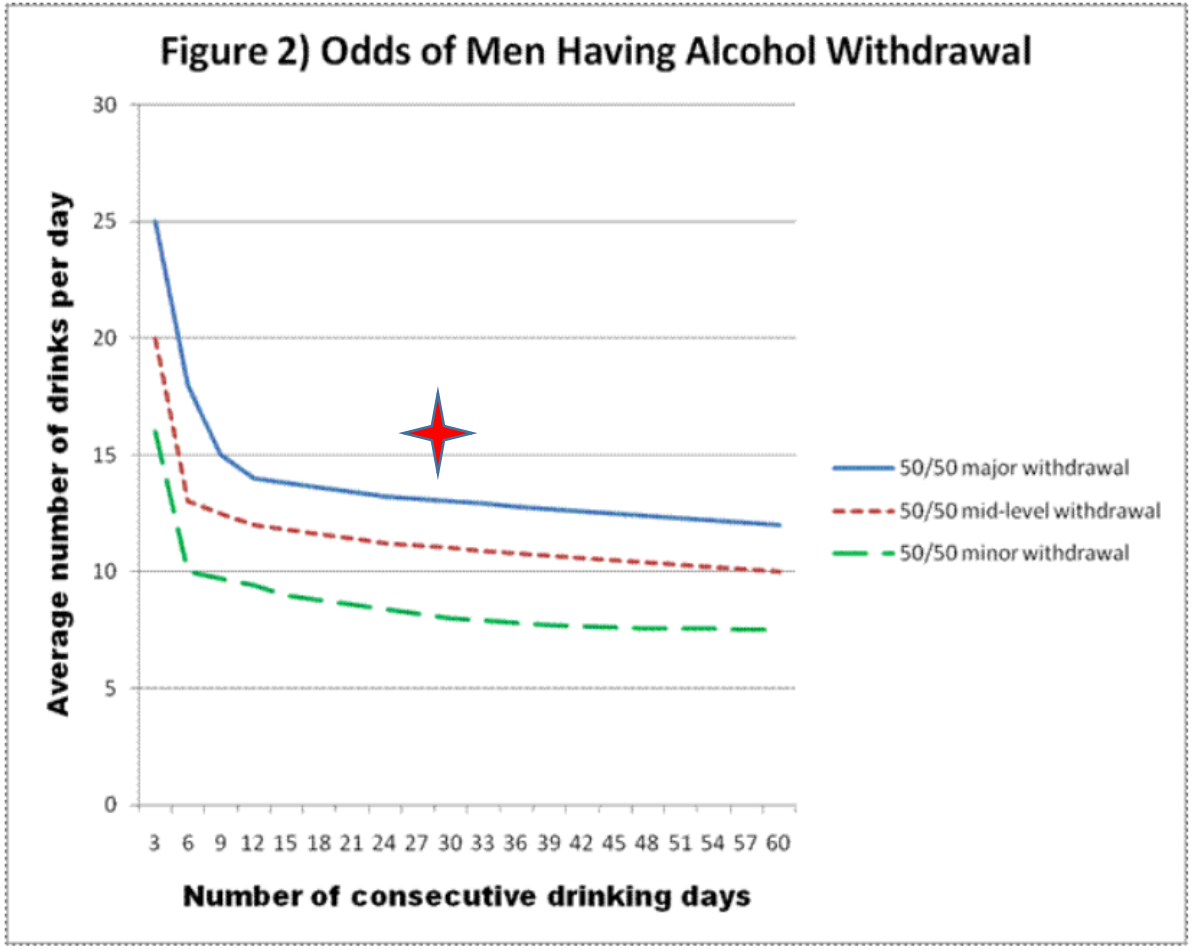
Stages of Intoxication and Withdrawal



How much does he drink?

- One drink = 1.5 ounces of distilled spirits (40% alcohol)
- 1.5 ounces = 45 ml
- 750 ml per day = 16.7 drinks per day

Risk of withdrawal



From HAMS Harm Reduction Network, 2015

Where Else Could He Go?

