# Capsule Commentary on Stephens et al., Who Needs Inpatient Detox? Development and Implementation of a Hospitalist Protocol for the Evaluation of Patients for Alcohol Detoxification

*Thomas O. Staiger, MD*

Division of General Internal Medicine, University of Washington School of Medicine, Seattle, WA, USA.

J Gen Intern Med 29(4):647
DOI: 10.1007/s11606-014-2772-6


In this paper, Stephens et al.[1] describe the development, implementation, and outcomes of a protocol to determine which patients presenting to an academic health center emergency department (ED) requesting alcohol detoxification require inpatient admission. Their interdisciplinary group synthesized existing evidence and developed a protocol that recommended admission for patients with a Clinical Institute Withdrawal Assessment (CIWA) score> 15, or for those with CIWA scores 8–15 and a prior history delirium tremens (DT). Admissions decreased from 18.9/month to 15.9/month post-implementation. ($p$=0.037) Complete follow-up was not available for patients discharged from the ED; however; no patient discharged to outpatient treatment returned to the ED within 48 h and required inpatient admission for detoxification. Patient-centered alcohol outcomes, health-related and otherwise (patient costs, arrests, family stress, etc.) were not obtained.

There is very limited previous literature. A 2004 algorithm admitted patients based on comorbidities, history of DTs and CIWA score > 8.[2] They reported a decline in admissions for DT, but provided few details of patient outcomes. A randomized controlled trial (RCT) comparing inpatient and intensive (daily) outpatient management of acute alcohol detoxification found no difference in patient outcomes.[3] Additional studies with more robust outcome information, including more patient-centered outcome assessment, will be needed to determine the optimal protocol for this common problem.

There is an increasing need for physicians to lead quality improvement activities; however, physicians engaged in quality improvement (QI) often confront challenges converting those activities into tangible scholarly products.[4] Standards for Quality Improvement Reporting Excellence Guidelines (SQUIRE) provide an excellent checklist of items for authors to include when reporting QI activities, but don't include specific recommendations on how to format a report on the development and implementation of a protocol.[5] Stephens chose to employ a format that includes methods and results sections for each of protocol development, implementation, and evaluation. Others interested in taking a scholarly approach to protocol development and implementation may find this a useful template to follow.

***Conflict of Interest:*** *The author has no conflict of interest with this manuscript.*

***Corresponding Author:*** *Thomas O. Staiger, MD; Division of General Internal Medicine, University of Washington School of Medicine, Seattle, WA, USA (e-mail: staiger@u.washington.edu).*

## REFERENCES

1. **Stephens JR, Liles EA, Dancel R, et al.** Who needs inpatient detox? Development and implementation of a hospitalist protocol for the evaluation of patients for alcohol detoxification. J Gen Intern Med. 2013; doi:10.1007/s11606-013-2571-5.
2. **Asplund CA, Aaronson JW, Aaronson HE.** 3 regimens for alcohol withdrawal and detoxification. J Fam Pract. 2004;53(7):545–54.
3. **Hayashida M, Alterman AI, McLellan AT, et al.** Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-moderate alcohol withdrawal syndrome. New Eng J Med. 1989;320(6):358–65.
4. **McIntyre K, Shojonia KG.** The challenges of quality improvement reports and the urgent need for more of them. Thorax. 2011;66(12):1020–2.
5. **Davidoff F, Batalden P, Stevens D, et al.** Publication guidelines for improvement studies in health care: Evolution of the SQUIRE project. Ann Intern Med. 2008;149(9):670–6.

*Published online January 22, 2014*