weitzman institute

Translating Research into Practice on Alcohol and Polysubstance Use Disorders by Educating the Interprofessional Primary Care Team

Conducting Assessments and Referrals

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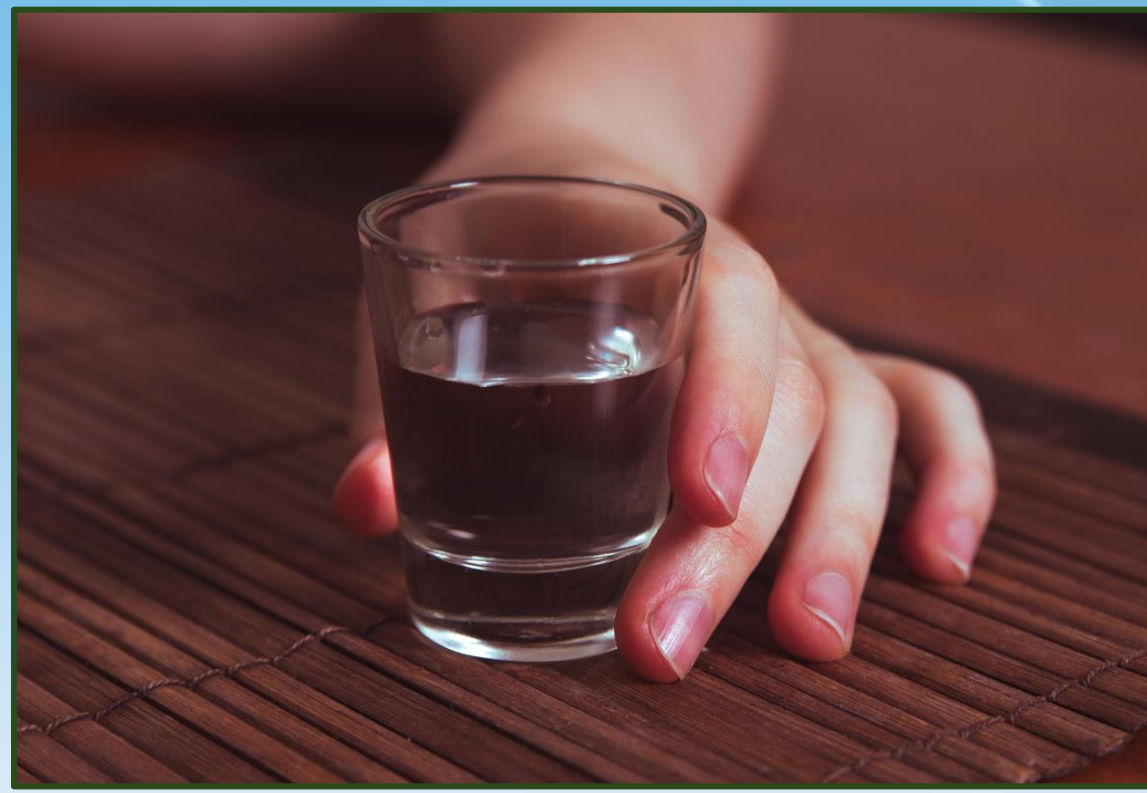
Learning objectives

By the end of this session, participants will be able to…

1. Assess risk for alcohol withdrawal based on individual and environmental risk factors
2. Incorporate American Society of Addiction Medicine (ASAM) Level of Care Criteria in treatment planning
3. Identify common misperceptions about treatment
4. Outline steps to develop and maintain a referral network

Heavy drinking in primary care

- Population estimates range from **5-10%** report episode of heavy drinking
- About **10-20%** of those reporting heavy drinking days (HDD) are likely to have moderate to severe AUD
- Number of HDDs (5+ in a 3-month period) correlates with severe AUD
- Lifetime heavy drinking years can predict AUD severity (and can supplement standard screening for current and past year use)
- Those with chronic obstructive pulmonary disease (COPD), hypertension (HTN), and chronic liver disease had higher odds of being heavy drinkers



Ambulatory vs. Inpatient Withdrawal Management

Patient factors

- Preference
- Readiness
- Medical/psych comorbidities
- Prior withdrawal history
- Use history