- Inpatient at Acute Care Hospital (Covered by Medi-Cal)
- Specialty SUD Treatment Hospital (rare in Nor Cal)
- Emergency Department Observation
- Jail (has RN)
- Sobering center (without medical supervision)
- Medically supervised residential recovery program
- Residential recovery program (non-medically supervised)
- Home with a responsible friend/family member
- Home alone
- Street (homeless)

Where should he go?

- Poll 1

- Inpatient Acute Care Hospital
- Jail
- Sobering center (without medical supervision)
- Medically supervised residential recovery
- Need more information to decide

Case I, Continued

Past History:

- Also uses methamphetamine and marijuana daily
- Has been told he has cirrhosis
- Diagnosed with bipolar disorder, but no current psychosis or suicidal ideation
- No prior history of withdrawal seizures/medically complicated withdrawal

Vitals:

- Pulse 101
- BP 140/94
- Resp 14
- O2Sat 93%
- Temp 99.8
- BMI 29

Case I, Continued

Labs: (abnormal findings)

- CBC: Hb 11, MCV 102, WBC 12K
- Electrolytes/Renal: K 3.4, CO2 19, Cr 1.2, BUN 30, Glucose 110, A.Gap 10
- Mag, phosphorus normal
- LFTs: AST 98 ALT 51
- Total Cholesterol 120
- INR 1.2
- Blood alcohol level: 300 mg/dl
- Urine tox screen: positive for methamphetamine

Radiology:

- Head CT no bleed
- CXR: no infiltrates

Standardized Assessment of Withdrawal Risk

- Standardized tools: choose one!
  - For withdrawal symptom severity:
    - Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-Ar), (required by MediCal for inpatient admission)
    - Brief Alcohol Withdrawal Scale (BAWS)
    - Short Alcohol Withdrawal Scale (SAWS)
    - Newcastle Alcohol Withdrawal Scale (AWS)
  - For risk of alcohol withdrawal:
    - Prediction of Alcohol Withdrawal Severity Scale (PAWSS)
    - Luebeck Alcohol-Withdrawal Risk Scale (LARS)

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CIWA-Ar

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

Standardized Assessment of Withdrawal Risk

- High risk
  - High score on standardized tool (e.g. CIWA-Ar > 15)
  - Comorbid risk plus medium score on standardized tool (e.g. CIWA-Ar between 8-14)

Example of CIWA-Ar Assessment

- Nausea and Vomiting: 1
- Tremor: 0
- Paroxysmal Sweats: 1
- Anxiety: 1
- Agitation: 4
- Tactile Disturbances: 2
- Auditory Disturbances: 0
- Visual Disturbances: 0
- Headache: 0
- Orientation: 3

Total score 12: Moderate Risk

What Factors Increase Risk?

- Multiple substances used
- Mental illness: schizophrenia, bipolar disorder with active psychosis, suicidality, etc.
- Prior medically complicated alcohol withdrawal(e.g., seizures/delirium)
- Unstable housing status
- Significantly abnormal lab test
- Medical Risk Factors
  - Pregnancy
  - Kidney failure
  - Liver Failure
  - Angina
  - CHF
  - Severe HTN

Case I, Conclusion

- Chronic Alcohol Intoxication, BAL: 300
- Multiple substances used
- Cirrhosis, compensated
- Bipolar disorder without psychosis or suicidality
- High risk for major alcohol withdrawal
  - Reported alcohol use history plotted on WD risk graph
  - CIWA-R score moderately high with co-morbid conditions

- **Not** cleared for sobering center or jail
- **Admitted to acute hospital** for withdrawal management under medical supervision
- Patient had two seizures in first 2 days and developed Delirium Tremens starting on the 4th hospital day.

