

## **Withdrawal Management Benefit Narrative**

The Substance Abuse Prevention and Control (SAPC), a program within the Los Angeles County Department of Public Health (DPH) and Health Agency, will implement an initial benefit package of Substance Use Disorder (SUD) services within the initial twelve months of approval of its Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation plan. The initial benefit package will include Withdrawal Management (WM) levels of care for adults, including ambulatory WM (ASAM levels 1-WM and 2-WM), residential WM (ASAM 3.2-WM), and inpatient WM (ASAM 3.7-WM and 4-WM) in Chemical Dependency Recovery Hospital (CDRH) and Free Standing Psychiatric Hospital (FSPH) settings. Inpatient WM benefits within SAPC's network are yet to be defined. Importantly, when inpatient WM services are provided in general acute hospital settings, they are funded outside of the Drug Medi-Cal system.

Withdrawal Management is not an ASAM level of care for youth and is not included in the DMC-ODS youth benefit package. However, it may be approved for youth on a case-by-case basis if determined to be medically necessary, and may be integrated with services in other settings.

Withdrawal Management services do not require pre-authorization or authorization in any setting.

### **Background:**

When individuals stop using alcohol and/or other drugs, their body and mind may experience physical and/or psychological symptoms; this process is commonly referred to as withdrawal. Physical symptoms of withdrawal may include sweating, increased heart rate, muscle tension, difficulty breathing, shakes, nausea, vomiting, diarrhea, seizures, and coma or death. Withdrawal may also lead to psychological symptoms such as restlessness, irritability, anxiety, insomnia, poor concentration, and depression.

The severity of these withdrawal symptoms can vary depending on the substance used, the amount/duration/frequency of use, and individual factors such as metabolism and body composition. Importantly, withdrawal from alcohol and sedative-hypnotic medications (benzodiazepines such as alprazolam, diazepam, etc.) can be life threatening without appropriate management of withdrawal symptoms. Additionally, withdrawal from other substances may also lead to distressful symptoms that may lead to life threatening outcomes such as suicide, risky behavior, or relapse. As a result, patients being considered for withdrawal management may require acute medical and/or psychiatric care.

Given the significant discomfort and distress that is frequently associated with withdrawal, these symptoms oftentimes lead affected individuals to continue to use substances in order to relieve these withdrawal symptoms. As such, the withdrawal period represents a critical treatment engagement opportunity for SUD providers because it may represent a point of first contact with the SUD treatment system and serve as the first step in an individual's recovery journey.

### **Withdrawal Management**

Withdrawal management, also known as detoxification, is a set of treatment interventions aimed at managing acute intoxication and withdrawal from alcohol and other substances. The rationale for WM is to provide the appropriate level of support to allow for patient safety during the

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withdrawal period, which then allows the client and treatment team to work together to determine the optimal ongoing treatment strategy. Effective WM will increase the likelihood that an individual will complete withdrawal successfully in order to transition to the next stage in the addiction treatment process.

While WM may be an opportunity to initiate lasting abstinence from alcohol and/or other drugs, the primary goal is patient safety to minimize the health risks associated with withdrawal, not long-term abstinence. As such, patients should have access to WM services regardless of their perceived commitment to long-term abstinence.

Additionally, treatment for SUDs should occur along a continuum of care and WM is a critical point within the ASAM continuum of care. All SUD patients, particularly those with alcohol and opioid use disorders, should be considered for WM and have access to these essential treatment services. However, in and of itself, WM does not constitute adequate treatment for addiction. As such, patients who receive WM should be connected with ongoing treatment services for their addiction.

For many patients, effective WM will include the use of medication-assisted treatments (e.g., buprenorphine, methadone) and other medications (e.g., clonidine, lorazepam, chlordiazepoxide) to manage the symptoms of withdrawal. Medications are used to treat complications and coexisting conditions, provide symptomatic relief, and reduce the intensity of withdrawal symptoms. Concurrent psychosocial interventions (when feasible and appropriate), supportive care, and patient choice are also vital to successful WM.

