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**VETERANS HEALTH ADMINISTRATION**

# Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal

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# Executive Summary

The VA Office of Inspector General (OIG) initiated a review of the Veterans Health Administration's (VHA) inpatient management of alcohol withdrawal. Following the identification of adverse clinical outcomes in prior OIG inspections that likely contributed to patient deaths, the OIG chose to review VHA's assessment and management of inpatient alcohol withdrawal.[1] Throughout VHA, patients with an alcohol withdrawal diagnosis represented approximately 4 percent of all acute inpatient admissions in fiscal years 2020 (21,163 of 584,746) and 2021 (22,999 of 594,272).[2] During fiscal year 2020, 129 of 139 VHA healthcare systems with inpatient settings had at least one inpatient admission of a patient identified as having an alcohol withdrawal-related diagnosis.[3] A sample of 30 healthcare systems were included in this review.

Some symptoms of alcohol withdrawal, such as withdrawal seizures, can be severe and may progress to delirium tremens, which could be fatal if untreated or under-treated; however, with appropriate assessment and pharmacotherapy, the progression to severe withdrawal can be prevented.[4] Delirium tremens are associated with a worse prognosis and may lead to death in up to 5 percent of patients with alcohol withdrawal.[5] Access to inpatient alcohol withdrawal

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[1] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, Report No. 20-01917-242, August 26, 2021; VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

[2] "The fiscal year of the Treasury begins on October 1 of each year and ends on September 30 of the following year." 31 U.S.C. § 1102. https://budgetcounsel.com/laws-and-rules/%c2%a7300-000-sections-from-chapter-11-of-title-31-of-the-u-s-code/%c2%a7302-31-usc-1102-fiscal-year/#:~:text=%C2%A71102.%20Fiscal%20year%20The%20fiscal%20year%20of%20the,year%20shall%20be%20published%20for%20the%20fiscal%20year. This website was accessed on August 15, 2022. The OIG defines fiscal year 2020 as October 1, 2019, through September 30, 2020. Fiscal year 2021 is considered October 1, 2020, through September 30, 2021.

[3] The diagnosis entered by the healthcare provider at time of admission or discharge contained the terms alcohol and withdrawal. VHA defines a healthcare system as medical centers and clinics that work together in a geographic area to offer services to provide more efficient care and easier access to advanced medical care closer to their homes. VHA has 171 VA Medical Centers and 1,113 outpatient sites that make up the total 140 healthcare systems. The total count of VHA healthcare systems does not include the VA Manila Outpatient Clinic in Pasay City, Philippines, designated as "other outpatient service" in VA administrative data.

[4] Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome," *CNS Drugs*, no. 28(5) (April 30, 2014): 401–410, https://doi.org/10.1007/s40263-014-0163-5.

[5] I. Pribek et al., "Evaluation of the Course and Treatment of Alcohol Withdrawal Syndrome with the Clinical Institute Withdrawal Assessment for Alcohol – Revised: A Systematic Review-Based Meta-Analysis," *Drug and Alcohol Dependence*, no. 220 (2021): 108536, https://doi.org/10.1016/j.drugalcdep.2021.108536; Delirium tremens is a clinical condition that presents with both delirium and severe alcohol withdrawal symptoms, which may include seizures, hallucinations, increased psychomotor activity, and tremor (shaking). Whereas delirium is characterized by a rapid onset and intermittent disturbances in consciousness, cognition, psychomotor activity, and sleep-wake cycle, without the presence of tremor. Sandeep Grover and Abhishek Ghosh, "Delirium Tremens: Assessment and Management," *J Clin Exp Hepatol*, no. 8(4) (December 2018): 460–470, https://doi.org/10.1016/j.jceh.2018.04.012.

services, and staff knowledgeable in the identification of high-risk indicators and the management of severe alcohol withdrawal, is vital to reduce the prevalence of the potential adverse outcome of death.[6]

Without guidance specific to the inpatient management of alcohol withdrawal, staff may not have the knowledge or training to adequately or consistently assess and treat severe alcohol withdrawal, thus increasing the risk for progression in severity and potential death. The OIG looked at available VHA inpatient management of alcohol withdrawal guidance for consistency with the comprehensive guidance from American Society of Addiction Medicine (ASAM), a professional medical society representing addiction medicine expertise on this subject matter.[7]

Management of inpatient alcohol withdrawal does not fall under one VHA national program office. Therefore, the OIG chose to evaluate guidance and oversight at both the national and healthcare system levels.[8] Guidance reviewed included the VA/Department of Defense Clinical Practice Guidelines (VA/DoD CPG), VHA's Substance Use Disorder Handbook, Inpatient Mental Health Services Handbook, and The Joint Commission (TJC) standards.[9]

In addition to the evaluation of guidance, the OIG distributed a survey to the directors of the 30 healthcare systems included in the review to assess applicable alcohol withdrawal management setting types (general medical, critical care, or mental health); alcohol withdrawal scale(s) used; discipline(s) responsible for the initial and ongoing assessments of alcohol withdrawal severity; and method of any required training for assessing alcohol withdrawal severity. The OIG also interviewed leaders from a number of VA program offices, including the Office of Nursing Services, Pharmacy Benefits Management, Physician Assistant Services, Office of Mental Health and Suicide Prevention (OMHSP), and National Hospital Medicine Program (NHMP).

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[6] High-risk indicators are identified using an algorithm of either the assessment scale score or presence of certain conditions.

[7] The American Society of Addiction Medicine (ASAM), *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, January 23, 2020; "About Us," ASAM, accessed July 14, 2022, https://www.asam.org/about-us. The industry practice guidelines from ASAM on alcohol withdrawal management were referred to as a resource by VHA leaders from the Office of Mental Health and Suicide Prevention and the National Hospital Medicine Program.

[8] VHA Handbook 1160.04, *VHA Programs for Veterans with Substance Use Disorders (SUD)*, March 7, 2012. The VISN director is responsible for ensuring compliance with relevant policy and procedures; however, VHA Handbook 1160.04 does not describe any responsibility of the VISN director for the development of such policies. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.04, *VHA Programs for Veterans with Substance Use Disorders,* December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language as the rescinded 2012 handbook.

[9] VA and Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders 4.0*, August 2021 (VA-DoD CPG); VHA Handbook 1160.04; VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language as the rescinded 2013 handbook; The Joint Commission, *Standards Manual*, January 1, 2022.

The OIG evaluated four key areas of inpatient management of alcohol withdrawal: the determination of alcohol withdrawal severity, treatment of alcohol withdrawal, staff training for assessing alcohol withdrawal severity, and oversight of the management of alcohol withdrawal.

## Determination of Alcohol Withdrawal Severity

VHA guidance states a patient's need for treatment of alcohol withdrawal must be based on a systematic assessment of withdrawal symptoms and the risk for serious adverse consequences.[10] The assessment and determination of the severity of alcohol withdrawal is critical in facilitating treatment decisions, including inpatient admission and appropriate pharmacotherapy, that may prevent the progression of severity that could otherwise be fatal.[11] While the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar), is the scale referred to most often in VHA guidance, a VHA leader reported there is not one specific scale required.

The progression of alcohol withdrawal severity can be prevented with frequent and repetitive assessments of symptom severity and timely pharmacotherapy interventions. TJC requires written guidance for determining the frequency of inpatient reassessments, which includes alcohol withdrawal patient reassessments.[12] The OIG found 15 of the 30 (50 percent) healthcare systems did not have written guidance identifying when reassessment should be completed, which is inconsistent with TJC standards. Although not currently required by VHA, written guidance at either the national or healthcare system levels could facilitate the proper use and consistency of assessments with alcohol withdrawal severity scales, thus minimizing the risk of adverse patient safety outcomes.

In addition to determining alcohol withdrawal severity, validated scales can also be used for determining patients' appropriate level of care based on the alcohol withdrawal severity. The OIG found that 17 of the 30 (57 percent) healthcare systems reviewed did not have written guidance to determine the appropriate inpatient level of care, such as a general medical, intensive care, or mental health setting, to manage alcohol withdrawal at the time of admission. Although healthcare system guidance is not currently required, written guidance for determining patients' level of care may assist staff in the proper assessment and identification of patients' high-risk indicators, thus supporting decisions of when to manage alcohol withdrawal in the inpatient setting.

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[10] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, amended November 16, 2015; VHA Handbook 1160.06.

[11] Treatment decisions include but are not limited to pharmacotherapy and the most appropriate level of care setting. Pharmacotherapy is the treatment of disease with medication. *Merriam-Webster.com Dictionary*, "pharmacotherapy," accessed April 13, 2022, https://www.merriam-webster.com/dictionary/pharmacotherapy; Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[12] TJC, *Standards Manual*, PC.01.02.01.

## Inpatient Treatment of Alcohol Withdrawal

The treatment of severe alcohol withdrawal symptoms should involve an evaluation of co-occurring conditions, to include medical and mental health conditions, in consultation with appropriate substance use disorder (SUD) specialists for treatment planning and pharmacotherapy.[13] According to the VA/DoD CPG, providers should determine the diagnoses and develop a treatment plan that manages co-occurring medical and mental health conditions.[14] The OIG found that 23 of the 30 (77 percent) healthcare systems reviewed did not have written guidance applicable to inpatient alcohol withdrawal that requires prescribers to evaluate both medical and mental health co-occurring conditions.[15] The failure to evaluate patients' co-occurring conditions during inpatient management of alcohol withdrawal may lead to worsening medical and mental health conditions and increased risk of death. Although not currently required, written guidance at the healthcare system level could help enforce prescribers' evaluation of co-occurring conditions for effective treatment planning and management of alcohol withdrawal.

The Substance Abuse and Mental Health Services Administration, part of the Department of Health and Human Services, states a physician [prescriber] should be available to conduct a face-to-face evaluation of patients within 24 hours of admission for alcohol withdrawal, and daily thereafter.[16] Patients being treated for alcohol withdrawal in the inpatient setting should be carefully monitored for potential changes in the severity of their condition and complications, as fatal outcomes can occur.[17] The OIG found 29 of the 30 (97 percent) healthcare systems lacked written guidance to define when a prescriber should respond with a face-to-face patient evaluation due to a change in the patient's alcohol withdrawal symptoms. This is not a VHA standard, but written guidance that defines criteria for when a prescriber should evaluate a patient face-to-face may reduce the risk in delaying care or missing changes in a patient's condition that could lead to adverse patient safety outcomes.

VHA requires "consultations from specialists in substance use disorders [SUD]" be available to diagnose and develop a plan when needed for SUD withdrawal treatment.[18] The OMHSP was

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[13] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; VHA Handbook 1160.04. For the purpose of this report, the OIG defines SUD Specialists as VHA staff that may be consulted regarding patient diagnosis and treatment planning due to their expertise in SUD services, including alcohol withdrawal management.

[14] VA-DoD CPG.

[15] For the purpose of this review, the OIG uses the term *prescribers* to include physicians, physician assistants, advanced nurse practitioners, and clinical pharmacy specialists who may prescribe medications.