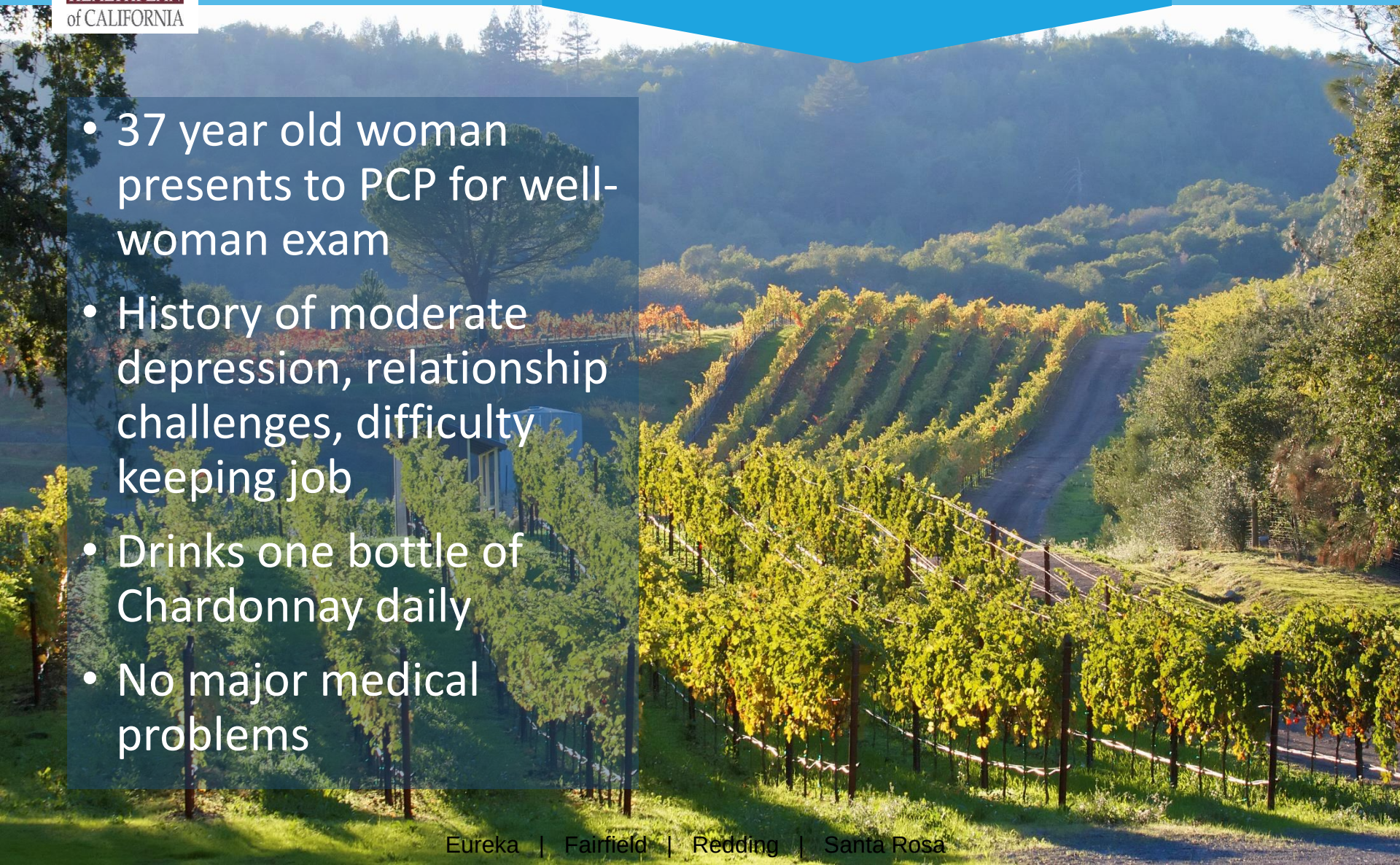
Inpatient Detox

Withdrawal management at an acute care hospital covered in two possible ways:

- PHC covers:
  - If admitted for another reason, and also incidentally withdrawing from alcohol, or
  - If patient develops complications of severe alcohol withdrawal
- State Medi-Cal covers: If no other reason for admission
  - Retrospective TAR review: will review H&P to demonstrate meets criteria for Voluntary Inpatient Detox (VID)

  - For details see APL 18-001 Voluntary Inpatient Detoxification

Case Presentation Sonoma



- 37 year old woman presents to PCP for well-woman exam
- History of moderate depression, relationship challenges, difficulty keeping job
- Drinks one bottle of Chardonnay daily
- No major medical problems

Case II, con't

Normal Physical Exam

Health maintenance exam screenings:

1. Depression: PHQ2 positive, PHQ9 score of 10
2. Anxiety screen (2 question): positive
3. Alcohol Misuse Screening: One question screen positive; AUDIT-C: 8/12
4. Drug use screen: Negative
5. Intimate Partner Violence Screening (PVS): Negative
6. Adverse Childhood events screening: 2/10

Brief intervention for alcohol use disorder: Confirmed Alcohol Use Disorder, Chronic Alcohol Use. Patient indicates a desire to quit drinking but is worried about withdrawal.