Withdrawal management should consist of three essential features:

1. Assessment of needs
2. Stabilization
3. Facilitation of follow up, including readiness for and entry into SUD treatment

### **Assessment**

Assessment of WM needs must occur during every initial SUD assessment when a patient presents for treatment. This assessment needs to be performed by appropriate medical personnel operating within their scope of practice and licensure, and include a determination of anticipated risks confronting clients that will inform the need for WM, the intensity of services needed, and the most appropriate treatment setting. Oftentimes, the ASAM assessment conducted as a part of the intake process can be helpful to determine if WM services are necessary, but additional assessment is needed to determine the appropriate intensity of WM services. In these instances, additional WM assessments need to rely on the use of validated clinical tools, such as the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) or Clinical Opioid Withdrawal Scale (COWS), in order to determine the most appropriate clinical intervention.

Individuals recommended for WM in ambulatory settings should be at lower risk for complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential or inpatient settings. Assessments need to also take into

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consideration the unique situations of the individual, the severity of the presenting symptoms, as well as patient preference.

Once it is determined that a patient would benefit from and is interested in WM, a determination needs to be made about whether the most appropriate intervention is acute management of the withdrawal symptoms, or induction onto agonist (methadone), partial agonist (buprenorphine), or antagonist (naltrexone) maintenance therapy. Assessing this determination early is paramount given that it impacts the medications and interventions used during an individual's care in WM settings.

Frequent observation of the patient is the mainstay of WM so that providers can continually assess for any changes in condition and health status, and respond appropriately. The appropriate frequency of these re-assessments of clinical progress during WM services will vary depending on the clinical situation and patient presentation. The time spent observing and re-assessing individuals should also be viewed as an important opportunity to begin building an effective therapeutic relationship with the patient.

### **Stabilization**

Following a comprehensive assessment of WM needs, the focus of the stabilization period is on developing a treatment plan to effectively manage the withdrawal symptoms of the patient, while also considering the potential general medical and psychiatric complications that may accompany withdrawal.

Stabilization should, when appropriate, consist of a combination of psychosocial interventions and medications. Although not all individuals will be in a state of mind to effectively engage in behavioral/talk therapy during WM, psychosocial interventions are an important component of the services that should be offered in the withdrawal management setting. Motivational interviewing, for example, can be skillfully employed during WM to better understand clients' readiness to change and help them progress along the readiness continuum to encourage them to continue with treatment after their withdrawal symptoms are addressed.

Appropriate WM at times involves acute management of withdrawal symptoms with a plan to discontinue all medications after the withdrawal period. In other circumstances, it may be most appropriate for a patient entering WM to be inducted, or transitioned, onto medication-assisted treatment (MAT) for maintenance therapy. When WM medications are indicated, an evidence-supported approach should be used to select the pharmacological agent, dosage, and route of administration. Examples of standards of practice from the ASAM and the Substance Abuse and Mental Health Services Administration (SAMHSA), respectively are listed below:

- The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use  
<http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=16>
- SAMHSA – Medication for the Treatment of Alcohol Use Disorder: A Brief Guide  
<http://store.samhsa.gov/shin/content/SMA15-4907/SMA15-4907.pdf>

The science of comprehensive and effective SUD treatment supports the use of medications for WM and the use of medications in addiction treatment. The fact that individuals have recovered

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from SUDs previously without the aid of WM services does not imply that these services are unnecessary. Rather, it is crucial that addiction treatment evolves with the science that guides treatment, and research has consistently demonstrated that the use of medications, both in the form of WM and maintenance treatment, help to improve treatment engagement and SUD outcomes, particularly when combined with evidence-based psychosocial interventions. As such, the passive or active discouragement of the use of medications for WM and FDA-approved MAT is contrary to the science of addiction treatment, and WM and MAT must be discussed as a treatment option for all patients for whom it may be appropriate and helpful.

### Facilitation of Follow Up

Developing strategies to help patients cope both during and after withdrawal is critical to successful completion of WM. When in active withdrawal, patients often find it difficult to engage in treatment and psychosocial interventions, such as counseling. As such, the initial focus of WM is generally on assessing and stabilizing an individual's withdrawal symptoms.

However, as early during the withdrawal process as is feasible and appropriate, SUD providers must engage their clients in discussions about their readiness for change and begin preparing them for entry into ongoing SUD treatment at the next point along the continuum of SUD care. Case management can and should support this level of care transition. As mentioned, in and of itself, WM does not constitute adequate addiction treatment and patients who receive withdrawal services should be connected with ongoing SUD treatment.