Environmental factors

- Caregiver support
- Housing
- Access to clinic/clinic staff

Factors for Hospitalization in Patients with AWS

Absence of caregiver support, unstable dwelling situation

Active psychiatric conditions

Consumption of > 8 drinks per day

Failure to benefit from ambulatory treatment

History of severe alcohol withdrawal < 1 year ago

Medical conditions (e.g., non–alcohol-related seizure disorder, clinically significant abnormal results on laboratory testing, unstable chronic condition, inability to tolerate anything by mouth, suspected head injury)

Physiologic dependence on opioids or other substances

Risk of imminent relapse, harm to self or others, or low commitment and questionable cooperativeness

Severe and complicated withdrawal symptoms (CIWA-Ar ≥ 19)

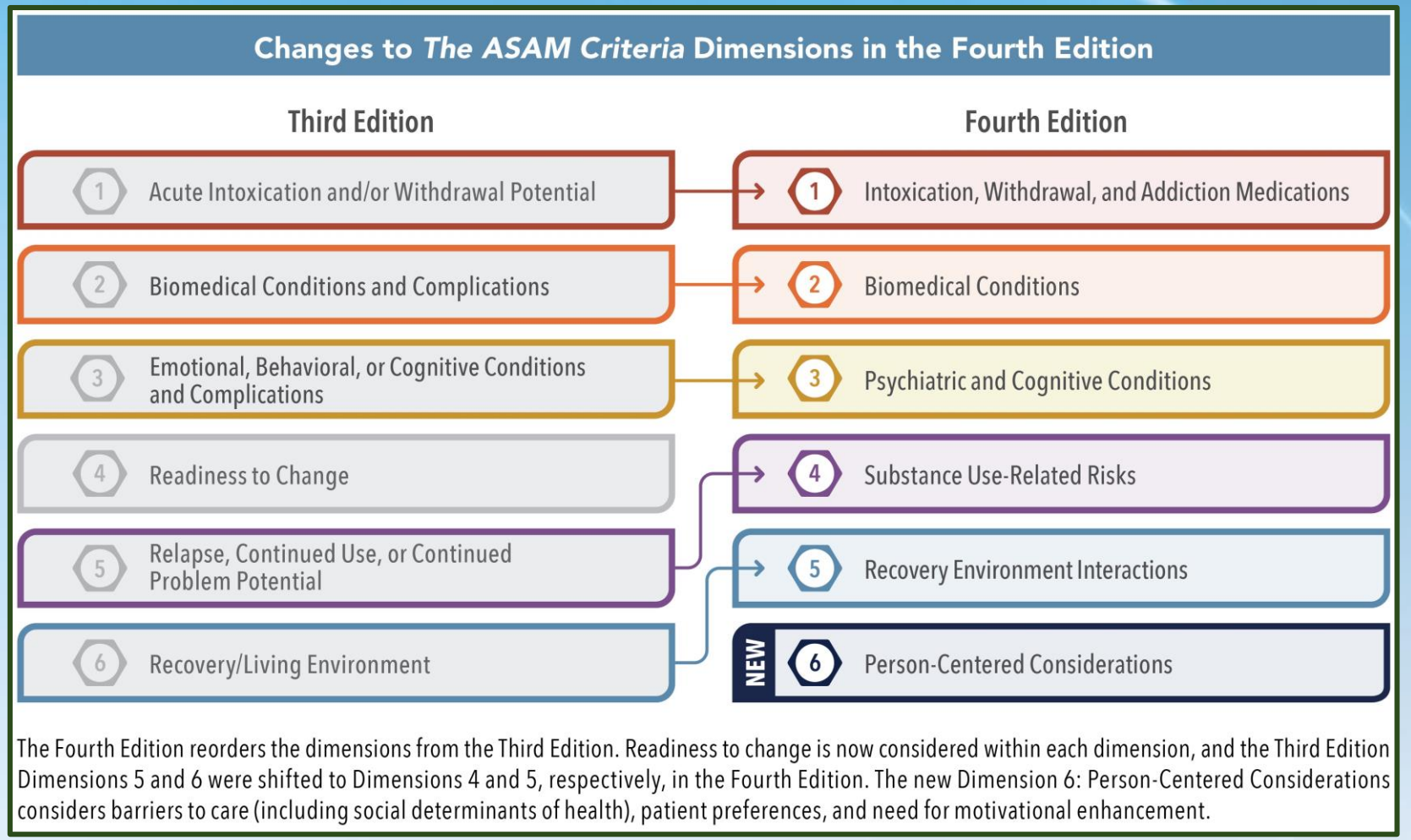
Unstable housing or transportation situation

