MANAGEMENT OF ALCOHOL WITHDRAWAL IN A SUPPORTIVE HOUSING SETTING

Addressing the Complex needs of individuals with alcohol use disorder in the 1811 Eastlake Program

PRESENTERS

HARBORVIEW MEDICAL CENTER
UW Medicine

DESC

- Sonya Starr, ARNP
  Onsite medical provider
  at 1811 Eastlake

- Patrick Duffie
  1811 Eastlake Project Manager

PRESENTATION OUTLINE

- Definitions and context
- Role of non-medical staff
- Role of medical staff
- What happens next
- Discussion / Q & A

1811 EASTLAKE– A BRIEF HISTORY

- Opened in 2005, 1811 provides HF/HR supportive housing to 75 formerly homeless individuals with AUD
- Move in process prioritizes the highest utilizers
- A controversial model with a long road to realization
- 1811 has been the subject of rigorous research and evaluation:
  - Significant cost effective outcomes
  - Decreases in alcohol use and alcohol related problems
  - Motivation to change vs. required treatment participation

1811 – SERVICES OFFERED

Much offered, Nothing required

- 24 hour staffing
- On-site housing and CD CM services
- On-site primary care
- Outreach MH connections
- Medication/Alcohol/Tobacco Management

1811 MEDICAL SERVICES

- Downtown Emergency Service Center partnership with Harborview Medical Center
- Full time on-site RN support transitioned into split ARNP / RN support
- Medical services:
  - Triage / Urgent evaluation
  - Acute concerns
  - Chronic illness
  - Preventative care

UNIQUE MEDICAL NEEDS

- 1811 residents are a population with unique and complex medical needs

- Many of the chronic conditions associated with alcohol use disorder lead to frequent ER visits and hospital admissions

- Onsite medical provider has a multidimensional role:
  - Caring for residents
  - Interfacing with outside medical providers to coordinate care
  - Working with staff to enhance understanding of resident's medical needs

DEFINITIONS

- Alcohol Use Disorder (AUD) is a chronic, relapsing brain disease
  - Compulsive alcohol use
  - Loss of control over intake
  - Negative emotional state when not drinking

  - Withdrawal symptoms are experienced by roughly 50% of patients with AUD when they stop or reduce drinking
    - Symptoms are generally seen within 6-24 hours of cessation or significant reduction in alcohol intake
    - Generally, if no symptoms of withdrawal manifest within the first 24 hours, withdrawal is less likely, although onset is variable, and may not occur until blood alcohol level reaches zero.

ALCOHOL WITHDRAWAL

- Symptoms of withdrawal may be:
  - Mild: insomnia, tremor, anxiousness, alcohol craving, sweating, headache, racing heart (heart rate can be greater than 120), loss of appetite, nausea and vomiting
  - Severe:
    - Alcohol hallucinosis – typically visual hallucinations WITHOUT alterations in cognition, disorientation or altered vital signs
    - Seizures – Can occur as a single event, or clustered. Risk of seizures increases with repeated episodes of withdrawals
    - Withdrawal delirium (Delirium tremens or "DTs") – features disturbances in attention and cognition, possible associated with agitation, and in severe cases, significantly elevated heartrate and blood pressure, fever, and drenching sweats. Without appropriate medical treatment, mortality was as high as 20%. With appropriate treatment, mortality ranges between 1 and 4%

CASE STUDY

- Mr. Thompson is a 52 year-old male who typically drinks 1 pint of vodka daily. Yesterday, he drank his typical pint, in addition to sharing “a few beers” and second pint with one of his friends. He comes to the front desk at 10 AM and states, “I think I’m withdrawing.”

NON-MEDICAL ASSESSMENT

- When in doubt call 911
- Assess for severity of symptoms
- Do they want to detox?
- Next drink problem solving

CASE STUDY CONTINUED

- Mr. Thompson is a 52 year-old male who typically drinks 1 pint of vodka daily. Yesterday, he drank his typical pint, in addition to sharing “a few beers” and second pint with one of his friends. He comes to the front desk at 10 AM and states, “I think I’m withdrawing.”
- Mr. Thompson states he is out of alcohol and out of money. He thinks he may have some friends in the building that could help him out, but he also already owes some of them money. He will next get money from his payee in 6 days.