[16] Face-to-face care is indicative to a prescriber or nurse being "present to administer" an assessment. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Detoxification and Substance Abuse Treatment, A Treatment Improvement Protocol (SAMHSA* TIP*) 45*, 2006, revised 2015.

[17] SAMHSA, TIP 45.

[18] VHA Handbook 1160.01.

unable to provide the OIG with a description of the healthcare system SUD specialist's role and responsibilities, and stated, "facilities designate their own SUD treatment experts and consultation processes are locally defined." However, when the OIG assessed the healthcare systems included in this review, the OIG found 26 of the 30 (87 percent) healthcare systems reviewed did not have written guidance related to consulting an SUD specialist for inpatient management of alcohol withdrawal. More specific VHA or system-level written guidance for the consultation of SUD specialists may assist in designating resources, such as staff, for assistance in diagnosing and developing a plan of treatment for inpatient alcohol withdrawal, and avoiding treatment delays.

Pharmacotherapy is an important component in the management of alcohol withdrawal, particularly for moderate to severe symptoms. At the time of the review, VHA required clinical practice guidelines, including the VA/DoD CPG, be consulted and utilized for pharmacotherapy, in addition to clinical judgment, for treating SUD, which encompasses alcohol withdrawal.[19] The VA/DoD CPG state that fixed-dosing or symptom-triggered dosing may be used for alcohol withdrawal management.[20] The OIG requested all relevant guidance from the 30 healthcare systems' to determine the pharmacotherapy approach for patients experiencing alcohol withdrawal in an inpatient setting. However, 14 of 30 (47 percent) healthcare systems did not provide written pharmacotherapy guidance. While written guidance at the healthcare system level is not currently required, written pharmacotherapy guidance for inpatient alcohol withdrawal management that supports prescriber decision-making could decrease the risk of treatment delays, potential errors, and inconsistent prescribing practices.[21]

## Inpatient Staff Training to Assess Alcohol Withdrawal Severity

In a prior OIG inspection, the OIG found there was insufficient training and quality controls for inpatient medicine nurses regarding alcohol withdrawal care, including protocols for the assessment of alcohol withdrawal severity.[22] TJC states staff performing SUD assessments and treatment planning must demonstrate the required knowledge and ability for assessing intoxication, withdrawal symptoms, co-occurring mental health conditions, and risk of self-

[19] VHA Handbook 1160.06. This handbook was active during this review and rescinded when replaced by VHA Directive 1160.06, September 27, 2023. The OIG reviewed the 2023 directive and found the language referenced in this statement is still consistent for use of clinical judgement. While the directive no longer states clinical practice guidelines must be consulted, the clinical practice guidelines remain as a tool to support evidence-based practices.

[20] VA-DoD CPG.

[21] Steven H. Woolf et al., "Potential benefits, limitations, and harms of clinical guidelines," *British Medical Journal*, 318, (1999): 527–530. https://doi.org/10.1136/bmj.318.7182.527.

[22] VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

harm.[23] The NHMP director stated that due to the subjectivity in scales such as CIWA-Ar, healthcare systems should train staff to ensure consistent utilization and scoring.

VHA does not require nor offer national training related to the assessment of alcohol withdrawal severity. However, ASAM recognizes that reliable administration of the CIWA-Ar scale, including scoring that is used to guide decisions for the management of alcohol withdrawal, requires staff training.[24] In response to the OIG's survey, 22 of the 30 (73 percent) healthcare systems reported not requiring training related to the assessment of alcohol withdrawal severity for either nurses or prescribers. In addition, the OIG found that 13 of the 30 (43 percent) healthcare systems reviewed did not have written guidance for training inpatient staff on the assessment of alcohol withdrawal severity. In the absence of both VHA national and healthcare system-specific written guidance related to staff training, there may be an overall lack of staff training and familiarity with administering standardized alcohol withdrawal severity scales. If healthcare systems had written guidance for staff training on assessing alcohol withdrawal severity, the risk of delay or failure to identify and appropriately treat severe alcohol withdrawal could be reduced.

## Oversight and Monitoring of Inpatient Management of Alcohol Withdrawal

TJC requires organizations to assess the outcomes of patient care, treatment, or services through the aggregation and analysis of population data.[25] VHA SUD guidance states that Veterans Integrated Service Network (VISN) directors are responsible for ensuring compliance with any "relevant law, regulation, policy, and procedures," and healthcare system directors are responsible for ensuring oversight of the quality and compliance of SUD services.[26] However, the OIG found that VHA SUD guidance does not detail the specific expectations of oversight responsibilities for the VISN or healthcare system director. Of the 30 healthcare systems reviewed, the OIG found that 29 (97 percent) did not have healthcare system written guidance for the oversight of inpatient management of alcohol withdrawal. If national or healthcare system written guidance detailed the specific expectations for oversight, the quality of inpatient management of alcohol withdrawal could be evaluated and assessed for compliance with available SUD guidance.

OMHSP leaders reported to the OIG that "VA does not currently systematically monitor alcohol withdrawal treatment, or clinical outcomes of alcohol withdrawal." The National Mental Health

[23] TJC, *Standards Manual*, HRM.01.06.03.

[24] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[25] TJC, *Standards Manual*, CTS.03.01.09.

[26] VHA Handbook 1160.04.

Director of SUD further detailed in a written statement that inpatient management of alcohol withdrawal is inconsistently coded, and therefore, unreliable for collection across healthcare systems. Given the lack of national level data collection, the OIG evaluated whether healthcare systems collect and monitor patient outcome data to ensure the quality of inpatient management of alcohol withdrawal.[27] The OIG found none of the healthcare systems reviewed provided written guidance to demonstrate the collection of data for monitoring patient outcomes related to inpatient management of alcohol withdrawal. Implementation of healthcare systems' written guidance to require and demonstrate how to monitor patient outcome data for inpatient management of alcohol withdrawal may result in improved evaluation of effectiveness and appropriateness of care.

The OIG made three recommendations to the Under Secretary for Health including consideration of identifying a national program office responsible for oversight, guidance, and implementation of alcohol withdrawal management across inpatient settings. The identified national office should consider requiring the development and implementation of written guidance for the management of alcohol withdrawal across inpatient settings, as well as consider implementing inpatient staff training on the administration of standardized alcohol withdrawal severity scales.

## VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see appendix A). The OIG will follow up on the planned actions until they are completed.

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion. For this report, VHA provided the OIG comments during the draft phase. Based on the review, the OIG made minor changes to the report for clarification, but no changes were made to the OIG findings.

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[27] Examples of this data might include the number of patients admitted for alcohol withdrawal management and the duration of care in the inpatient setting.

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# Abbreviations

| | |
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| ASAM | American Society of Addiction Medicine |
| CIWA-Ar | Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised |
| NHMP | National Hospital Medicine Program |
| OIG | Office of Inspector General |
| OCS | Office of Clinical Services |
| OMHSP | Office of Mental Health and Suicide Prevention |
| PAS | Physician Assistant Services |
| PCS | Office of Patient Care Services |
| PBM | Pharmacy Benefits Management |
| SUD | Substance Use Disorder |
| TJC | The Joint Commission |
| VA/DoD CPG | VA/Department of Defense Clinical Practice Guidelines |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) initiated a review of the Veterans Health Administration's (VHA) inpatient management of alcohol withdrawal on September 02, 2021, due to potential risks to patient safety. In prior inspections, the OIG found patient safety was compromised during inpatient management of alcohol withdrawal and likely contributed to patient deaths.[1]

The OIG evaluated various aspects of inpatient management of alcohol withdrawal, including staff assessment and treatment of patients, staff training for the assessment of alcohol withdrawal severity, and oversight.[2] The OIG also reviewed national and healthcare systems' substance use disorder (SUD) guidance for any delineation of expectations specific to inpatient management of alcohol withdrawal.[3]

## Background

Throughout VHA, patients with an alcohol withdrawal diagnosis represented approximately 4 percent of all acute inpatient admissions in fiscal years 2020 (21,163 of 584,746) and 2021 (22,999 of 594,272).[4] Despite the prevalence of the diagnosis, minimal research has been conducted and presented in literature to guide inpatient management of severe alcohol withdrawal.[5]

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[1] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, Report No. 20-01917-242, August 26, 2021; VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

[2] VHA defines a healthcare system as medical centers and clinics that work together in a geographic area to offer services to provide more efficient care and easier access to advanced medical care closer to their homes. VHA has 171 VA Medical Centers and 1,113 outpatient sites that make up the total 140 healthcare systems.

[3] The term substance use disorder is used to refer to the wide range of substance related disorders including alcohol withdrawal. VHA Handbook 1160.04, *VHA Programs for Veterans with Substance Use Disorders (SUD)*, March 7, 2012. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.04, *VHA Programs for Veterans with Substance Use Disorders*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language as the rescinded 2012 handbook; Alcohol withdrawal is an alcohol-related disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), "Substance Related and Addictive Disorders," accessed June 12, 2023, https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders.

[4] The fiscal year begins on October 1 of each year and ends on September 30 of the following year. Fiscal year 2020 was October 1, 2019, through September 30, 2020. Fiscal year 2021 was considered October 1, 2020, through September 30, 2021. 31 U.S.C. § 1102.

[5] Tessa L. Steel et al., "Research Needs for Inpatient Management of Severe Alcohol Withdrawal Syndrome: An Official American Thoracic Society Research Statement," *American Journal of Respiratory and Critical Care Medicine*, 204:7 (October 1, 2021), https://doi.org/10.1164/rccm.202108-1845ST.

Alcohol withdrawal typically occurs after prolonged heavy alcohol consumption followed by a reduction in consumption or a period of cessation. The initial symptoms of alcohol withdrawal may present "within several hours to a few days" after cessation.[6] A thorough history and physical exam of a patient should be completed to diagnose alcohol withdrawal.[7]

A diagnosis of alcohol withdrawal includes at least two of the following physical symptoms: central nervous system effects (sweating, increased heart rate, increased blood pressure); hand tremors; changes in sleep, nausea or vomiting; auditory or visual hallucinations; agitation; anxiety; and seizures.[8] Long-term, heavy, and regular alcohol consumption increases the risk of severe alcohol withdrawal. Severe alcohol withdrawal may prolong a hospitalization and may even be fatal without appropriate and frequent medication administration.[9] Frequent causes of alcohol withdrawal-related death are complications from delirium tremens, including excessively high body temperature, cardiac arrhythmias, and complications of withdrawal seizures.[10] These severe complications of delirium tremens are associated with a worse prognosis and may lead to death in up to 5 percent of patients with alcohol withdrawal.[11] For this reason, the main goals of alcohol withdrawal management are the reduction of withdrawal symptoms and prevention of delirium tremens.[12] Alcohol withdrawal management revolves around early identification of patients who are at risk for severe alcohol withdrawal and symptom assessment using a validated

[6] DSM-5-TR, *Substance Related and Addictive Disorders*; Elizabeth C. Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome," *CNS Drugs,* no. 28(5) (April 30, 2014): 401–410, https://doi.org/10.1007/s40263-014-0163-5.

[7] The American Society of Addiction Medicine (ASAM), *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, January 23, 2020.