AWS = alcohol withdrawal syndrome; CIWA-Ar = Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised.

Information from reference 8.

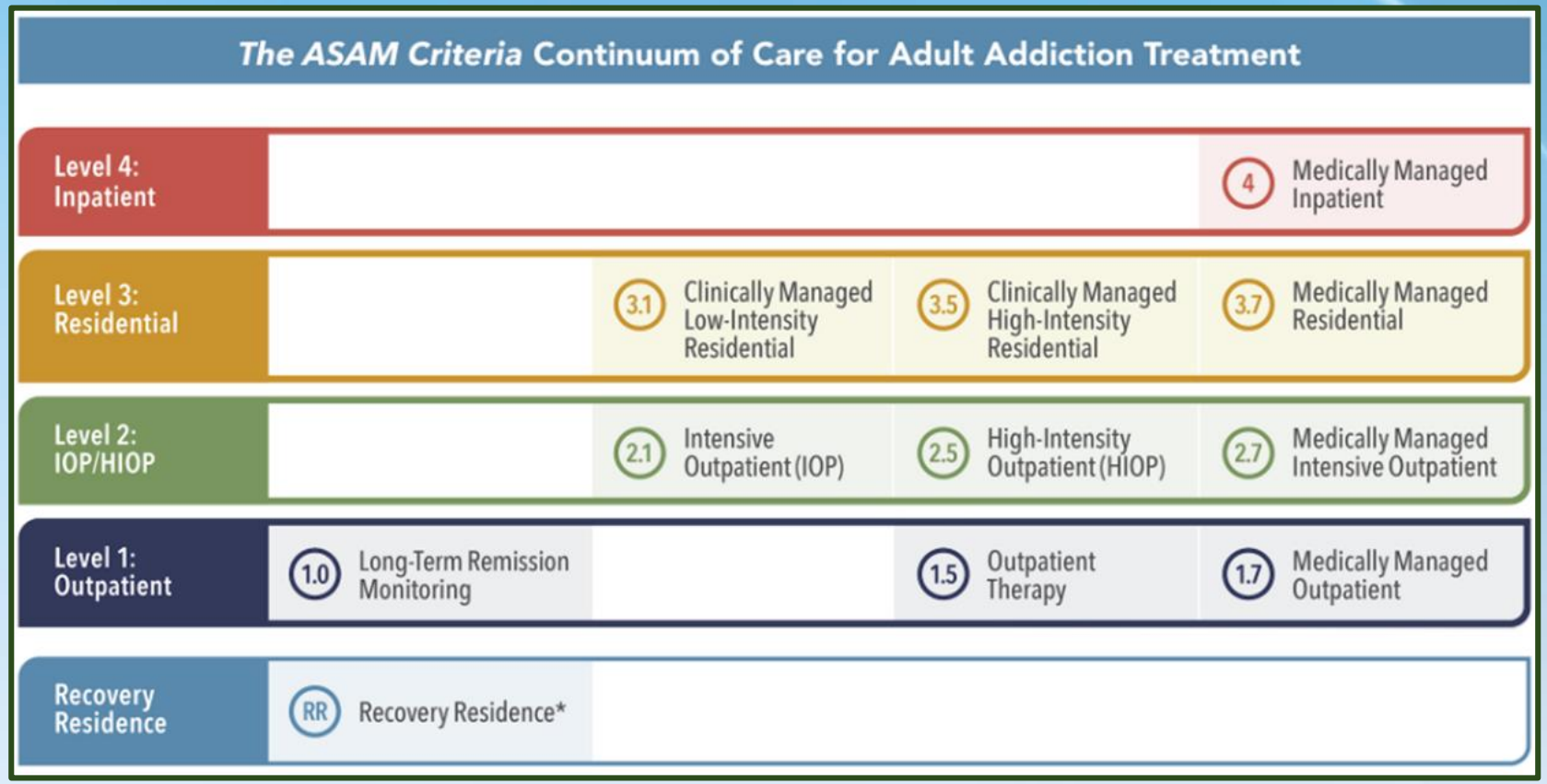
(Tiglao et al., 2021)

