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Owner	Shama Faheem: Chief Medical Officer
Policy Area	Medical
References	DSM-V, MDHHS, SAMSHA

Medication Assisted Treatment (MAT) for Alcohol Use Disorder (AUD)

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POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to provide guidance to its providers of Medication Assisted Treatment (MAT) that services be clinically driven and are delivered based on individual need. MAT providers are required to provide counseling, based on medical necessity criteria and in combination with medications used in MAT.

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to have guidelines on identification and treatment of all persons served who have Alcohol Use Disorder.

PURPOSE

Alcohol use disorders are among the most prevalent of all substance use disorders worldwide. The single year prevalence globally has been estimated to be over 100 million individuals [1]. Additionally, nearly 3 million deaths (5.3 percent of all deaths globally) have been attributed to alcohol in a single year.

Alcohol use disorder (AUD) involves frequent or heavy alcohol drinking that becomes difficult to control and leads to problems such as in relationships, work, school, family, or other areas. AUD is common and often goes untreated. There are treatments that work, including medication, therapies, and support/self-help groups. Less than 5% of individuals in the U.S. with a diagnosis of alcohol use disorder receive any treatment. Evidence-based treatments including behavioral treatments (therapy/counseling), medication, and mutual support programs can play a major role in treating AUD.

The purpose of this policy is to specify standards on providing MAT services based on medical necessity to individuals in order to reduce drug related harm and address their symptoms. Individuals with substance use disorder can benefit from treatment services in combination with medication.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Clinically Responsible Service Provider (CRSP) and their subcontractors, Specialty Providers, Crisis Services Vendors, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, Individuals with Intellectual and/or

Developmental Disabilities (I/DD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), Autism

3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Opioid Health Homes, Autism, Grants, General Fund

KEYWORDS

Substance Use Disorder (SUD): Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Medication Assisted Treatment(MAT): MAT refers to medications approved by the FDA to treat substance use disorders in combination with counseling and support services.

Alcohol Use Disorder (AUD): As defined by the DSM-5, an alcohol use disorder or AUD, is a problematic pattern of alcohol use that leads to clinically significant impairment or distress. This is sometimes referred to as alcohol dependence, alcoholism, or alcohol abuse.

Medications for Alcohol Use Disorder (MAUD): Acamprosate, disulfiram, and naltrexone are the most common medications used to treat alcohol use disorder. They do not provide a cure for the disorder but are most effective for people who participate in a treatment program.

ASAM means the comprehensive set of standards and decision rules established by the American society of addiction medicine that use a holistic, person-centered approach to determining the appropriate level of care and developing treatment plans for individuals with addiction and co-occurring conditions.

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Alcohol Withdrawal: Cessation of (or reduction in) alcohol use that has been heavy and prolonged ***and*** two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use: autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm), increased hand tremor, insomnia, nausea or vomiting, transient visual, tactile, or auditory hallucinations or illusions, psychomotor agitation, anxiety, generalized tonic-clonic seizures ***and*** the signs or symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning ***and*** the signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

STANDARDS

1. At the point of initial contact, individuals requesting MAT services are screened by the DWIHN Access and Call Center to determine the level of risk as emergent, urgent or routine. The Access Center is required to address all six dimensions of the ASAM criteria during the screening to determine the most appropriate type and level of treatment for the person and provide a provisional eligibility determination. Individuals will be presented with minimum eligibility considerations to include the following:.
    a. Acute intoxication and/or withdrawal potential.
    b. Biomedical conditions and complications.
    c. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).
    d. Treatment acceptance/resistance.
    e. Relapse/continued use potential.
    f. Recovery/living environment.
        1. Additional considerations include:

i. Past treatment failure(s)
ii. Access to transportation
iii. Individual mobility
iv. Pregnant Women
v. Adolescents