Where should she go to manage withdrawal symptoms?

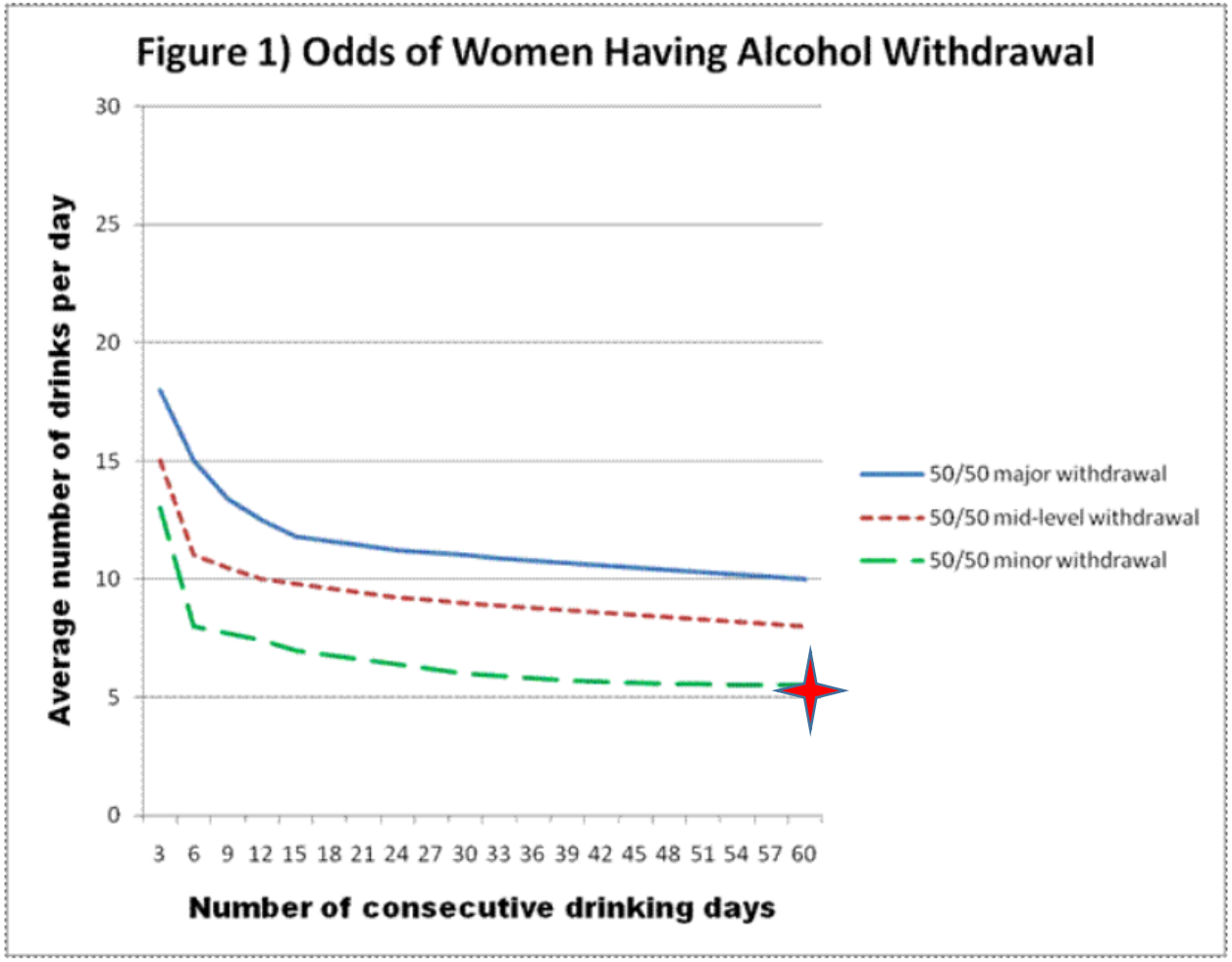
- Poll 2

- Sobering center (without medical supervision)
- Medically supervised residential recovery
- Home alone with outpatient counseling
- Need more information to decide

How much does she drink?