[8] National Library of Medicine MedlinePlus, *Central Nervous System*, accessed April 13, 2022, https://medlineplus.gov/ency/article/002311.htm. The central nervous system, consisting of the brain and spinal cord, is the processing center that controls all the workings of the body; DSM-5-TR, *Substance Related and Addictive Disorders*.

[9] Steel et al., "Research Needs for Inpatient Management of Severe Alcohol Withdrawal Syndrome: An Official American Thoracic Society Research Statement."

[10] National Heart, Lung, and Blood Institute, "Arrhythmia," accessed February 18, 2021. https://www.nhlbi.nih.gov/health-topics/arrhythmia. "A problem with the rate or rhythm of the heartbeat." If left untreated, the heart may not be able to pump blood to the rest of the body, resulting in damage to organs; Sandeep Grover and Abhishek Ghosh, "Delirium Tremens: Assessment and Management," *Journal of Clinical and Experimental Hepatology* no. 8(4) (December 2018): 460–470, https://doi.org/10.1016/j.jceh.2018.04.012; Marc A. Schuckit, "Recognition and Management of Withdrawal Delirium," *The New England Journal of Medicine* (2014) 371:2109-13, https://doi.org/10.1056/NEJMra1407298.

[11] I. Pribek et al., "Evaluation of the Course and Treatment of Alcohol Withdrawal Syndrome with the Clinical Institute Withdrawal Assessment for Alcohol – Revised: A Systematic Review-Based Meta-Analysis." *Drug and Alcohol Dependence* 220 (2021): 108536, https://doi.org/10.1016/j.drugalcdep.2021.108536; Delirium tremens is a clinical condition that presents with both delirium and severe alcohol withdrawal symptoms, which may include seizures, hallucinations, increased psychomotor activity, and tremor (shaking). Whereas, delirium is characterized by a rapid onset and intermittent disturbances in consciousness, cognition, psychomotor activity, and sleep-wake cycle, without the presence of tremor. Grover and Ghosh, "Delirium Tremens: Assessment and Management."

[12] I. Pribek et al., "Evaluation of the Course and Treatment of Alcohol Withdrawal Syndrome with the Clinical Institute Withdrawal Assessment for Alcohol – Revised: A Systematic Review-Based Meta-Analysis."

scale such as the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar).[13] Access to inpatient alcohol withdrawal services, and staff knowledgeable in the identification of high-risk indicators and the management of severe alcohol withdrawal, is vital to reduce the prevalence of the potential adverse outcome of death.[14]

## Determination of Alcohol Withdrawal Severity

The VA/DoD Clinical Practice Guidelines for SUD (VA/DoD CPG) states alcohol withdrawal is determined to be **severe** if the score from the CIWA-Ar is 20 or greater, or if any of the following conditions are present: co-occurring medical conditions that would pose a higher risk for withdrawal in the outpatient setting, potential for polysubstance withdrawal, inability to tolerate medications orally, or a history of withdrawal seizures or delirium tremens.[15]

The American Society of Addiction Medicine (ASAM) recommends alcohol withdrawal severity be monitored by ongoing measurement of patient vital signs and the use of a validated alcohol withdrawal assessment scale.[16] Ideally, the same scale should be used throughout the course of a patient's alcohol withdrawal to track symptom progression and response to medication.[17] The CIWA-Ar is cited as the most commonly used, gold standard of validated and reliable assessment scales for evaluating the severity of alcohol withdrawal.[18] The CIWA-Ar is an example of a scale for use with patients in early abstinence as well as severe alcohol withdrawal.[19] See appendix B for other examples of validated assessment scales for alcohol withdrawal.[20]

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[13] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[14] High-risk indicators are identified using an algorithm of either the assessment scale score or presence of certain conditions.

[15] VA and Department of Defense (DoD), *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders 4.0*, August 2021.

[16] *Validated* is defined as granted official sanction to by marking, proven to be true, worthy, or justified. *Merriam-Webster.com Dictionary,* "validated," accessed April 28, 2022*,* https://www.merriam-webster.com/dictionary/validate; ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; ASAM, *About Us,* accessed July 14, 2022, https://www.asam.org/about-us. ASAM "is a professional medical society representing over 7,000 physicians, clinicians and associated professionals in the field of addiction medicine." ASAM provides industry practice guidelines on alcohol withdrawal management that VHA leaders from the Office of Mental Health and Suicide Prevention and the National Hospital Medicine Program referred to as a resource for clinical guidance.

[17] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[18] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; I. Pribek et al, "Evaluation of the Course and Treatment of Alcohol Withdrawal Syndrome with the Clinical Institute Withdrawal Assessment for Alcohol – Revised: A Systematic Review-Based Meta-Analysis," *Drug and Alcohol Dependence* 220 (2021): 108536.

[19] VA-DoD CPG.

[20] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

The CIWA-Ar relies on a patient's ability to self-report (communicate) symptoms and should not be used to assess patients with delirium or impaired communication. The CIWA-Ar scores the severity of alcohol withdrawal using the patient's self-report for the presence and degree of the following symptoms: "nausea, tremor, autonomic hyperactivity, anxiety, agitation, perceptual disturbances [auditory, tactile, and visual hallucinations], headache, and disorientation" (see appendix C).[21] Severe withdrawal symptoms, such as withdrawal seizures, may progress to delirium tremens and be potentially fatal if untreated or under-treated.[22] The progression of alcohol withdrawal severity can be prevented with frequent and repetitive assessments of symptom severity to inform timely pharmacotherapy interventions.[23] Pharmacotherapy dosing and the reassessment frequency for alcohol withdrawal may be determined based on the patient's preceding assessment score.[24]

## Level of Care Determination for Alcohol Withdrawal

The management of alcohol withdrawal may be delivered in outpatient, inpatient, and residential settings.[25] Level of care determinations for patients with moderate to severe alcohol withdrawal should be "based on the patient's [current] signs and symptoms, past history, co-occurring general medical and psychiatric [mental health] conditions, and psychosocial support network."[26] However, level of care determinations should not be based on the use of an alcohol withdrawal assessment scale alone.[27] Admission to an inpatient setting should be considered when conditions are present that might exacerbate the severity of alcohol withdrawal, including co-occurring medical conditions, impaired ability to participate in the treatment, acute danger to self or others, and failed previous outpatient treatment.[28] These conditions are typically contraindications for management of alcohol withdrawal in an outpatient setting. According to VHA,

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[21] Perceptual disturbance types include auditory, tactile, and visual hallucinations. Sullivan et al., "Assessment of Alcohol Withdrawal: The Revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar)," *British Journal of Addiction* 84 (1989): 1353–1357, https://doi.org/10.1111/j.1360-0443.1989.tb00737.x.

[22] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome;" National Institute on Alcohol Abuse and Alcoholism, SAMHSA, *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*, 2015.

[23] Pharmacotherapy is the treatment of disease with medication. *Merriam-Webster.com Dictionary*, "pharmacotherapy," accessed April 13, 2022, https://www.merriam-webster.com/dictionary/pharmacotherapy; Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[24] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[25] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[26] American Psychiatric Association, *Treating Substance Use Disorders: A Quick Reference Guide*, August 2006, accessed April 26, 2021, https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-guide.pdf.

[27] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[28] American Psychiatric Association, *Treating Substance Use Disorders: A Quick Reference Guide*, August 2006; ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

> Acute hospital-based [inpatient SUD] care is focused on assessing withdrawal risk, evidence-based withdrawal management, comprehensive biopsychosocial assessment, medical and mental health stabilization, identifying initial recovery goals, initiating or arranging for care of co-occurring medical and mental health conditions, and effective linkage to continuing care in the residential or outpatient setting for relapse prevention.[29]

## Inpatient Treatment of Severe Alcohol Withdrawal

The treatment of severe alcohol withdrawal symptoms should involve an evaluation of co-occurring conditions, to include medical and mental health conditions, in consultation with appropriate SUD specialists for treatment planning and pharmacotherapy.[30] Some co-occurring medical conditions, such as heart disease and liver disease, can present a challenge when managing alcohol withdrawal with medications. For example, patients with significant liver disease may not metabolize benzodiazepines, such as diazepam, commonly used for alcohol withdrawal; as such, they may require an alternative benzodiazepine, such as lorazepam.[31] In addition, cardiac arrhythmia risk may be increased with prescribing haloperidol, an appropriate pharmacotherapy for the alcohol withdrawal symptoms of delusions, hallucinations, or agitation.[32]

Severe alcohol withdrawal, which can include delirium tremens and alcohol withdrawal seizures, typically requires inpatient monitoring with hourly symptom assessment and pharmacotherapy.[33] If the alcohol withdrawal symptoms progress in severity, the patient may need to transfer to an intensive inpatient care setting. Up to one-third of patients with severe alcohol withdrawal need care in an intensive care setting.[34]

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[29] VHA Handbook 1160.04.

[30] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; VHA Handbook 1160.04. For the purpose of this report, the OIG defines SUD Specialists as VHA staff that may be consulted regarding patient diagnosis and treatment planning due to their expertise in SUD services, including alcohol withdrawal management.

[31] Benzodiazepines are a class of medications that reduce activation of the central nervous system and relax muscles. The use of benzodiazepines help avoid the progression to delirium tremens, the most severe form of alcohol withdrawal. Benzodiazepines may cause over sedation requiring close monitoring; American Psychological Association, Dictionary, "Benzodiazepines," accessed March 28, 2022, https://dictionary.apa.org/benzodiazepine; Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[32] Haloperidol, also known as Haldol, is a high potency antipsychotic effective for controlling "acute agitation" in hospital or intensive care settings. It can be administered in an oral formulation or an intermuscular injection. Haloperidol should be used with caution and monitored in patients at risk of heart failure or cardiac events during coadministration with depressants and alcohol. Prescribers Digital Reference, "Haldol," accessed June 15, 2023, https://www.pdr.net/drug-summary/Haldol-haloperidol-942.

[33] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[34] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

## Staff Training to Assess Alcohol Withdrawal

Nurses and prescribers responsible for SUD assessment and treatment planning must be able to demonstrate the required knowledge and ability for assessing intoxication. This includes withdrawal symptoms, medical or mental health conditions, and risk of self-harm.[35]

## VHA Oversight of Inpatient Alcohol Withdrawal Operations

Inpatient management of alcohol withdrawal involves the delivery of care from nurses and various prescriber-types, each practicing under the oversight from either their respective discipline or treatment setting. The national VHA programs involved in the delivery of inpatient management of alcohol withdrawal are aligned under either the VHA Office of Patient Care Services (PCS) or Office of Clinical Services (OCS) (see figure 1).

The PCS is divided into multiple program offices, each under its own authority, based on the respective discipline: the Office of Nursing Services, Pharmacy Benefits Management (PBM) Services, and Physician Assistant Services (PAS). The OCS is divided into multiple program offices for oversight of operational guidance based on the respective treatment setting or specialty: the Office of Mental Health and Suicide Prevention (OMHSP), Primary Care, and Specialty Care. These program offices are further sub-divided into specialized treatment programs. The Specialty Care program office, which includes the National Hospital Medicine Program (NHMP), operates in the inpatient medicine setting without designated responsibility for SUD or alcohol withdrawal guidance within the inpatient setting.[36] In addition, the OMHSP includes the SUD program, which is responsible for operational guidance related to SUD services in inpatient settings.[37] To assist in these responsibilities, the SUD program utilizes consultants and technical assistants from within and outside of the OMHSP.