2. The Individual is offered appropriate options for treatment based on medical necessity and the condition.
3. The individual is assigned to a DWIHN-SUD provider that delivers MAT services. MAT is a covered service for all Medicaid enrollees who meet the medical necessity criteria for receipt of the service.
4. **Screening for Alcohol Use Disorder:**
    a. Clinicians should routinely screen persons served for at-risk drinking, provide brief interventions as needed, and assess for alcohol use disorder when indicated. Universal screening for alcohol problems can be conducted concurrently with screening for other medical disorders as part of a routine examination.
    b. Screening also should be conducted before prescribing one of the many medications that may interact negatively with alcohol or if a patient reports using an over-the-counter product or herbal preparation that may precipitate an adverse reaction.
    c. Screening is especially important in patients who:
        1. Are pregnant or trying to conceive.
        2. Are at risk for binge drinking or heavy drinking.
        3. Have health problems that may be induced or exacerbated by alcohol (e.g., cardiac arrhythmia, depression or anxiety, dyspepsia, insomnia, liver disease, a history of traumatic injury).
        4. Have one or more chronic health problems (e.g., diabetes, heart disease, hypertension, gastrointestinal [GI] disorders, chronic pain) that are not responding to treatment.
        5. Have social or legal problems that may be caused or worsened by alcohol use (e.g., marital/family issues, driving-while-under-theinfluence convictions).
    d. Screening can be conducted through use of a simple, validated self-report instrument such as the Alcohol Use Disorders Identification Test (AUDIT) (http://www.whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf), which takes fewer than 5 minutes to complete, or through interview questions.
    e. Clinicians should also consider using Screening, Brief Intervention, and Referral to Treatment (SBIRT), an approach in which screening is followed up as appropriate with brief intervention, and with referral to treatment for those needing more extensive care (http://www.samhsa.gov/sbirt)
5. Providers should get comprehensive history and perform physical and mental status exam. The physical examination should evaluate neurocognitive function and identify signs and sequelae of alcohol use.
6. Laboratory tests help confirm the presence of heavy drinking and identify alcohol-related damage. Initial and followup laboratory testing can help motivate individuals and reinforce their progress in treatment.
7. The provider and person served should mutually agree on an initial goal for MAT (MAUD) and be willing to refine and revise that goal as treatment progresses. Providers should ensure individuals are educated about what to expect during treatment and are offered hope and the expectation of recovery.
8. Appropriate informed consent should be obtained before MAT is initiated. Before treatment begins, the person-served should understand what to expect, including how the proposed medication works and the

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associated risks and benefits. Elements of effective patient education include the following points:

   a. Information about alcohol use disorder as a chronic medical disorder
   b. A description of what to expect from treatment
   c. Information about the medication and the reasons it was selected, including a discussion of potential risks and benefits and the time to full effect
   d. For women of childbearing age, explanation of the importance of using an effective birth control method
   e. Clear information about what to do if the patient resumes alcohol use after a period of abstinence
   f. The importance of informing all physicians and dentists that the patient is taking a medication for alcohol use disorder, to avoid inadvertent drug interactions, especially when surgery (including dental surgery) is being considered
   g. Symptoms that should be reported to the prescribing physician
   h. A discussion of the importance of concurrent psychosocial treatment and participation in a mutual-help group ? Plans for follow-up care

9. **Alcohol withdrawal syndrome:**
   a. Alcohol withdrawals can be severe and potentially fatal, so it is particularly important to assess the need for residential/medically managed level withdrawal. It is also important to discuss these risks and resources with person served. Patients who need medically supervised detoxification may need to be referred to an addiction specialist or substance use disorder treatment program that can provide the needed level of withdrawal treatment.
   b. Withdrawal symptoms can include anxiety, tremors, nausea, and insomnia. In severe cases, withdrawal can progress to seizures and delirium tremens, which is characterized by visual hallucinations, profound confusion, agitation, hyperthermia, and cardiovascular collapse.
   c. Use of a standardized clinical rating instrument for withdrawal, such as the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar) (https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf), is helpful because it guides the clinician through multiple domains of alcohol withdrawal.