ASAM Criteria Dimensions



(American Society of Addiction Medicine, 2025)

ASAM Continuum of Care Criteria



(American Society of Addiction Medicine, 2025)

Patient journey across levels of care: Zoom poll

Which level of care are you least familiar with in terms of what typically happens for the patient?

HOSPITAL → "DETOX" → RESIDENTIAL → PARTIAL HOSPITAL → INTENSIVE OUTPATIENT → OUTPATIENT

Patient journey across levels of care

HOSPITAL

- Psychiatric
- Med/Surg
- High Acuity Conditions
  - Pancreatitis
  - Delirium
  - Seizure
  - Hallucinations
  - Suicidality
  - Psychosis

"DETOX"

3-10 days

- Protocol driven
- Medically monitored
- Inpatient setting

RESIDENTIAL

14-45 days

- "Rehab"
- Curriculum Driven
- Lengths of stay vary by program and payer
- Address comorbidities
- Address familial and environmental factors

PARTIAL HOSPITAL

Typically 4-8 weeks

- Attendance for 6-8 hours/day 4-5 days per week
- Patient is in community often in recovery housing
- Medication management

INTENSIVE OUTPATIENT

Typically 4-12 weeks

- 3-4 hrs/day 3-4 days/week
- Patient in community
- Patient expected to transition to outpatient provider

OUTPATIENT

- Patient in community
- Indefinite duration of engagement
- Psych med management, primary care, chronic disease management, MAUD

Misperceptions and barriers

- Low motivation and unwillingness to change
  - There is a difference between perceived need, ambivalence, and unwillingness to change
- Affordability and access to providers/programs are common reasons cited for not pursuing treatment
- A treatment episode cannot guarantee complete sustained remission
- Moderation, “sobriety sampling”, and non-abstinence approaches must be offered/considered
- MAUD should be thought of as a condition modifier, not an abstinence cure
- A 25% reduction in alcohol use over 10 years matters the same way a 20mmHg reduction in systolic blood pressure (SBP) or a 2-point reduction in HA1C matters

How to spot a “good” program/provider

- Mainstream, evidence-based behavioral treatment and MAT
- Clinical staff are career professionals in SUD and co-occurring disorders
- Medical staff capable of addressing medical and psychiatric co-morbidity
- Transparent and simple billing policies
- Stable leadership, preferably by career health care professionals
- Accreditation by Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission
- Not leading with amenities and location over their practitioners and program

How to develop a referral network

Think about your payer mix and match treatment and referral expectations to funding

Think about the entire continuum of care and where you fit

- Primary care is a natural hub and spoke model
- Set a goal to identify and contact one program at each level of care that matches your payer mix and what you can't offer in house
- Agree to a referral workflow between entities

Unmute or share in the chat: What challenges do you face in developing a referral network?

Make friends!

- Collaborate on grants and RFPs if possible
- Set a goal to attend at least one recovery event in your community
- Don't alienate either side in the SUD culture war (i.e. 12-Step Abstinence vs Safe Injection); maintain a pragmatic focus on helping your patients above all
- Authentically connected referral networks take time to develop and are based on human connection

Questions?

Feel free to unmute or put your questions in the chat!

References

American Society of Addiction Medicine. (2025). *About the ASAM Criteria*. https://www.asam.org/asam-criteria/about-the-asam-criteria

Tiglao, S. M., Meisenheimer, ES., & Oh, R. C. (2021). Alcohol Withdrawal Syndrome: Outpatient Management. *American Family Physician*, *104*(3), 253-262.