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[35] The Joint Commission (TJC), *Standards Manual*, HRM.01.06.03. For the purpose of this review, the OIG uses the term *prescribers* to include physicians, physician assistants, advanced nurse practitioners, and clinical pharmacy specialists who may prescribe medications.

[36] "About ONS," Office of Nursing Services, https://vaww.va.gov/NURSING/About_ONS.asp. (This website is not publicly accessible.) The ONS, aligned under the PCS, provides "leadership, guidance and strategic direction on all issues related to nursing practice, education, research & workforce for clinical programs across the continuum of care;" "Pharmacy Benefits Management Services," PCS, http://vaww.patientcare.va.gov/PCS/PBM.asp. (This website is not publicly accessible.) PBM, aligned under the PCS, is the national program office that provides "leadership for pharmacy activities in the Veterans Health Administration (VHA) and provides advice and support regarding pharmacy issues;" "Physician Assistant Services," PCS, http://vaww.patientcare.va.gov/PCS/Physician_Assistant_Services.asp. (This website is not publicly accessible.) PAS, aligned under the PCS, is the national program office that provides "review of VA qualification standards and clinical practice policy development for physician assistants;" "National Specialty Programs," Specialty Care Program Office, https://vaww.specialtycare.va.gov/programs/programs.asp. (This website is not publicly accessible.)

[37] VHA defines the term SUD as encompassing "the family of alcohol and other drug-use" diagnoses; this includes the diagnosis of alcohol withdrawal as defined by criteria in the Diagnostic Statistical Manual. VHA Handbook 1160.04.

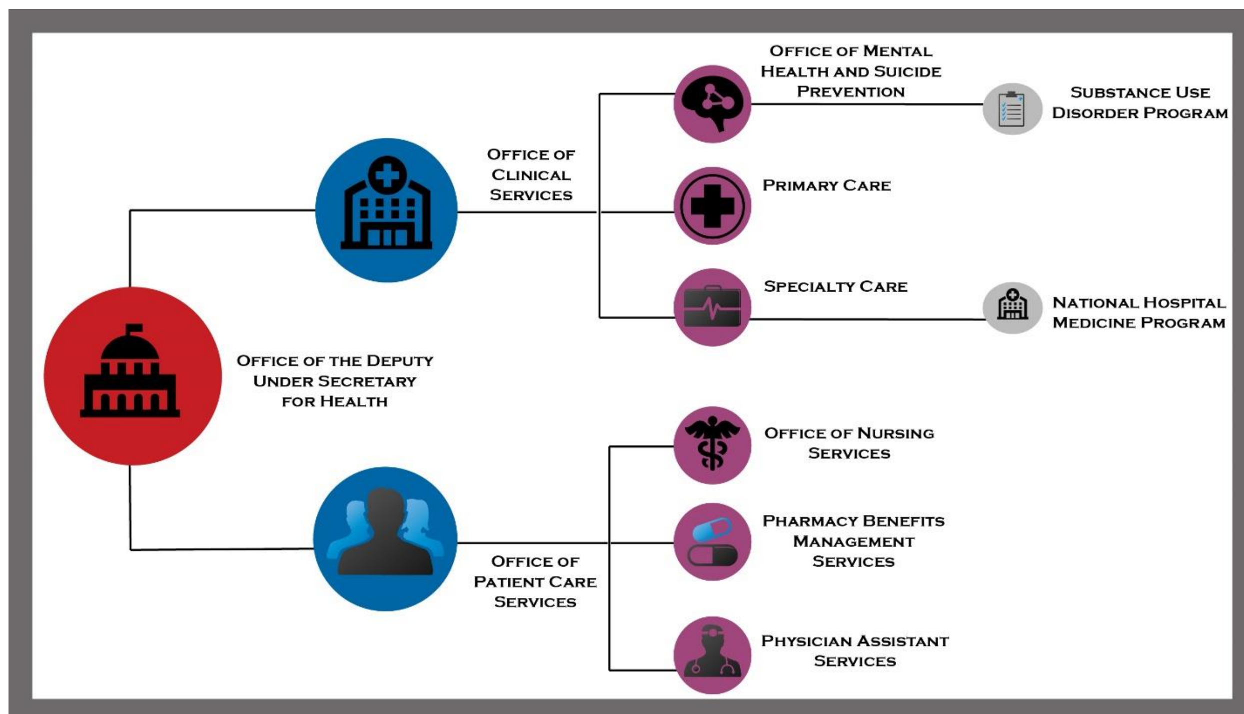


***Figure 1.*** *Organizational structure of the VHA program offices included in this review.*
*Source: VHA Organizational Chart as of July 1, 2020.*
*Note: Although other services fall organizationally under the OCS and PCS, they are not part of this review and, therefore, are not listed in this figure.*

## Prior OIG Reports

The OIG has published three reports related to topics covered in this review within the past three years. The 2021 and 2022 reports described below were used to develop the scope of this review, while the 2023 report was published after the review period.

In the 2021 VA OIG report, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, the OIG found medical mismanagement may have contributed to the cause of death for a patient admitted to an inpatient medical unit for alcohol withdrawal.[38] This included a failure by physicians to prescribe an adequate benzodiazepine medication to effectively address the patient's delirium tremens, and to review and follow up on the patient's abnormal electrocardiogram prior to administering haloperidol. In addition, the OIG found medical record documentation was not appropriately completed, and staff lacked training to provide adequate inpatient management of alcohol withdrawal. The OIG determined the lack of CIWA-Ar assessments may have contributed to an insufficient understanding of the patient's alcohol withdrawal status and risk for an adverse clinical outcome. The OIG made 10 recommendations,

[38] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, Report No. 20-01917-242, August 26, 2021.

including some related to staff training on inpatient management of alcohol withdrawal, use of restraints, staff adherence to CIWA-Ar protocols, and compliance with inpatient admission criteria. As of February 2023, all the recommendations were closed.

In the 2022 VA OIG report, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, the OIG determined medical-surgical unit nurses failed to adequately assess and treat the patient's alcohol withdrawal symptoms in accordance with physician orders and facility alcohol withdrawal treatment protocols.[39] This included a failure to complete a CIWA-Ar assessment every four hours for the first 24 hours and administer benzodiazepines for moderate or severe alcohol withdrawal symptoms. The OIG determined that medical-surgical unit nursing leaders did not have adequate training or quality controls in place to ensure the provision of safe and effective alcohol withdrawal nursing care, likely contributing to deficiencies in the patient's alcohol withdrawal care. The OIG also discovered concerns with facility alcohol withdrawal protocols that could be discontinued by nurses prior to the onset of a patient's withdrawal symptoms. Of the 10 OIG recommendations, two were related to the findings above. The first was to ensure all medical-surgical unit nurses demonstrate competency to provide adequate alcohol withdrawal care. The second recommendation was to ensure the medical center's alcohol withdrawal treatment protocol is specific, does not conflict with physicians' orders, and aligns with the probable onset of patients' alcohol withdrawal symptoms. As of March 18, 2023, these recommendations were closed.

In the 2023 VA OIG report, *Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*, the OIG determined the emergency department mismanaged the alcohol withdrawal assessment and treatment of a patient seeking detoxification, who died two days after discharge.[40] This included inadequate assessment for complicated alcohol withdrawal and failure to consider further monitoring or inpatient admission. Physicians did not consider the patient's history of withdrawal seizures a risk factor on the basis that they occurred in the distant past. The assessment for complicated withdrawal also failed to include the patient's history of tremors, hallucinations, and six months of repeated emergency department visits for alcohol withdrawal. The OIG was unable to determine if severe alcohol withdrawal contributed to the patient's death due to the absence of medical assessment post-discharge, but found it likely the patient's alcohol withdrawal symptoms continued to progress after discharge. Of the seven OIG recommendations, one was related to the findings above. This recommendation was for Emergency Department staff to evaluate and ensure alcohol withdrawal treatment policies are in

[39] VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

[40] VA OIG, *Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*, Report No. 21-03680-80, March 29, 2023.

accordance with evidence-based care guidelines. As of April 2023, this recommendation remained open.

# Scope and Methodology

The OIG initiated this review on September 2, 2021, following the identification of adverse clinical outcomes, including death, during prior OIG inspections.[41] The adverse clinical outcomes identified in the prior reports were attributed, in part, to inadequate management and assessment of alcohol withdrawal severity.[42] During the prior inspections, the OIG found that the alcohol withdrawal protocols in place were not followed or did not align with evidence-based care guidelines, staff were inadequately trained to provide appropriate care, and there was insufficient oversight of care.[43] This review evaluates national and healthcare system guidance for inpatient management of alcohol withdrawal. In the absence of a single responsible national program office, and the deferred responsibility for guidance and oversight to the healthcare systems, the OIG chose to look at guidance at both the national and healthcare system levels.

For the purpose of this review, inpatient settings include general medicine, critical care, and mental health. Residential and other non-acute units were excluded.[44] The OIG did not evaluate VHA's outpatient management of alcohol withdrawal.

The OIG determined that during fiscal year 2020, 129 of 139 (93 percent) VHA healthcare systems with inpatient settings had at least one inpatient admission of a patient identified as having an alcohol withdrawal-related diagnosis.[45] Among healthcare systems with differing

[41] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, Report No. 20-01917-242, August 26, 2021; VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

[42] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, Report No. 20-01917-242, August 26, 2021; *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

[43] VA OIG, *Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*, Report No. 21-03680-80, March 29, 2023; VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 21-01048-154, May 12, 2022.

[44] This review included admissions to acute inpatient settings. Therefore, inpatient settings not considered acute were excluded from this review and include domiciliary and substance abuse residential units, observation beds, nursing home care units, non-acute hospice units, Substance Treatment and Recovery (STAR) units, and compensated work therapy transitional residences.

[45] The diagnosis entered by the healthcare provider at time of admission, discharge, or both contained the terms alcohol and withdrawal. The total count of VHA healthcare systems does not include the VA Manila Outpatient Clinic in Pasay City, Philippines, designated as "other outpatient service" in VA administrative data.

complexity levels, the total number of admissions varied widely.[46] Therefore, the OIG selected healthcare systems that fell within the top 10 percent and healthcare systems that fell within the bottom 10 percent of admissions within each of the five complexity levels to equally represent healthcare systems with a range of available resources and services.[47] This method was used to capture healthcare systems' diversity in patient population size, as well as experience with inpatient management of alcohol withdrawal. Ultimately, 30 healthcare systems were included in the review.

