



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF STATE OPERATED HEALTHCARE FACILITIES

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ALCOHOL & DRUG ABUSE TREATMENT CENTER

Date of Revision 01/11/2018

Subject: ADATC Referrals to Acute Unit

To Whom It May Concern,

To provide better customer service within our catchment area we have consolidated our admissions team to a few individuals to: 1) ensure that the admission criteria we are utilizing are based on accepted standards of care (ASAM criteria) and 2) that there is consistency in information given to referring agencies. We hope that the information in the following paragraphs will assist you in helping us improve the referral and admission process. The paragraphs have **bolded topics** that may help you skip to the sections that address the topics of most concern to you and your organization.

Screening focused on clinical presentation- We have heard concerns from the community, particularly on the issue of overutilization of area Emergency Rooms. We have markedly simplified our requests for information and laboratory data to the following: 1) Copy of NC State Regional Referral Form- fully completed; 2) Appropriate Authorizations; 3) Relevant Clinical information (e.g. assessments, progress notes, MAR's, etc.) from the current assessment; 4) Urine Drug Screen (**dipstick is acceptable**) - must include results for opiates, benzodiazepines, amphetamines, and cocaine; 5) Blood Alcohol or Breathalyzer; 6) Pregnancy test (dipstick is acceptable) – if indicated 7) Completed CIWA (alcohol and benzodiazepine withdrawal) and or COWS (opiate withdrawal) 8) Lab tests as indicated by clinical presentation (See next section).

In an attempt to make referral easier, we do not **require liver function tests or Chemistry Profiles, etc., unless the Clinical situation merits it. This means that an assessment can be performed at a community agency (non-emergency room)—that has a physician, physician assistant, or Family Nurse Practitioner on site. This medical professional can perform a clinical assessment to determine the correct ASAM Level of care required and whether additional testing is indicated.** Attachment 1 is provided as a tool that highlights the most common reasons that patients may need an ASAM Level IV facility.

Involuntary versus Voluntary Patients- Commitments require that a patient be either dangerous to themselves or others **AND** be a substance abuser or mentally ill. JFK-ADATC's Division Mandated primary mission for the Acute Care Unit (hereafter ACU) is to handle: 1) Involuntary Patients that have either a Substance Use Disorder OR 2) Involuntary patients with a Substance Use Disorder combined with a Mental Illness. When ADATC Acute Care bed supply is limited--- **these patients get preferential admission as required by the involuntary commitment statutes.** When the census is lower, we do accept voluntary patients needing crisis services that are provided by our unit, whether or not detoxification is needed.

Involuntary Substance Abuse Commitments:

Voluntary Referrals-PLEASE Don't confuse ACU and ARS- Please be aware that the process of referring patients to ACU for either Crisis Intervention or detox is **different** than the referral of Voluntary patients to JFK-ADATC for rehabilitation services. These are two separate processes that should not be confused.

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Primarily Mental Health Patients- Patients, who have mental health treatment needs that supersede the need for substance treatment, may be best served in a facility whose primary focus is Mental Health Disorders. If you have questions about this, the please call for a consultation.

Medical Issues to be Considered-(Voluntary or Involuntary)- Physicians and Physician Extenders (PA's and FNP's) referring patients should be fully aware that we provide Medical Services at an **ASAM III.7 level**. ***JFK -ADATC does not have the capacity to start or administrate Intravenous fluids or medications and does not have an on-site laboratory.*** Patients should be able to utilize oral methods of nutrition and medication intake for four hours prior to discharge to JFK-ADATC. In general, patients considered for admission to JFK, are patients that could otherwise be discharged home if psychiatric and/or inpatient substance abuse treatment was not needed. Attachment 1 is a list of Medical Issues that should be closely reviewed to make a decision as to whether the patient is best served at an ASAM III.7 or ASAM IV level facility.

Short Term – versus- Long Term Unit- Our ACU and ARS units provide short term treatment with an average length of stay of 21 days. Patients who are known to require longer treatment are best referred to facilities that are equipped to handle long term treatment needs. This allows us to serve more patients that fall within the capability and mission of our facility.

Pregnancy: Will assess on case-by-case basis.

Hearing Impaired- Inpatient substance abuse services for the hearing impaired are provided at Broughton Hospital.

Sincerely,

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Attachment:

1) Patients that may need ASAM IV level care.

The following clinical problems may be better served at an **ASAM IV level facility**. If the patient meets one or more of these criteria and the referring facility wishes to refer them to ADATC—then a phone conversation with one of our Medical Staff would be needed.

Detoxification Issues (Signs of Complicated withdrawal).

1. CIWA-AR score greater than 20.
2. Blood alcohol > 100mg/dl with CIWA-AR greater than 15
3. Blood alcohol level greater than 300 mg/dl
4. Blood pressure greater than 180/110 or
5. Pulse greater than 120.
6. History of seizures or delirium tremens that significantly increases the likelihood of complicated detox.
7. Withdrawal seizures not controlled by medication given at area emergency department.
8. Daily ingestion of sedative/hypnotics above the maximum recommended dose for greater than four weeks.
 - a. **Equal to or greater than 10mg Alprazolam (Xanax), Clonazepam (Klonopin), Lorazepam (Ativan)**
 - b. **Equal to or greater than 60mg Valium**
9. Patient presenting with substance induced psychosis or acute psychotic episode.
10. Patient requesting detoxification using methadone or buprenorphine as the detox agent.
11. **Methadone equal to or greater than 80mg.**
12. **Buprenorphine equal to or greater than 16mg.**