- One drink = 5 fluid ounces of wine
- 5 fluid ounces = 150 ml
- 750 ml bottle of wine = 5 drinks

Risk of Withdrawal



From HAMS Harm Reduction Network, 2015

Medications for Mild Withdrawal

- Gabapentin 300mg #28, 1 in am, 1 mid-day, 2 at bedtime for 7 days

Standard support medications for Alcohol Withdrawal

- Thiamine 100mg for 3 days
- Multivitamin with minerals daily
- Ondansetron 4mg SL q4 hours prn nausea
- Loperamide 2mg: 1-2 prn loose stools
- Acetaminophen 500mg q6hr, prn pain
- Hydroxyzine 25-50mg q6hr, prn anxiety

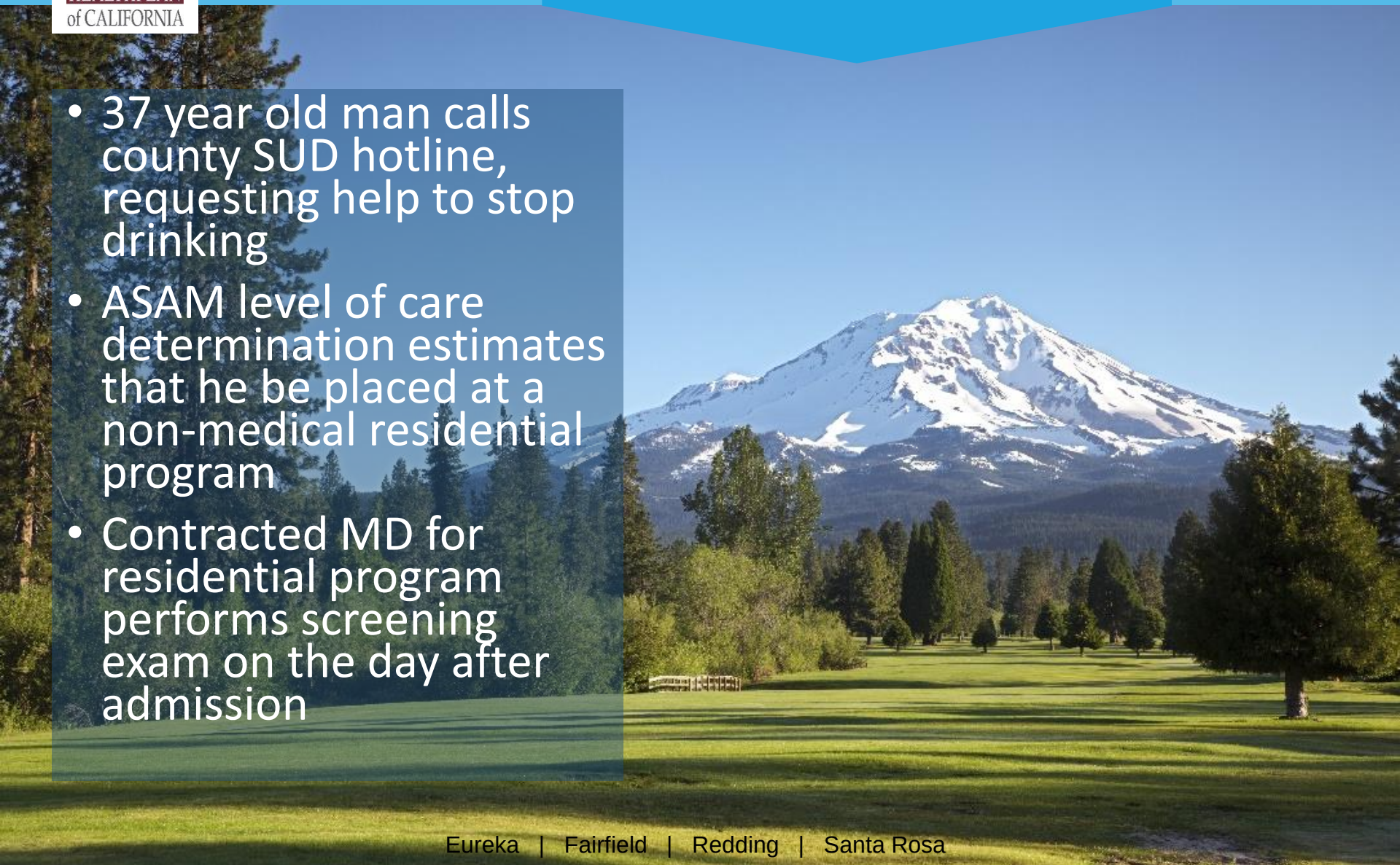
Summary Case II

- Alcohol Use Disorder, Chronic Alcohol Use, not Currently in Withdrawal
- Moderate Depression
- No at-risk co-morbidities

- Disposition: home with medications to treat potential mild withdrawal symptoms