The OIG requested that each of the directors of the 30 healthcare systems provide any written healthcare system-level guidance relevant to inpatient management of alcohol withdrawal, including: staff assessment of patients' symptoms and severity of alcohol withdrawal; the determination for inpatient level of care; treatment including evaluation of co-occurring conditions, pharmacotherapy, and SUD expert consultation; staff training for assessing alcohol withdrawal severity; and operational oversight responsibilities, data collection, and monitoring from VHA, Veterans Integrated Service Network (VISN), and healthcare systems.[48]

The OIG also distributed a survey to each of the 30 healthcare systems requesting the healthcare system provide a response for each setting where inpatient management of alcohol withdrawal may occur. Data collected, via multiple choice responses, for each inpatient setting included: (1) setting type (general medical, critical care, or mental health); (2) alcohol withdrawal scale(s) used; (3) discipline(s) responsible for the initial and ongoing assessments of alcohol withdrawal severity; and (4) method of any required training for assessing alcohol withdrawal severity. Among the 30 healthcare systems' responses, 104 inpatient settings were identified that could manage alcohol withdrawal.

In the absence of a single VHA national office with responsibility for policy development and operational oversight for inpatient management of alcohol withdrawal, and in an effort to ensure all settings and disciplines were represented, leaders from both the OCS and the PCS were

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[46] The VHA categorizes healthcare systems by complexity level based on scored elements including patient population, administrative complexity, range of clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3, with level 1a facilities considered the most complex and level 3 facilities the least complex. VHA Office of Productivity, Efficiency and Staffing, "Data Definitions VHA Complexity Model," January 28, 2021.

[47] For this review, admissions only included patients with a diagnosis of alcohol withdrawal.

[48] For this review, written guidance is inclusive of any policies, handbooks, standard operating procedures, protocols and algorithms.

interviewed by the OIG. The leaders interviewed included representatives from NHMP, OMHSP, ONS, PAS, and PBM.[49]

The OIG requested the OCS and the PCS provide all national policy and guidance utilized by VHA for inpatient management of alcohol withdrawal, including the four key areas defined by the OIG: determination of alcohol withdrawal severity, inpatient treatment of alcohol withdrawal, inpatient staff training to assess alcohol withdrawal severity, and operational oversight. These offices provided the OIG with VHA's SUD Handbook and Inpatient Mental Health Services Handbook, as well as The Joint Commission (TJC) standards and the VA/DoD CPG.[50] TJC is nationally recognized for its external quality reviews and accreditation. Currently, all VHA healthcare facilities are accredited by TJC.[51] The OMHSP responded that since VHA healthcare facilities are accredited, TJC standards "govern inpatient alcohol withdrawal management."

The OIG also looked at available VHA inpatient management of alcohol withdrawal guidance from national and healthcare systems for consistency with the comprehensive guidance from ASAM.[52]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VHA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the national review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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[49] OIG interviews included the following national leaders: NHMP's National Hospital Medicine Program Director and two Hospital Medicine Section Chiefs; OMHSP's National Mental Health Director of Substance Use Disorders, National Director of Inpatient Mental Health Services, National Director of Mental Health Rehabilitation and Residential Treatment Program, and a subject matter expert from the Center for Excellence; ONS's Clinical Nurse Advisor to Mental Health, Director of Clinical Practice, Advanced Registered Nurse Practitioner Program Manager; PAS's Executive Director of Physician Assistant Services; and PBM's Executive Director of Pharmacy Benefits Management, and Associate Chief Consultant for Clinical Practice and Policy of Pharmacy Benefits Management.

[50] VHA Handbook 1160.04; VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language as the rescinded 2013 handbook.

[51] VHA Office of Quality and Patient Safety, *External Accreditation*, accessed March 28, 2023, https://vaww.qps.med.va.gov/divisions/qm/ea/jointcommission.aspx. (This web page is not publicly accessible.)

[52] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

# Review Results

VHA requires that inpatient management of substance withdrawal be made available for all patients in need, either by the healthcare system or a referral outside the healthcare system.[53] According to VHA, management of alcohol withdrawal may be conducted in any inpatient medical, intensive care, or mental health setting, so long as it is clinically appropriate and consistent with healthcare system policies and VA/DoD CPG.[54] When interviewed, an OMHSP leader described the VA/DoD CPG as broad recommendations for substance use treatment.[55] The VA/DoD CPG do not specifically address inpatient management of alcohol withdrawal, beyond determining appropriateness for inpatient placement and pharmacotherapy recommendations.[56]

Delirium tremens could be fatal if untreated or under-treated; however, with appropriate assessment and pharmacotherapy, the progression to severe withdrawal could be prevented.[57] The risk of progression in alcohol withdrawal severity, including the potential for death, can be reduced given specific guidance that increases staff knowledge or training for adequate or consistent assessment and treatment of severe alcohol withdrawal. In this review, national and healthcare system written guidance was evaluated for specificity to inpatient management of alcohol withdrawal in four key areas: determination of alcohol withdrawal severity, inpatient treatment of alcohol withdrawal, inpatient staff training for assessing alcohol withdrawal severity, and oversight of inpatient management of alcohol withdrawal (guidance and monitoring).

## 1. Determination of Alcohol Withdrawal Severity

The assessment of symptoms with a validated scale, such as the CIWA-Ar scale, is critical for the early identification and management of severe alcohol withdrawal, including guiding inpatient admission decisions and pharmacotherapy.[58] The OIG reviewed whether healthcare systems have established written guidance for assessing the severity of alcohol withdrawal symptoms, and subsequently determining the appropriate level of care based on the assessment. Of the 30 healthcare systems reviewed, almost half did not have written guidance for the

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[53] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, amended November 16, 2015; VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. Alcohol withdrawal is one type of substance withdrawal.

[54] VHA Handbook 1160.04; VHA Handbook 1160.06, September 16, 2013. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. Unlike the 2013 handbook, the revised directive does not delineate the settings where alcohol withdrawal management may be conducted; however, when interviewed, OMHSP leaders supported that this statement remains true.

[55] VA-DoD CPG.

[56] VA-DoD CPG.

[57] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[58] Treatment decisions include but are not limited to pharmacotherapy and the most appropriate level of care setting.

assessment (13 of 30) or reassessment (15 of 30) of alcohol withdrawal severity; nor did they have written guidance for determining the appropriate level of care (17 of 30) for inpatient management of alcohol withdrawal.

## Guidance for Alcohol Withdrawal Severity Assessment Scales

VHA guidance states that a patient's need for treatment of alcohol withdrawal must be made based on a systematic assessment of withdrawal symptoms and the risk for serious adverse consequences.[59] The VA/DoD CPG states that a validated instrument [scale] should be used to assess the severity of alcohol withdrawal symptoms.[60] The National Mental Health Director of SUD told the OIG that although there is not one specific assessment scale that is required by VHA, the CIWA-Ar is the validated scale referred to most often within VHA guidance. However, the NHMP director reported variability in assessment scale use and scoring practices across all VHA facilities. This was also identified in the prior inspections where both facilities used the CIWA-Ar; however, the resulting scores prompting pharmacotherapy interventions differed among staff.[61]

In response to the OIG's survey, all 30 healthcare systems reported using the CIWA-Ar to assess alcohol withdrawal severity. However, the OIG found that 13 of the 30 (43 percent) healthcare systems reviewed did not have written guidance for assessing alcohol withdrawal severity. Although not currently required, written guidance at either the national or healthcare system levels could facilitate the proper use and consistency of assessments with alcohol withdrawal severity scales, thus minimizing the risk of adverse patient safety outcomes.

## Guidance for Reassessment Frequency

The onset of alcohol withdrawal symptoms in patients varies, typically occurring 6 to 48 hours after last drink, and could progress to delirium tremens three to five days after the last ingestion of alcohol.[62] Frequent and repetitive assessments are typically conducted to ensure timely pharmacological intervention to prevent progression of withdrawal symptoms.[63] TJC requires that a "hospital [define], in writing, criteria that identify when additional, specialized, or more in depth assessments are performed" for any patient care, and that the determination of

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[59] VHA Handbook 1160.01; VHA Handbook 1160.06. For the purpose of this report, the OIG will define this systematic assessment of withdrawal symptoms and the risk for serious adverse consequences as the assessment of alcohol withdrawal severity.

[60] VA-DoD CPG.

[61] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*; VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*.

[62] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

[63] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome."

reassessment frequency be based on the patient's condition and the type of care and treatment provided.[64]

The following are examples provided by ASAM of when reassessments should be conducted based on a patient's condition. Patients with severe alcohol withdrawal symptoms should be strongly considered for admission to an inpatient setting, which will include monitoring with symptom reassessment every 1 to 4 hours for the first 24 hours.[65] Patients with moderate to severe alcohol withdrawal, or those requiring pharmacotherapy, should continue to be reassessed every 1 to 4 hours until the CIWA-Ar score is less than 10 (mild severity) for 24 hours, then may be reassessed every 4 to 8 hours.[66] However, if withdrawal seizures are present, the patient should be reassessed every 1 to 2 hours for 6 to 24 hours.[67]

Although requested, the OIG was not provided, nor able to find, national VHA guidance regarding the frequency for reassessing patients' alcohol withdrawal severity during inpatient care. A written response from OMHSP staff stated that the frequency for reassessing alcohol withdrawal severity in the inpatient setting was a clinical decision.

The OIG found that 15 of the 30 (50 percent) healthcare systems reviewed did not have written guidance for determining when alcohol withdrawal reassessments should be performed during inpatient care, as required by TJC standards.[68] The OIG believes healthcare systems may have failed to create written guidance for inpatient management of alcohol withdrawal due to the lack of VHA national requirements. Written guidance and training at either the national or healthcare system-level could facilitate the knowledge of proper administration and consistency of assessments conducted using alcohol withdrawal severity scales, thus minimizing the risk of adverse patient safety outcomes.[69]

## Guidance for Level of Care Determination

VHA requires healthcare systems "have a plan in place to ensure Veterans [patients] have access to the needed level of care."[70] The goal, according to VHA, is to care for and stabilize patients in the least restrictive setting possible. SUD treatment services, including management of alcohol

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[64] TJC, *Standards Manual*, PC.01.02.01; The OIG considers specialized SUD assessments to include alcohol withdrawal severity. For the purposes of this review, the OIG did not review whether TJC has had any prior concerns in this area during their reviews of VHA.

[65] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[66] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[67] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[68] TJC, *Standards Manual*, PC.01.02.01.

[69] For the purpose of this review, adverse patient safety outcomes may include delayed, missed, or improper: assessment, identification, and treatment of high-risk indicators for severe alcohol withdrawal that may otherwise halt the progression of symptoms that could potentially result in death of patients.

[70] VHA Handbook 1160.06.

withdrawal, is offered by VHA in various settings, including outpatient, inpatient, and residential care. SUD treatment services have levels of care within a continuum based on intensity, setting, and services available to meet patients' unique needs. Examples of the inpatient levels of care within the continuum include general medical, intensive care, mental health, and residential care.

TJC requires use of "an evidence-based, multidimensional admission assessment that includes, at a minimum, mental health, medical, and substance-use history for placement of the individual at the appropriate level of care."[71] The VA/DoD CPG recommends use of an algorithm that determines the appropriateness of inpatient management of alcohol withdrawal based on either use of the standardized assessment score from the CIWA-Ar or the presence of certain high-risk indicators.[72] OMHSP leaders stated that treatment decisions should be aligned with the recommendations in the VA/DoD CPG, to include determining the appropriate level of care for patient placement.[73]

In response to the OIG's request, the OMHSP did not provide delineated national guidance for determining the appropriate level of care for alcohol withdrawal management of patients. Instead, the OMHSP response stated, "there is insufficient evidence to recommend for or against using a standardized assessment that would determine initial intensity and setting of substance use disorder care rather than the clinical judgment of trained providers."