10. **Medication: Medications for Alcohol Use Disorder (MAUD**) Medications are often used to treat AUD. There are three FDA-approved medications for AUD.
    a. Acamprosate - for people in recovery, who are no longer drinking alcohol and want to avoid drinking. It works to prevent people from drinking alcohol, but it does not prevent withdrawal symptoms after people drink alcohol. The use of acamprosate typically begins on the fifth day of abstinence, reaching full effectiveness in five to eight days. It is taken in tablet form three times a day.
    b. Disulfiram - treats chronic alcoholism and is most effective in people who have already stopped drinking alcohol or are in the initial stage of abstinence. Taken in a tablet form once a day, disulfiram should never be taken while intoxicated and it should not be taken for at least 12 hours after drinking alcohol. Unpleasant side effects (nausea, headache, vomiting, chest pains, difficulty breathing) can occur as soon as ten minutes after drinking even a small amount of alcohol.
    c. Naltrexone - blocks the euphoric effects and feelings of intoxication and allows people with alcohol use disorders to reduce alcohol use and to remain motivated to continue to take the medication, stay in treatment, and avoid relapses.Behavioral treatments

11. Some patients may respond to psychosocial interventions and others to medication therapy alone, but most patients benefit from a combination of these approaches.
    a. **Behavioral treatments**, therapy or counseling, can help people understand and change

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behaviors that lead to heavy drinking. Counseling can involve:

1. Developing skills to help stop or reduce drinking.
2. Helping to build a strong social support system.
3. Working to set reachable goals.
4. Learning to cope with or avoid triggers that might lead to relapse.
5. Behavioral treatments can include therapies such as cognitive behavioral therapy, motivational enhancement therapy, marital and family counseling, brief interventions, and others. (See more on psychotherapy.)

b. **Mutual Support**

1. Community-based peer support groups such as Alcoholics Anonymous and other 12-step programs are helpful for many people but are not a substitute for medication and therapy
2. NAMI (National Alliance on Mental Illness) offers a variety of resources, support phone lines, support groups, and more for individuals and for family members.

c. **Support for Family and Friends**

1. Al-Anon and Al-Ateen – Support for people who are worried about someone with a drinking problem.
2. Adult Children of Alcoholics/Dysfunctional Families - A Twelve Step, Twelve Tradition program of people who grew up in dysfunctional homes.
3. NAMI (National Alliance on Mental Illness) – NAMI offers a variety of resources, support phone lines, support groups, and more for individuals and for family members.
4. CRAFT: Community Reinforcement and Family Training: CRAFT teaches family and friends effective strategies for helping their loved one to change and to feel better themselves. CRAFT works to affect the loved one's behavior by changing the way the family interacts with him or her. It is a skills-based program that impacts families in multiple areas of their lives, including self-care, pleasurable activities, problem-solving, and goal setting. At the same time, CRAFT addresses their loved one's resistance to change.

12. Addressing Co-Occurring Disorders is crucial. Research studies show that the most effective way to treat co-occurring disorders is through integrated treatment. When medication management and addiction treatment services are delivered by separate providers, close coordination and integration of services is essential. All individuals involved in the patient's treatment, including addiction medicine specialists, need to establish close linkages and open communications.
13. FASD prevention should be a part of all substance use disorder treatment programs that serve women. Providing education on the risks of drinking during pregnancy and FASD detection and services are easily incorporated into the treatment regimes. It is also recommended that programs who serve men with children, consider providing FASD prevention information.
14. DWIHN and its SUD providers are contractually obligated to meet the requirements of the Medicaid Provider Manual with regard to delivery of substance abuse services. For additional information please see the attachment below titled **Behavioral Health and Intellectual Developmental Disability Supports and Services-MPM-Substance Abuse Services) MPM Jan 2023**
15. Michigan law requires the review of Michigan Automated Prescription System (MAPS) report prior to prescribing or dispensing to a person a controlled substance in a quantity that exceeds a 3-day supply. Further, the act requires that a licensed prescriber be registered with MAPS prior to prescribing or dispensing a controlled substance to a person.