MEDICAL ASSESSMENT

- Initial assessment
- History of alcohol and drug use:
  - Time of last alcohol use
  - Duration, frequency and quantity of use
- Prior withdrawal experience
- Medical and mental health history

CASE STUDY CONTINUED

- Mr. Thompson is a 52 year-old male who typically drinks 1 pint of vodka daily. Yesterday, he drank his typical pint, in addition to sharing “a few beers” and second pint with one of his friends. He comes to the front desk at 10 AM and states, “I think I’m withdrawing.”
- Mr. Thompson states he is out of alcohol and out of money. He thinks he may have some friends in the building that could help him out, but he also already owes some of them money. He will next get money from his payee in 6 days.
- Mr. Thompson has a history of high blood pressure, COPD, and depression. He takes 2 blood pressure medications, 2 types of inhaled medications and an antidepressant.

CIWA PROTOCOL

- The Clinical Institutes Withdrawal Assessment Scale for Alcohol (CIWA-Ar) is the most widely utilized and most studied scale for the assessment of severity of withdrawal symptoms.
  - **Nausea/vomiting:** 0 - 7 (0 = none; 7 = constant nausea and frequent vomiting)
  - **Anxiety**: 0 – 7
  - **Sweating:** 0 – 7
  - **Tactile Disturbances:** 0 – 7
  - **Visual Disturbances:** 0 – 7
  - **Tremors:** 0 – 7
  - **Agitation:** 0 – 7
  - **Orientation and clouding of sensorium:** 0 – 4
  - **Auditory Disturbances:** 0 – 7
  - **Headache:** 0 - 7

CIWA PROTOCOL SCORING

- Score of 0 – 9: Minimal or absent withdrawal
- Score of 10 – 19: Mild to Moderate withdrawal
- Score of >20: Severe withdrawal
- In the inpatient setting, vital signs are also evaluated as part of the protocol

CASE STUDY CONTINUED

- Mr. Thompson is a 52 year-old male who typically drinks 1 pint of vodka daily. Yesterday, he drank his typical pint, in addition to sharing "a few beers" and second pint with one of his friends. He comes to the front desk at 10 AM and states, "I think I'm withdrawing."
- Mr. Thompson states he is out of alcohol and out of money. He thinks he may have some friends in the building that could help him out, but he also already owes some of them money. He will next get money from his payee in 6 days.
- Mr. Thompson has a history of high blood pressure, COPD, and depression. He takes 2 blood pressure medications, 2 types of inhaled medications and an antidepressant.
- He has a history of withdrawal seizures, and had an episode of DTs during withdrawal once, about 5 years ago.
- He endorses intermittent nausea without vomiting, a moderate level of anxiety, and a mild headache. He denies any visual, tactile, or auditory hallucinations, and disorientation. He is not agitated

MANAGEMENT OF WITHDRAWAL

- Depending upon the presentation and severity of symptoms, patients require different levels of management:
  - Outpatient
  - Inpatient in a treatment facility
    - Non-medical management – counselor and peer support
    - Medical monitoring – 24 hour nursing with provider consultation
  - Inpatient management in a hospital setting
    - General Medical unit
    - Intensive Care unit

DETERMINING THE APPROPRIATE LEVEL OF CARE FOR WITHDRAWAL

- How likely are severe withdrawal complications?
- Are there other acute or chronic conditions which may complicate management?
- Is it likely that other substances are involved?
- What social supports are available?

MANAGING WITHDRAWALS AT 1811

- Evaluation of symptoms
- Medical History
- “Tolerable” vital signs and CIWA < 19
- Future planning (what happens tomorrow)
- Plan for check-in
- Emergency alcohol distribution

WHAT HAPPENS NEXT

- Limits to how many times we will manage
- Discussions about other interventions
  - Payee
  - Alcohol monitoring
  - CD connection
  - Inpatient

CAN THIS MODEL BE "NON-MEDICAL"?

- Alcohol withdrawal is a medical diagnosis with specific criteria
- Deciding the severity of withdrawals can be a matter of following basic protocol, but also involves understanding the intricacies of the effects comorbid disorders
- Alcohol withdrawals are potentially fatal
- Is alcohol a medicine? Can it be treated as such?

DISCUSSION

- What are some potential roadblocks to implementing this model in existing housing?
- How could this model be applied in housing where there is no medical staff on-site? What would be the potential issues, and could they be easily resolved?
- Are there situations where on-site management is not appropriate? How can staff be trained to recognize these situations?

QUESTIONS?