The OIG found that 17 of the 30 (57 percent) healthcare systems reviewed did not have written guidance to determine the inpatient level of care needed for management of alcohol withdrawal at the time of admission. Standardized written guidance for determining patients' level of care may contribute to staff's proper assessment and identification of patients' high-risk indicators used to support a decision to manage alcohol withdrawal in the inpatient setting. For example, this may result in a patient with a known history of withdrawal seizures or co-occurring conditions not receiving adequate monitoring in the inpatient setting for progression of severe alcohol withdrawal symptoms, including the potential for delirium tremens that could result in death.

## 2. Inpatient Treatment of Alcohol Withdrawal

VHA healthcare systems were generally found to not have written guidance for inpatient management of alcohol withdrawal, including the following treatment aspects: evaluation of co-

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[71] TJC, *Standards Manual,* CTS.02.03.13 EP1.

[72] Inpatient admission is recommended for patients with a severe alcohol withdrawal CIWA-Ar score greater than 19 or any one of the following high-risk indicators: history of delirium tremens or withdrawal seizures, inability to tolerate oral medication, co-occurring medical conditions, or risk of polysubstance withdrawal. Patients with a moderate alcohol withdrawal CIWA-Ar score greater than or equal to 10 and any of the following conditions: "recurrent unsuccessful attempts at ambulatory withdrawal management, reasonable likelihood that the patient will not complete ambulatory withdrawal management (e.g., due to homelessness), active psychosis or severe cognitive impairment." VA-DoD CPG.

[73] VA-DoD CPG.

occurring medical and mental health conditions, nursing consultation with prescriber, prescriber face-to-face evaluations, consultation with SUD experts, pharmacotherapy, and transfer of care determination.

### Evaluation of Co-occurring Medical and Mental Health Conditions

According to the VA/DoD CPG, providers should determine diagnoses per the DSM-5 criteria and develop a treatment plan that manages co-occurring medical and mental health conditions.[74] While this is not specific to inpatient alcohol withdrawal patients, the recommendation to evaluate co-occurring conditions in patients with alcohol withdrawal is implied.[75]

Alcohol withdrawal symptoms have the potential to worsen co-occurring conditions.[76] As such, patients with co-occurring medical conditions should receive alcohol withdrawal treatment concurrently in a setting appropriate to the monitoring required. For example, a patient with co-occurring heart disease should be in a setting with ongoing vital sign monitoring due to the increased risk of changes in blood pressure, heart rate, and potential arrythmias.[77]

The OIG found that 23 of the 30 (77 percent) healthcare systems reviewed did not have written guidance applicable to inpatient alcohol withdrawal that requires prescribers to evaluate both medical and mental health co-occurring conditions. The failure to evaluate patients' co-occurring conditions during inpatient management of alcohol withdrawal may lead to worsening medical and mental health conditions and increased risk of death. Although not currently required, written guidance at the healthcare system-level could help to ensure prescribers' evaluation of co-occurring conditions for effective treatment planning and management of alcohol withdrawal.

### Nursing Consultation with Prescriber

Safe, high quality, coordination of care "demands reliable teamwork and collaboration."[78] A lack of team member interactions can contribute to clinical harm; poor communication between nurses and prescribers could lead to issues for the patient, impacting effective recovery.[79] Applying this understanding to the treatment of alcohol withdrawal, the OIG reviewed

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[74] VA-DoD CPG.

[75] VA-DoD CPG.

[76] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*; American Psychiatric Association, *Treating Substance Use Disorders: A Quick Reference Guide*, August 2006.

[77] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Detoxification and Substance Abuse Treatment*, A Treatment Improvement Protocol (SAMHSA TIP) 45, 2006, revised 2015.

[78] MA Rosen et al., "Teamwork in healthcare: Key discoveries enabling safer, high-quality care," Am Psychol (2018).

[79] MA Rosen et al., "Teamwork in healthcare: Key discoveries enabling safer, high-quality care," Am Psychol (2018).

documents provided by VHA and found no evidence of written VHA-wide guidance for when nurses should consult prescribers regarding a patient's alcohol withdrawal severity.

In addition, the OIG found that 15 of the 30 (50 percent) healthcare systems reviewed did not have written guidance specifying requirements for when nurses should consult with a prescriber based on the alcohol withdrawal severity assessment findings. Written guidance regarding when nurses should consult with prescribers may reduce the risk in delays and inadequate treatment.

## Prescriber Face-to-Face Evaluation

Although not a VHA standard, SAMHSA states a physician [prescriber] should be available to conduct a face-to-face evaluation of patients within 24 hours of admission for alcohol withdrawal, and daily thereafter.[80] Alcohol withdrawal symptoms can be highly variable from patient to patient. Patients being treated for alcohol withdrawal in the inpatient setting should be carefully monitored for potential changes in the severity of their condition and complications, as fatal outcomes can occur.[81] During this review, the OIG did not identify written VHA-wide guidance in the information provided by VHA describing when prescribers should respond to a nurse's assessment of new or worsening complications of alcohol withdrawal by evaluating the patient face-to-face.

Of the 30 healthcare systems reviewed, the OIG found that 29 of the 30 (97 percent) healthcare systems lacked written guidance to define when a prescriber should respond with a face-to-face patient evaluation due to a patient's change of alcohol withdrawal symptoms. Written guidance that defines criteria for when a prescriber should evaluate a patient face-to-face may reduce the risk in delaying care or missing changes in a patient's condition that could lead to adverse patient safety outcomes.

## Consultation with SUD Specialists

VHA requires "consultations from specialists in substance use disorders [SUD]" be available to diagnose and develop a plan when needed for SUD withdrawal treatment.[82] Additionally, VHA guidance states the healthcare systems' SUD specialists may be required to assist staff in the inpatient setting with the assessment, identification, and management of a patient's withdrawal risk.[83] OMHSP leaders reported there was no national level guidance on how healthcare systems should be staffed with respect to SUD specialists; instead, it is the healthcare systems' responsibility to have adequate resources to ensure quality care. The OMHSP was unable to

[80] Face-to-face care is indicative to a prescriber or nurse being "present to administer" an assessment. SAMHSA, TIP 45.

[81] SAMHSA, TIP 45.

[82] VHA Handbook 1160.01.

[83] VHA Handbook 1160.04.

provide the OIG with a description of the healthcare system SUD specialist's role and responsibilities, and instead stated, "facilities designate their own SUD treatment experts and consultation processes are locally defined."

The OIG found that 26 of the 30 (87 percent) healthcare systems reviewed did not have written guidance related to consulting a SUD specialist for inpatient management of alcohol withdrawal. More specific VHA or system-level written guidance for the consultation of SUD specialists may assist in designating resources, such as staff, for assistance in diagnosing and developing a plan of treatment for inpatient alcohol withdrawal and avoiding treatment delays.

## Pharmacotherapy

Pharmacotherapy is an important component in the management of alcohol withdrawal, particularly for moderate to severe symptoms. In a prior OIG inspection, the OIG found that the selected medication regimen was insufficient to effectively address the patient's delirium tremens.[84]

At the time of the review, VHA required clinical practice guidelines, including the VA/DoD CPG, be consulted and utilized for pharmacotherapy in addition to clinical judgment for treating SUD, which includes alcohol withdrawal.[85] Benzodiazepines are the most common medications used for alcohol withdrawal to reduce the risk of withdrawal seizures and delirium tremens.[86] These drugs may be administered with either fixed-dosing, symptom-triggered dosing, front-loading dosing, or some combination of the three.[87] The VA/DoD CPG states benzodiazepines should be used for moderate to severe alcohol withdrawal management unless the risks of use outweigh the benefits, and that fixed-dosing or symptom-triggered dosing may be used for alcohol withdrawal management.[88] Patients receiving pharmacotherapy for withdrawal

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[84] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, Report No. 20-01917-242, August 26, 2021.

[85] VHA Handbook 1160.06. This handbook was active during this review and rescinded when replaced by VHA Directive 1160.06, September 27, 2023. The OIG reviewed the 2023 directive and found the language referenced in this statement is still consistent for use of clinical judgement. While the directive no longer states clinical practice guidelines must be consulted, the clinical practice guidelines remain as a tool to support evidence-based practices.

[86] Perry, "Inpatient Management of Acute Alcohol Withdrawal Syndrome;" Sandeep Grover and Abhishek Ghosh, "Delirium Tremens: Assessment and Management;" ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[87] Fixed dosing uses a consistent dose or lowering dose of medication administered to the patient according to a timed schedule. The symptom-triggered dosing is a medication regimen adjusted based on symptom severity as assessed with reoccurring evaluation of the patient with a validated assessment scale, such as the CIWA-Ar. A front-loading dosing regimen can include a moderate to high dose of long-acting medication given to control severe withdrawal symptoms of seizures and delirium. ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

[88] VA-DoD CPG.

symptoms, regardless of dosing modality, should be monitored for oversedation and decreased breathing.

Of the 30 healthcare systems reviewed, the OIG found 14 (47 percent) did not have evidence of healthcare system-level written pharmacotherapy guidance. Of the 16 (53 percent) healthcare systems that had written pharmacotherapy guidance, 15 described combining pharmacotherapy modalities, including symptom-triggered and fixed-dosing, with clinical judgment.[89] While written guidance at the healthcare system level is not currently required, written guidance for pharmacotherapy decision-making in inpatient alcohol withdrawal management could decrease the risk of treatment delays, potential errors, and inconsistent prescribing practices.[90]

### Transfer of Care Determination

VHA guidance states healthcare systems with mental health and other specialty care services, including SUD, must have written guidance or service agreements that define when and how to transfer and co-manage a patient's care between settings.[91] Patients must be monitored for the potential need to transfer to a different care setting within or outside the healthcare system.[92]

The OIG assessed whether healthcare systems had specific guidance for when and how to transfer the care of patients being treated for severe alcohol withdrawal. In order to make this assessment, the OIG reviewed all healthcare system-level written guidance submitted in response to the OIG's request. The OIG found that 17 of the 30 (57 percent) healthcare systems reviewed did not have written guidance for determining when and how to transfer patients to a different care setting after inpatient admission for alcohol withdrawal management. If healthcare systems had written guidance specific to the transfer of care for patients undergoing alcohol withdrawal management, the determination of when and how to transfer patients may reduce the risk of inappropriate or missed transfers to the needed care setting.

## 3. Inpatient Staff Training to Assess Alcohol Withdrawal Severity

ASAM recognizes that reliable administration of the CIWA-Ar scale, including scoring that is used to guide decisions for the management of alcohol withdrawal, requires staff training.[93] OMHSP, NHMP, and Office of Nursing Services leaders confirmed that VHA does not require nor offer national training related to the assessment of alcohol withdrawal severity; instead, individual healthcare systems are responsible for staff training.