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16. SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR § 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana) (https://www.samhsa.gov/sites/default/files/grants/fy22-award-standard-terms-conditions.pdf)
17. For additional guidance on MDHHS policy and procedure regarding Behavioral Health and Substance Use please refer to MDHHS https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories
18. Attached resources and evidence-based guidelines can be used as resources and guidelines to help manage Substance Use Disorder Treatment and Medication Assisted Treatment.
19. **References:**

    a. NIAAA. "Understanding Alcohol Use Disorder." https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-use-disorder
    b. NIAAA. "Alcohol Facts and Statistics." https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics Worley, J. "Alcohol Use Disorder Providing Better Care." J. Psychosoc. Nurs. Ment. Health Serv. 2021. https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories
    c. https://psychiatryonline.org/doi/book/10.1176/appi.books.9781615371969
    d. https://ars.apps.lara.state.mi.us/AdminCode/DownloadAdminCodeFile?FileName=R%20325.1301%20to%20R%20325.1399.pdf&ReturnHTML=True
    e. https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/treatment
    f. https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/drugcontrol/reportstats/reportcontent/policies-and-advisories
    g. https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
    h. https://store.samhsa.gov/sites/default/files/sma13-4380.pdf
    i. https://store.samhsa.gov/sites/default/files/sma15-4907.pdf
    j. https://www.samhsa.gov/medications-substance-use-disorders

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QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, risk management program, and Quality Assessment/Performance Improvement Program.

The quality improvement programs of Network Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Contracted Network Providers, and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended..

LEGAL AUTHORITY

1. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended)
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/

CMHSP contracts in effect, and as amended)

3. Substance Abuse and Mental Health Services Administration (SAMSHA)
4. Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.1301 to R 325.1399

RELATED POLICIES AND PROCEDURES

1. SUD Assessment Policy
2. SUD Network Policy
3. IPOS
4. Integrated Biopsychosocial Assessment
5. MAT for Opioid Use Disorder

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

This policy applies to internal and external DWIHN operations.

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Attachments

ALCOHOL SCREENING YouthGuide.pdf

ALcohol use TIP-sma13-4380.pdf

american-psychiatric-association-2018-the-american-psychiatric-association-practice-guideline-for-the-pharmacological.pdf

Behavioral Health and Intellectual Developmental Disability Supports and Services-MPM Jan 2023 Substance Abuse Service.pdf

CMS mandated coverage.pdf

fy22-award-standard-terms-conditions.pdf

MAt alcohol-sma15-4907.pdf

MAT in ED-pep21-pl-guide-5.pdf

MDHHS__SUD_Manual.pdf 2018.pdf

Pharmacological Treatment of Patients with Alcohol Use Disorders.pdf

Approval Signatures

Step Description	Approver	Date
Stakeholder Feedback	Allison Smith: Project Manager	Pending

Compliance/Administrative Review	Yolanda Turner: VP of Legal Affairs	07/2024
Compliance/Administrative Review	Stacie Durant: VP of Finance	06/2024
Compliance/Administrative Review	Tiffany Devon: Director of Communications	06/2024
Compliance/Administrative Review	Sheree Jackson: Vice President of Compliance	06/2024
Compliance/Administrative Review	Manny Singla: Executive VP of Operations	06/2024
Clinical Review Committee	Marlena Hampton: UM Administrator	06/2024
Clinical Review Committee	Cassandra Phipps: Director of Children's Initiatives	05/2024
Clinical Review Committee	Judy Davis: Director of Substance Abuse Disorders	05/2024
Clinical Review Committee	April Siebert: Director of Quality Improvement	05/2024
Clinical Review Committee	Vicky Politowski: Director of Integrated Care	05/2024
Clinical Review Committee	Daniel West: Director of Crisis Services	05/2024
Clinical Review Committee	Ebony Reynolds: Vice President of Direct Clinical Services	05/2024
Clinical Review Committee	Jacquelyn Davis: Clinical Officer	05/2024
Clinical Review Committee	Melissa Moody: VP of Clinical Operations	05/2024
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	05/2024
Clinical Review Committee	Ryan Morgan: Director of Residential Services	05/2024
NCQA Committee	Shana Norfolk: Strategic Planning Administrator	05/2024
NCQA Committee	Tania Greason: Quality Administrator	05/2024
NCQA Committee	Maria Stanfield: Director of Strategic Operations	05/2024
NCQA Committee	Allison Smith: Project Manager	05/2024
Unit Review and Approval	Shama Faheem: Chief Medical Officer	05/2024

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