**Table 1: ASAM Withdrawal Management Levels of Care**

<b>Level of Withdrawal Management</b>	<b>Level</b>	<b>Description</b>	<b>Provider</b>
Ambulatory withdrawal management without extended onsite monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	<ul style="list-style-type: none"> <li>- DHCS Certified Outpatient Facility with Detox Certification</li> <li>- Licensed prescriber</li> <li>- OTP</li> </ul>
Ambulatory withdrawal management with extended onsite monitoring	2-WM	Moderate withdrawal with all-day withdrawal management and support and supervision; at night has supportive family or living situation.	<ul style="list-style-type: none"> <li>- DHCS Certified Outpatient Facility with Detox Certification</li> <li>- Licensed prescriber</li> <li>- OTP</li> </ul>
Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	<ul style="list-style-type: none"> <li>- DHCS Certified Residential Facility with Detox Certification</li> <li>- Chemical Dependency Recovery Hospitals</li> <li>- Licensed prescriber</li> </ul>
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.	<ul style="list-style-type: none"> <li>- Hospital</li> <li>- Chemical Dependency Recovery Hospitals</li> <li>- Free Standing Psychiatric Hospitals</li> </ul>

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Level of Withdrawal Management	Level	Description	Provider
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and physician visits to modify withdrawal management regimen and manage medical instability.	<ul style="list-style-type: none"> <li>- Hospital</li> <li>- Chemical Dependency Recovery Hospitals</li> <li>- Free Standing Psychiatric Hospitals</li> </ul>

Withdrawal management constitutes various levels of care within the ASAM continuum of care and can be provided in various outpatient, residential, and inpatient settings (see Table 1). Depending on the unique circumstances of each case, all patients who are diagnosed with SUDs may benefit from WM services, particularly if they are experiencing withdrawal symptoms or have a history of withdrawal, and should have access to these levels of care. In order to maximize the evidence-based treatment options available to clients within SAPC's system of care, SUD providers from across disciplines will be expected to work together to ensure familiarity with and access to WM in all settings of care.

Given that even mild to moderate withdrawal symptoms may lead to relapse or more serious consequences, it is important to adequately address withdrawal within the continuum of SUD treatment services. Ambulatory WM services are provided in outpatient settings for individuals for whom the provider is concerned about mild to moderate withdrawal symptoms. Individuals treated in ambulatory WM settings (ASAM 1-WM and 2-WM) should be physically and psychiatrically stable enough to be managed in an outpatient setting, and should be at lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings. Patients appropriately treated in residential WM settings typically exhibit, have a history of exhibiting, or are at risk for exhibiting moderate withdrawal symptoms with a greater need for support than can be provided in ambulatory WM settings. Lastly, inpatient WM services should be provided for individuals for whom the provider is concerned about severe withdrawal symptoms with the need for more intensive medical intervention. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care.

The duration and treatment approach taken during WM must be based on patient need and take into consideration the unique situations of the individual, the clinical judgment of the WM provider, as well as patient preference.

Full details regarding comprehensive WM services are beyond the scope of this document. However, WM should follow standards of practice, such as those outlined in the resource listed below from the Substance Abuse and Mental Health Services Administration (SAMHSA):

- SAMHSA TIP 45 – Detoxification and Substance Abuse Treatment
  - o <http://store.samhsa.gov/shin/content//SMA15-4131/SMA15-4131.pdf>

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The provision of WM services must occur in full compliance with all federal, state, and local laws and regulations. The following is a description of billable service components, staffing requirements, and service expectations for withdrawal management benefits.

### **Service Components:**

The three essential features of WM (assessment, stabilization, facilitation of follow up) are contained within the following service components:

- *Intake:* The process of determining that a patient meets the medical necessity criteria, and then admitting a patient into a SUD treatment program. Intake includes the evaluation or analysis to determine whether or not an individual meets the current Diagnostic and Statistical Manual (DSM) of Mental Disorders criteria for an SUD diagnosis, and the assessment of treatment needs to provide medically necessary services using the ASAM Criteria. Oftentimes, the ASAM assessment conducted as a part of the intake process can be helpful to determine if WM services are necessary, but additional assessment with validated tools such as CIWA-Ar or COWS is needed to determine the appropriate intensity of WM services. Intake will include a physical examination and laboratory testing necessary for determining and providing appropriate SUD treatment. An important part of the intake process for WM settings is determining what setting of care is needed in order to adequately address the physical and mental health needs of an individual, so these considerations must be factored into level of care placement in WM settings.
- *Observation:* The process of monitoring the patient's progress and course of withdrawal; conducted as frequently as deemed appropriate for the patient and the level of care the patient is receiving. This should include, but is not limited to, observation of the patient's health status, including physical and mental health.
- *Medication Services:* MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol- and/or opioid-related SUD condition and who are receiving services at this level of care. The prescription or administration of MAT, and the assessment of side effects and/or impact of these medications, should be conducted by staff lawfully authorized to provide such services within their scope of practice and licensure. Youth under age 18 are eligible for MAT on a case-by-case basis with parental consent and authorization from SAPC.
- *Discharge Services:* The process to prepare the patient for referral into another level of care, post-treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. The discharge service process should be initiated from the onset of treatment services to ensure sufficient time to plan for the patient's transition to subsequent treatment or recovery support services.

### **Staffing for Withdrawal Management Services**

Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws. Certified SUD counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8 and must be certified by one of the National Commission for Certifying Agencies (NCCA) accredited organizations recognized by DHCS: Addiction Counselor Certification Board of California (affiliated with California Association for Alcohol/Drug Educators (CAADE)); California Association of DUI Treatment Programs (CADTP); California

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Consortium of Addiction Programs and Professionals (CCAPP). Services in the withdrawal management setting may be provided by registered or certified SUD counselors or Licensed Practitioners of the Healing Arts (LPHA), depending on the nature of the service with respect to their scope of practice. A LPHA is defined as one of the following professional categories:

- Physician\* (MD or DO)
- Nurse Practitioner\* (NP)
- Physician Assistant\* (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- License-Eligible Practitioners working under the supervision of licensed clinicians

All potential licensed prescribers\* (MDs, DOs, NPs, PAs) in SAPC's network of care are urged to practice at the top of their licensed capability and to receive sufficient training with MAT to be able to prescribe these medications for addiction on either a routine or case-by-case basis in order to increase patient access to this core component of SUD treatment. Of note, only MDs and DOs are permitted to prescribe buprenorphine for addiction with required training, whereas other MAT options can be provided by the full spectrum of potential prescribers.

Non-professional staff including clerical, billing, and facility management support shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff. Professional and non-professional staff are required to have appropriate experience and necessary training at the time of hiring.

### **Service Expectations for Withdrawal Management Services**

- *Culturally Competent Services:* Providers are required to provide culturally competent services that are culturally, linguistically, and developmentally appropriate in order to optimize treatment engagement. Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and are embedded into the organizational structure and day-to-day operations of the agency.
- *Case Management:* Providers will be expected to deliver a variety of case management and care coordination services including transitioning clients from one level of SUD care to another, and navigating the mental health, physical health, and social service delivery systems.
- *Documentation:* Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility. The SAPC will require that providers generate intake documentation based on the ASAM Criteria and that documentation provides justification for the care provided, including documentation of medical necessity, transitions in care, and care coordination. Documentation templates developed by SAPC shall be used for treatment plans, progress notes, and other documentation developed by the Quality

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Improvement/Utilization Management (QI/UM) Unit.

- *Field-Based Services (FBS)*: Field-Based Services are specialty SUD services provided by registered/certified SUD counselors or LPHAs specifically trained to recognize and respond to the unique biopsychosocial needs of their clients. Field-Based Services are responsive and appropriate to the cultural, linguistic, and developmental needs of patients, and are supported by evidenced-based practices. Depending on the treatment situation, MAT may be prescribed (but not administered) via FBS. The services will be provided to adults and youth, as well as parents or guardians, as needed. Service locations include, but are not limited to, client's residence, recreational centers, sober living facilities, homeless encampments, and co-locations in emergency departments, primary care, mental health, court, jail re-entry (not in-custody), probation, and child protective services settings.

### **Final Note:**

SUD treatment should be delivered across a continuum of services that reflect the severity of the condition and the intensity of services required. One of the key goals of the SAPC is to ensure that clients receiving SUD services in Los Angeles County receive the right service, at the right time, for the right duration, in the right setting. While the levels of care are presented as discrete hierarchies, they should be viewed as points along a continuum of treatment services.