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[89] VA/DoD CPG.

[90] Steven H. Woolf et al., "Potential benefits, limitations, and harms of clinical guidelines," *British Medical Journal* 318, (1999): 527–530.

[91] VHA Handbook 1160.01; VHA Handbook 1160.06.

[92] VHA Handbook 1160.04.

[93] ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*.

The NHMP director stated that due to the subjectivity in scales such as CIWA-Ar, healthcare systems should train staff to ensure consistent utilization and scoring. NHMP leaders emphasized the value of training based on the fact that healthcare systems may intermittently change the scale used based on resident physicians' familiarity alone. In a written statement, OMHSP leaders indicated that in lieu of training, expertise in patient care can be derived from staff's own professional training, licensure, and healthcare system policy. OMHSP leaders, however, reported an unwritten expectation that healthcare systems' chiefs of mental health services and inpatient medicine programs are responsible to appropriately educate staff to perform clinical care duties and ensure compliance with TJC standards. TJC states that staff performing SUD assessments and treatment planning must demonstrate the required knowledge and ability for assessing intoxication, withdrawal symptoms, co-occurring mental health conditions, and risk of self-harm.[94]

When asked specifically about how VHA ensures prescribers are trained on conducting assessments of alcohol withdrawal severity, a representative for OMHSP responded that prescribers are evaluated through competencies.[95] However, the NHMP director was unaware of any relevant competencies for clinicians [nurses and prescribers].

Of note, in a prior OIG inspection, the OIG found there was insufficient training and quality controls for inpatient medicine nurses regarding alcohol withdrawal care, including protocols for the assessment of alcohol withdrawal severity.[96]

When surveyed, 22 of the 30 (73 percent) healthcare systems reported not requiring training related to the assessment of alcohol withdrawal severity for either nurses or prescribers. When reviewing for written guidance, the OIG found that 13 of the 30 (43 percent) healthcare systems reviewed did not have written guidance for training inpatient staff, regardless of discipline, on the assessment of alcohol withdrawal severity. In addition, only 2 of the 17 (12 percent) healthcare systems with written staff training guidance ensured that the training was provided and applicable to both nurses and prescribers assessing alcohol withdrawal severity. While 13 were missing written guidance (as stated above), the OIG recognizes this did not correlate with the 22 healthcare systems that reported not requiring training.

In the absence of both national and healthcare system-specific written guidance related to staff training, along with the inconsistent understanding among the VHA program offices, there may

[94] TJC, *Standards Manual*, HRM.01.06.03.

[95] Competencies are described as a set of knowledge, skills, abilities and characteristics needed to perform a job, which are used to guide training, assessing and managing an employees' performance. Office of Personnel Management, *Policy, Data, Oversight Assessment & Selection*, accessed May 18, 2022, https://www.opm.gov/policy-data-oversight/assessment-and-selection/competencies/. For the purpose of this review, competencies were included as a method of training.

[96] VA OIG, *Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia,* Report No. 21-01048-154, May 12, 2022.

be an overall lack of staff training and familiarity with administering standardized alcohol withdrawal severity scales. If healthcare systems had written guidance for staff training on assessing alcohol withdrawal severity, the risk of delay or failure to identify and appropriately treat severe alcohol withdrawal could be reduced.

## 4. Oversight and Monitoring of Inpatient Management of Alcohol Withdrawal

According to the OMHSP, the National Mental Health Director of SUD is responsible for national VHA SUD written guidance and evaluating the quality of care for SUD services across healthcare systems. Of note, the National Mental Health Director of SUD reported VHA SUD guidance, as well as the VA/DoD CPG, are applicable to all clinicians regardless of inpatient setting. However, when the OIG inquired as to the national office responsible for alcohol withdrawal management guidance, specifically, OMHSP leaders reported a belief that the responsibility should be shared between both the SUD program and the medical programs from different clinical settings. In addition, when interviewed, the leaders of national programs and offices subject to the SUD guidance were aware of the SUD guidance but could not identify a program office ultimately responsible for inpatient management of alcohol withdrawal guidance across medical and mental health settings.[97] With the absence of national guidance specific to oversight of alcohol withdrawal management across inpatient settings, the OIG reviewed the broader national expectations, as well as healthcare system guidance, related to oversight responsibilities and monitoring.[98]

### Oversight Guidance for Inpatient Management of Alcohol Withdrawal

VHA SUD guidance states that the VISN director is responsible for ensuring compliance with any “relevant law, regulation, policy, and procedures,” and healthcare system directors are responsible for ensuring oversight of the quality and compliance of SUD services.[99] When interviewed, OMHSP leaders confirmed that oversight of SUD services was the responsibility of the VISNs and healthcare systems. Furthermore, the National Mental Health Director of SUD is responsible for assisting VISNs with healthcare system consultation and oversight of SUD services.

However, the OIG found that VHA’s SUD guidance does not delineate the specific expectations related to oversight responsibilities of SUD services for both the VISN and healthcare system

[97] Leaders were included from NHMP, ONS, OMHSP, PAS, and PBM programs and offices.

[98] VHA Handbook 1160.04. The VISN director is responsible for ensuring compliance with relevant policy and procedures; however, VHA Handbook 1160.04 does not describe any responsibility of the VISN director for the development of such policies.

[99] VHA Handbook 1160.04.

directors. The OIG would have expected the guidance to include this information; however, in its absence, the OIG reviewed whether healthcare systems had guidance to ensure oversight for the quality and compliance of SUD services, including inpatient management of alcohol withdrawal. Of the 30 healthcare systems reviewed, the OIG found that 29 (97 percent) did not have healthcare system written guidance for the oversight of inpatient management of alcohol withdrawal. If national or healthcare system written guidance detailed the specific expectations for oversight, the quality of inpatient management of alcohol withdrawal could be evaluated and assessed for compliance with available SUD guidance.

## Monitoring of Patient Outcomes for Alcohol Withdrawal Management

VHA quality management programs help ensure VHA facilities are compliant with industry standards, and screen for deviations from standards of care to support ongoing improvement of healthcare outcomes and delivery processes.[100]

While VHA program office leaders from the ONS, PAS, and PBM were unaware of any data collection efforts to monitor patient outcomes for inpatient management of alcohol withdrawal, leaders from the OMHSP and NHMP stated there is no hard look at alcohol withdrawal outcomes. According to the National Mental Health Director of SUD, while some SUD treatment data is collected nationally by evaluation centers to analyze and create benchmarks for performance, this data is not collected for the purpose of monitoring inpatient management of alcohol withdrawal. The National Mental Health Director of SUD further stated that inpatient management of alcohol withdrawal is inconsistently coded, and therefore, unreliable for collection across healthcare systems. When the OIG requested patient outcome data for inpatient management of alcohol withdrawal, OMHSP leaders reported, “VA does not currently systematically monitor alcohol withdrawal treatment, or clinical outcomes of alcohol withdrawal.”

Given the lack of national level data collection, the OIG evaluated whether healthcare systems collect and monitor patient outcome data to ensure the quality of inpatient management of alcohol withdrawal.[101] TJC requires organizations to assess the outcomes of patient care, treatment, or services through the aggregation and analysis of population data.[102] However, none of the healthcare systems reviewed provided written guidance to demonstrate the collection of data for monitoring patient outcomes related to inpatient management of alcohol withdrawal. The OIG would have expected healthcare systems to be assessing the outcomes of inpatient

[100] VA, “Quality and Patient Safety (QPS),” accessed May 18, 2022, https://www.va.gov/QUALITYANDPATIENTSAFETY/qm/index.asp.

[101] Examples of this data might include the number of patients admitted for alcohol withdrawal management and the duration of care in the inpatient setting.

[102] TJC, *Standards Manual*, CTS.03.01.09.

management of alcohol withdrawal in order to ensure compliance with the requirement set forth by TJC. Healthcare system written guidance to require and demonstrate how to monitor patient outcome data for inpatient management of alcohol withdrawal may result in improved evaluation of effectiveness and appropriateness of care.

The OIG concludes that the absence of national guidance for the collection and monitoring of patient outcomes from inpatient management of alcohol withdrawal is likely due to VHA's lack of a designated single program office with responsibility for nation-wide oversight.

# Conclusion

The OIG reviewed VHA national and healthcare system guidance for inpatient management of alcohol withdrawal; the review followed the identification of adverse clinical outcomes in prior OIG inspections that were attributed, in part, to inadequate assessment and management of alcohol withdrawal severity. Patients with severe alcohol withdrawal may develop the most serious complication called delirium tremens, which could be fatal if untreated or under-treated; however, with appropriate assessment and pharmacotherapy, the progression to severe withdrawal could be prevented.

Currently, there is no identified VHA national office with specific responsibility for policy development and operational oversight of inpatient management of alcohol withdrawal. When interviewed, OMHSP leaders deferred responsibility for the oversight of inpatient management of alcohol withdrawal guidance to VISNs and healthcare systems. Program offices provided the OIG with guidance utilized by healthcare systems, including the VA/DoD CPG, VHA SUD Handbook, VHA Inpatient Mental Health Services Handbook, and TJC standards. However, the OIG found an absence of national guidance that specifically addresses inpatient management of alcohol withdrawal.

The OIG evaluated national and healthcare system written guidance for specificity to inpatient management of alcohol withdrawal in four key areas: determination of alcohol withdrawal severity, inpatient treatment of alcohol withdrawal, inpatient staff training for assessing alcohol withdrawal severity, and oversight for inpatient management of alcohol withdrawal (guidance and monitoring).

The assessment of symptoms with a validated tool, such as the CIWA-Ar scale, is critical for the early identification and management of severe alcohol withdrawal, including guiding pharmacotherapy and inpatient admission decisions. The OIG found, via self-report, that all 30 of the healthcare systems reviewed use the CIWA-Ar to assess alcohol withdrawal severity.

When the OIG reviewed for written guidance related to alcohol withdrawal, 43 percent of the healthcare systems reviewed lacked guidance for the assessment of alcohol withdrawal symptoms, 50 percent for reassessment of alcohol withdrawal severity, and 57 percent for determining the appropriate inpatient level of care.

In general, the VHA healthcare systems reviewed did not have written guidance for inpatient management of alcohol withdrawal including the following aspects of treatment: evaluation of co-occurring medical and mental health conditions (77 percent), nursing consultation with prescriber (50 percent), prescriber face-to-face evaluations (97 percent), consultation with SUD experts (87 percent), pharmacotherapy (47 percent), and transfer of care determination (57 percent).

The OIG believes healthcare systems may have failed to create written guidance for inpatient management of alcohol withdrawal due to the lack of VHA national requirements. Written guidance and training at either the national or healthcare system level could facilitate increased knowledge of proper administration and consistency of assessments using alcohol withdrawal severity scales, thus minimizing the risk of adverse patient safety outcomes. The OIG found 43 percent of healthcare systems were missing written guidance for training inpatient staff on the assessment of alcohol withdrawal severity. Most of the healthcare systems reviewed also reported that training related to the assessment of alcohol withdrawal severity is not required for nurses or prescribers. ASAM recognizes that reliable administration of the CIWA-Ar scale, including scoring that is used to guide decisions for the management of alcohol withdrawal, requires staff training.