- Follow up: in 2-3 days by phone to assess severity of Withdrawal and reinforce need for counseling follow up
- Begin outpatient counseling for depression and AUD within next 7 days.

Case Presentation Shasta

- 37 year old man calls county SUD hotline, requesting help to stop drinking
- ASAM level of care determination estimates that he be placed at a non-medical residential program
- Contracted MD for residential program performs screening exam on the day after admission



Case III, con't

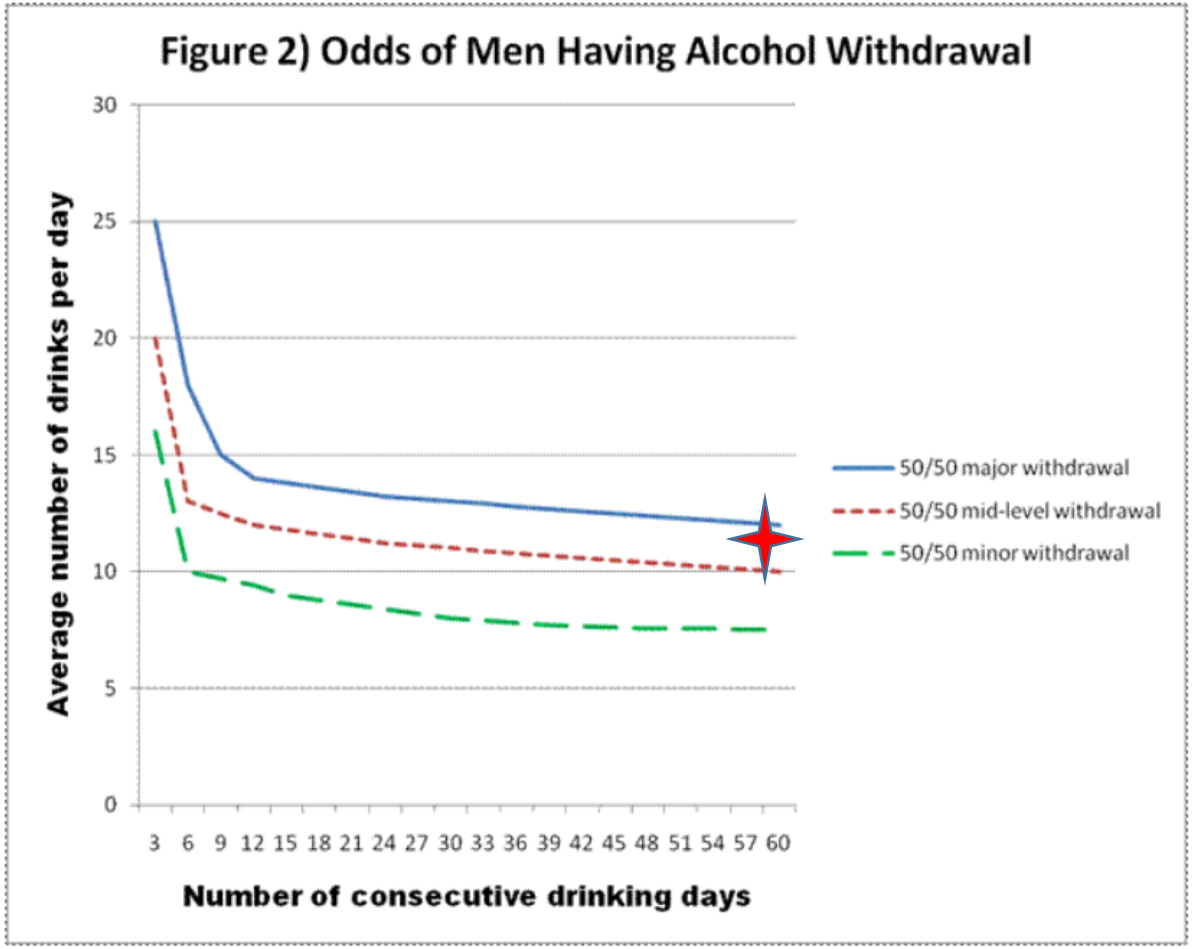
- Drinks 12 beers per day, for years.
- Smokes two joints of marijuana per day
- No history of withdrawal seizures or withdrawal delirium, but does feel shaky and anxious when stops drinking
- Moderate depression, no bipolar or schizophrenia
- No known DM, HTN, Liver Disease, Kidney Disease