Medical Issues (Other than Detoxification)-

1. Recent serious head trauma or loss of consciousness without a negative emergency department evaluation and intervening period of stability.
2. Patient has a medical condition that requires acute care inpatient monitoring or evaluation (see state medical clearance policy).
3. Overdose: Patient should meet criteria for discharge to home before transfer. For patients who are medically stable, but are exhibiting residual sedation, discuss with the receiving medical physician or NPMP. (Acetaminophen- see 4c below).
4. Diabetics: Blood sugar level should be between 65-500 and no evidence of DKA. If initial blood sugar is less than 65, hypoglycemia should be treated and patient observed in the ED. Patient can be transferred after blood sugar remains greater than 65 for 2 or more hours and is able to take PO intake. For clinical situations outside of these parameters, discuss with the receiving medical physician or NPMP.
5. WBC should be >2000/ Absolute Neutrophil Count > 1000 and less than 20,000. For WBCs outside of these parameters, discuss with the receiving medical physician or NPMP.
6. JFK-ADATC provides very basic skilled nursing interventions. (E.g. routine dressing changes, minimal ADL assistance). If you have questions regarding our capacity in this area, please call for clarification.
7. Stable Vital Signs: For elevated blood pressure, patient should have no signs of hypertensive urgency. Patients with a blood pressure greater than 200 systolic and/or 110 diastolic and no signs of a hypertensive urgency/emergency should have blood pressure therapy initiated consistent with ACEP guidelines.

ACEP Patient Management Recommendations: Do asymptomatic patients with elevated blood pressures benefit from rapid lowering of their blood pressure?

Level A recommendations. None specified.

Level B recommendations.

1. Initiating treatment for asymptomatic hypertension in the ED is not necessary when patients have follow up.
2. Rapidly lowering blood pressure in asymptomatic patients in the ED is unnecessary and may be harmful in some patients.

3. When ED treatment for asymptomatic hypertension is initiated, blood pressure management should attempt to gradually lower blood pressure and should not be expected to be normalized during the Initial ED visit.

8. When patients are sick enough to require additional labs, then please consider the following issues when making a referral:

- a. Serum potassium level should be greater than 2.8 and less than 6. For patients with a low potassium level, there should be no active vomiting for at least 4 hrs. For K+ of 2.8-3.1 patient should receive potassium replacement in the ED. No replacement is needed for levels greater than 3.1 if not vomiting and able to eat normally. For potassium levels outside of these parameters, discuss with the receiving medical physician or non-physician medical provider (NPMP) or the ED may repeat the level.
- b. Serum sodium level should be 128 or higher. If less than 128, must be documented history of chronic hyponatremia or repeat level demonstrating that sodium is not falling and no evidence that the low sodium is causing mental status changes. For sodium levels outside of these parameters, consult the receiving medical physician or NPMP or the ED may repeat the level.
- c. Acetaminophen overdose: Patient should have a 4-hour Acetaminophen level of less than 140 (or other appropriate non-toxic level if greater than 4 hours from ingestion) and have no other signs of significant overdose such as significantly elevated liver enzymes or persistent vomiting. INR levels and hepatic transaminases are requested if liver involvement is suspected.

Behavioral Issues:

1. Patient with a history of severe and persistent psychiatric instability without periods of mental illness and substance abuse recovery accompanied by significant agitation or aggression with recent physical restraint for safety.
2. Patients that have co-morbid SPMI Psychiatric and SA diagnosis are reviewed on a case by case basis. Issues that will be reviewed to make the determination as appropriateness include: Aggression, delirium, homicidal or suicidal ideation with intent to elope, delirium, disorientation, degree of psychoses, severe dissociative states, refusal to take meds, unstable violent sex offenders, forensic patients with high elopement risk, patients needing prolonged psychiatric stays.

Psychosis:

1. Grossly disorganized thoughts, speech and/or behaviors
2. Command hallucinations or any hallucinations powerful enough they may interfere in patient's ability to focus in group activities, regardless of etiology.
3. Paranoia that will make it difficult to engage in large group activities
4. Bizarre Delusions.

Mood Symptoms:

1. Acute Mania with psychotic features.
2. Recent (within the last 7 days) self-injurious behavior requiring medical attention, or any self-injurious behavior while in the current setting.
3. Recent (within the last 7 days) suicide attempts.
4. Strong suicidal ideation with plan and/or intent and patient is unable to contract for safety.
5. Recent (within the last 7 days) homicidal statements, threats towards others or violent behaviors.
6. Any patient who engaged in acting out behaviors while in the current setting requiring chemical and/or physical restrains or those who attempted to elope from the current setting.
7. Any patient who has been at our facility and engaged in assaultive behavior towards a staff member or peer including striking/kicking, spitting, hair pulling, scratching, choking, etc.
8. Any patient who has been at our facility and engaged in sexual activity with a peer or staff member or those who have engaged in sexually provocative and/or predatory behaviors.

9. Any patient, who, within the last 6 months, has been at our facility and engaged in threatening behavior including threatening to throw furniture, break doors/windows, threats of bodily harm to others, etc.

Other Psychiatric Conditions:

1. Patients with an eating disorder that is ongoing, weigh less than 85% of normal BMI, or those who have recently (within the last 14 days) engaged in severe calorie restriction, bingeing or purging behaviors.
2. Severe debilitating anxiety in which patient is unable to attend groups or requires a private room.

Patients We May be Able to Treat: Must Be Assessed on a Case-By-Case Basis

Psychosis:

1. Mild to moderate acute or chronic auditory hallucinations that are not command in nature.
2. Mild to moderate paranoia with intact reality testing.
3. Visual or tactile hallucinations that do not interfere in patient's ability to function.

Mood Symptoms:

1. Recent suicidal ideation with or without a plan but patient verbalizes desire for treatment and is able to contract for safety.
2. Mood states consistent with a hypomanic episode or resolving mania without current psychotic features.