The OIG found almost all 30 healthcare systems reviewed did not have written guidance ensuring oversight for the quality and compliance of SUD services, including inpatient management of alcohol withdrawal. In addition, none provided written guidance to demonstrate the collection and monitoring of patient outcome data for inpatient management of alcohol withdrawal. If national or healthcare system written guidance detailed specific oversight expectations, the quality of inpatient management of alcohol withdrawal could be evaluated and assessed for compliance with available SUD guidance. Implementation of healthcare system written guidance to require and demonstrate how to monitor patient outcome data for inpatient management of alcohol withdrawal may result in improved evaluation of effectiveness and appropriateness of care.

## Recommendations 1–3

1. The Under Secretary for Health consider identifying a national program office to be responsible for oversight of alcohol withdrawal management across inpatient settings.
2. The Under Secretary for Health ensures the identified national program office responsible for oversight of alcohol withdrawal management consider requiring the development and implementation of written guidance for the management of alcohol withdrawal across all inpatient settings, to include: (a) expectations for determining alcohol withdrawal severity, level of care, and when transfer of care is indicated; (b) expected actions of nurses to communicate with prescribers based on patients’ changes in symptoms or alcohol withdrawal severity and when that communication should be followed by a prescribers face-to-face

evaluation of a patient; (c) expectations for the evaluation of co-occurring conditions, expert consultation, and pharmacotherapy approaches; and (d) expectations for the collection and monitoring of outcome data for inpatient management of alcohol withdrawal at the national and healthcare system level.

3. The Under Secretary for Health consider the implementation of training for inpatient staff on the administration of standardized alcohol withdrawal severity scales.

# Appendix A: Under Secretary for Health Memorandum

## Department of Veterans Affairs Memorandum

Date: September 27, 2023

From: Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report regarding the Veterans Health Administration's (VHA) inpatient management of alcohol withdrawal. VHA concurs with all three recommendations and submits the attached action plan.
2. VHA agrees that national guidance on inpatient management of alcohol withdrawal management will improve the well-being of Veterans who obtain care from VHA medical facilities.
3. Thank you again for partnering with VHA to ensure Veterans receive the high-quality healthcare they deserve. Comments regarding this memorandum may be directed to the GAO OIG Accountability Liaison Office at VACOVHA10BGOALOIG@va.gov.

*(Original signed by:)*

Shereef Elnahal, M.D., MBA

[**OIG Comment:** The OIG received the above memorandum from the Office of the Under Secretary for Health on November 2, 2023.]

# Office of the Under Secretary for Health Response

**VETERANS HEALTH ADMINISTRATION (VHA)**
**Action Plan**

**Review of Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal**
**(2021-01488-HI-1146)**

**Recommendation 1. The Under Secretary for Health consider identifying a national program office to be responsible for oversight of alcohol withdrawal management across inpatient settings.**

**VHA Comments:** Concur

The Assistant Under Secretary for Health for Clinical Services has designated the Hospital Medicine program office as responsible for national oversight of alcohol withdrawal management across inpatient settings. VHA asks the Office of Inspector General to consider closing this recommendation.

Status: Completed Completion Date: September 2023

**OIG Comment:**

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

**Recommendation 2. The Under Secretary for Health ensures the identified national program office responsible for oversight of alcohol withdrawal management consider requiring the development and implementation of written guidance for the management of alcohol withdrawal across all inpatient settings, to include: (a) expectations for determining alcohol withdrawal severity, level of care, and when transfer of care is indicated; (b) expected actions of nurses to communicate with prescribers based on patients' changes in symptoms or alcohol withdrawal severity and when that communication should be followed by a prescribers face-to-face evaluation of a patient; (c) expectations for the evaluation of co-occurring conditions, expert consultation, and pharmacotherapy approaches; and (d) expectations for the collection and monitoring of outcome data for inpatient management of alcohol withdrawal at the national and healthcare system level.**

**VHA Comments:** Concur

The Hospital Medicine program is developing a VHA Notice that delineates a requirement that every facility develop local, written guidance for management of alcohol withdrawal across all its inpatient settings. In addition, the Notice will provide guidance about the setting and management of alcohol withdrawal. Each facility's

written guidance will require the inclusion of: (a) expectations for determining alcohol withdrawal severity, level of care and when transfer of care is indicated; (b) expected actions based on patient symptoms and assessment of alcohol withdrawal severity for nurses' consultation to prescribers and prescriber face-to-face evaluations; (c) expectations for the evaluation of co-occurring conditions, expert consultation and pharmacotherapy approaches; and (d) expectations for the collection and monitoring of outcome data for inpatient management of alcohol withdrawal at the health care system level. The Hospital Medicine program and collaborating program offices will monitor outcome data at the national level.

Status: In progress Target Completion Date: January 2024

**Recommendation 3. The Under Secretary for Health consider the implementation of training for inpatient staff on the administration of standardized alcohol withdrawal severity scales.**

**VHA Comments:** Concur

The aforementioned VHA Notice will mandate that all inpatient providers using the Clinical Institute Alcohol Withdrawal Assessment (CIWA-Ar) complete the CIWA-Ar training available in VA's Talent Management System: CLE-118 Withdrawal Assessment CIWA/COWS (Talent Management System #4490709). In order to permit the use of other validated scales such as the Minnesota Detoxification Scale (MINDS) and the Severity of Ethanol Withdrawal Scale (SEWS), facilities that don't use CIWA-Ar must provide standardized, equivalent training for the use of their scale.

Status: In progress Target Completion Date: April 2024

# Appendix B: Alcohol Withdrawal Scales

| Abbreviation | Scale Name | Brief Description | Primary Use | Appropriate setting | Summary of Evidence | Reference |
|---|---|---|---|---|---|---|
| ASSIST | Alcohol, Smoking and Substance Involvement Screening Test | 8 items<br>Interview format | Alcohol use screen | Any | Results of a study in 7 countries indicate that the ASSIST provides a valid measure of risk for individual substances and for total substance involvement. | WHO, 2002 |
| AUDIT | Alcohol Use Disorder Identification Test | 10 items | Alcohol use screen,<br>Risk of alcohol withdrawal | Any | AUDIT is a useful alcohol screen in general medical settings and that its ability to correctly predict which patients will experience alcohol withdrawal is increased when used in combination with biological markers. | Dolman et al., 2005; Saunders et al., 1993 |
| AUDIT-PC | Alcohol Use Disorders Identification Test-(Piccinelli) Consumption | 10 items<br>Range 0-19 | Alcohol use screen, Risk of alcohol withdrawal | Hospital | Admission AUDIT-PC score is an excellent discriminator of AWS (Sensitivity=91%, Specificity=98.7%) | Pecoraro et al., 2014 |
| AWS | Alcohol Withdrawal Scale | 11-items<br>Based on CIWA-A<br>In German | Risk of delirium | Hospital | AWS scale had good performance in predicting alcohol withdrawal delirium | Wetterling et al., 1997a |
| AWS - Newcastle | Alcohol Withdrawal Scale | 10 items Based on CIWA | Withdrawal Severity | Hospital | Patients demonstrated shorter overall course of alcohol withdrawal using the AWS compared with WAS | Foy et al., 2006 |
| BAWS | Brief Alcohol Withdrawal Scale | 5 items<br>Scored 0–3 | Withdrawal severity | Hospital | BAWS patients received less diazepam and had fewer assessments, but both groups had similar lengths of stay, treatment completion rate, no incidence of seizure or delirium. | Rastegar et al., 2017 |
| CAM-ICU | Confusion Assessment Method | 4 items | Confusion | ICU | Excellent reliability and validity in identifying patients with delirium in ICU | Ely et al., 2001 |
| CIWA-Ar | Clinical Institute Withdrawal Assessment, Revised | 10 items | Symptom Assessment Scale | Any | Well established reliability and validity | Sullivan et al., 1989 |
| DDS | Delirium Detection Scale | 8 items | Delirium | Hospital | Good reliability and validity specific to detection of delirium | Otter et al., 2005 |
| GMAWS | Glasgow Modified Alcohol Withdrawal Scale | 5 items<br>Scored 0–2 with max score of 10 | Withdrawal severity | Hospital | GMAWS score of >=1 predicted CIWA-A >=8, with a sensitivity of 100% and a specificity of 12%. GMAWS score of >=2 predicted CIWA-A >=8, with a sensitivity of 98% and a specificity of 39%. | Holzman et al., 2016b |

| | | | | | | |
|---|---|---|---|---|---|---|
| LARS | Luebeck Alcohol-Withdrawal Risk Scale | 11 items 10 items | Risk of severe withdrawal | Hospital | Predicted severe withdrawal among patients admitted for alcohol withdrawal management | Wetterling et al., 2006 |
| MINDS | Minnesota Detoxification Scale | 9 items | Symptom severity | Hospital; ICU | No formal validity study | DeCarolis et al., 2007 |
| PAWSS | Prediction of Alcohol Withdrawal Severity Scale | 10 items | Risk of severe withdrawal | Hospital; ICU | Predicted complicated alcohol withdrawal among medically ill, hospitalized patients | Maldonado et al., 2014; 2015 |
| RASS | Richmond Agitation-Sedation Scale | One item Scored on a continuum with +4 (combative), 0 (alert and calm), and -5 (unarousable) | Sedation and agitation | Medical and surgical | Reliability and validity in medical and surgical patients, including patients who are sedated and/or ventilated. | Sessler et al., 2002 |
| SAWS | Short Alcohol Withdrawal Scale | 10-items Scored 0–3 Designed to be self-administered | Withdrawal severity | Ambulatory and Inpatient | High internal consistency, good construct and concurrent validity. | Gossop et al., 2002 |
| SEWS | Severity of Ethanol Withdrawal Scale | 7 items Scored 0–3. | Withdrawal severity | ICU | SEWS-driven protocol led to shorter treatment episodes, possibly driven by high administration of medication in first 24hours of treatment | Beresford et al., 2017 |
| SHOT | Sweating, Hallucinations, Orientation, and Tremor | 4-items Range 0-10 | Withdrawal severity | Emergency Department | Showed potential for measuring pretreatment alcohol withdrawal severity in the emergency department. | Gray et al., 2010 |
| WAS | Withdrawal Assessment Scale | 18 Items Based on CIWA | Withdrawal severity | Hospital | Use of a shortened 10-item CIWA led to similar complication rates but reduced symptom duration compared to 18-item CIWA. | Foy et al., 2006 |

***Figure 2.*** *Alcohol Withdrawal Scales Table*
*Source: ASAM, The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management, January 23, 2020.*

# Appendix C: CIWA-Ar Scale

**Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)**

**Patient:**________________________ **Date:** _______________ **Time:** ______________ (24 hour clock, midnight = 00:00)

**Pulse or heart rate, taken for one minute:**_______________________ **Blood pressure:**______

**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

***Figure 3.*** *CIWA-Ar Scale, Revised.*
*Source: Sullivan et al., “Assessment of Alcohol Withdrawal: The Revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar),” British Journal of Addiction 84 (1989):1353–1357.*

# OIG Contact and Staff Acknowledgments


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