How much does he drink

- One drink = 12 ounces beer

- 12 beers per day = 12 drinks per day

Risk of withdrawal



From HAMS Harm Reduction Network, 2015

Case III, con't

Vitals

- Pulse 110
- BP 140/95
- Resp 16
- Temp 99.5
- BMI 35

Exam: tremulous arms and tongue

Dry mucous membranes

Abdomen: non-tender

Alert, oriented x 3

CIWA-Ar score of 12

Where should he go?

- Poll 3

- Inpatient Acute Care Hospital
- Medically supervised residential recovery
- Sobering center (non-medical)
- Residential recovery program (non-medical)
- Home with support

Case III, Con't

- Labs ordered:
  - CBC
  - CMP
  - Blood Alcohol Level
  - Mag, Phos
  - Urine tox screen
  - Quantiferon (for TB)
- Medications
  - Chlordiazepoxide (Librium) 25mg, #20 tablets: 4 now, 2 every 6-12 hrs for 1 day, then 1 every 6 hours for 1 day, then 1 twice a day for 1 day, then 1 at bedtime.
  - Routine supportive medications (doses on earlier slide)
    - Thiamine
    - MVI
    - Ondansetron
    - Loperamide
    - Acetaminophen
    - Hydroxyzine
  - Follow up phone call 1 day to assess withdrawal

Where Medical Clearance Evaluations Occur

- Emergency Department
- Inpatient Hospital
- Psychiatric Crisis Centers
- Jails
- Residential Facilities
- Primary care office

Getting it Right Every Time

- Written Protocol/Policy for organization
- Build history and physical template into electronic health record
- Train all clinicians
- Audit: chart review of medical clearance exams for completeness

PHC has sample policy and progress notes available for the ED and for the outpatient setting. LOCATION ON WEBSITE.

Disposition Case III

- On one day follow-up call, staff at the residential center say the patient is vomiting, confused, and very shaky. He has received four doses of Chlordiazepoxide

Labs from the prior day: Phosphorus 1.1, Magnesium 1.1, K 3.0, Anion Gap 14, CO2 12, Hb 9.0, Creatinine 2.5, BUN 40, Blood Alcohol Level 150, Quantiferon pending

Physician directs the staff to take the patient to the emergency room for admission to the hospital.

Pitfalls for screening physicians

- Pressure to not admit to the hospital
- Pressure to stick to the plan that the patient arrived with
- Time pressure: inadequate history and physical exam
- No assessment of withdrawal risk

Primum non nocere – First do no harm


Questions?

Contact Us

- Robert Moore, MD

rmoore@partnershiphp.org

- Jeffrey DeVido, MD

jdevido@partnershiphp.org