Health Services
LOS ANGELES COUNTY

Expected Practices

Specialty: Addiction Medicine
Subject: Outpatient Medication Management of Alcohol Use Disorder
Date: February 11, 2019

Purpose: To guide clinicians treating alcohol use disorder in the ambulatory care settings.

Target Audience: Outpatient Primary Care Providers

Expected Practice: Hazardous alcohol use and alcohol use disorder (AUD) are common among patients seen in outpatient settings. Clinicians should screen patients for hazardous alcohol use according to current DHS expected practices and identify patients with AUD using DSM-5 diagnostic criteria. Providers should deliver brief interventions and offer AUD pharmacotherapy alongside referrals to higher levels of substance use disorder care when appropriate.

Shared treatment goal development
Set a person-centered goal for alcohol consumption with patients with AUD and document these goal in the chart. Successful treatment strategies for AUD include both medications and/or psychosocial interventions.

Assess for risk of alcohol withdrawal
Patients who are experiencing withdrawal symptoms (Appendix 5) should be treated for withdrawal if they plan to abstain from alcohol, prior to initiating a maintenance medication for alcohol use disorder treatment. Patients who are medically unstable or have severe alcohol withdrawal symptoms should be referred to the nearest emergency department. Indications of medical instability during alcohol withdrawal include (but are not limited to) seizures, serious psychiatric features such as suicidal ideation or new psychotic symptoms, profound derangements in laboratory studies, and/or severe alcohol withdrawal. **See the Alcohol Withdrawal EP.**

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

Medications for Alcohol Use Disorder Treatment:

Medications can and should be prescribed / administered to patients who are actively drinking. Assess for reduced drinking after 1-2 months and discontinue these medications if they do not reduce drinking volume or frequency after 3 months at full dose. Do not continue to prescribe these medications indefinitely to patients who have not experienced a response. Assess 1-2 months after discontinuation of these medications to determine the patient's stability off medications. A re-trial of these medications is appropriate if drinking resumes or worsens. Overall, medication reduces alcohol use in patients with AUD, with outcomes that range from a number needed to treat of 5-20 to generate one person abstinent from alcohol.

Oral Naltrexone is an opioid antagonist and will precipitate withdrawal in patients who are currently taking or have recently taken opioids (including opioids). Thus, it is contraindicated in anyone who is currently taking any opioids or who is in opioid withdrawal. Naltrexone can be prescribed if the patient has been verified, by both self-report and toxicology, to be free from short acting opioids (such as morphine, oxycodone, hydrocodone, and hydromorphone) for at least seven days, extended release opioids (such as morphine sulfate extended-release or oxycodone extended-release) for at least ten days, and long acting opioids (such as methadone and buprenorphine) for at least fourteen days.

- To help with tolerability, recommend starting dose is 25mg daily for three days, and then 50mg daily thereafter.
- Naltrexone is dosed as 50mg once daily. It may be increased to 200mg or higher PO daily in patients who have experienced a positive partial response at lower doses.

Naltrexone Long Acting Injection is an injectable depot formulation that is dosed once monthly through a gluteal injection at a dose of 380mg monthly, with the same contraindications as exist for oral naltrexone (reviewed above)

- Oral naltrexone is first-line, so Naltrexone Long Acting Injection should only be considered in patients who have difficulty with adherence or nonresponse to oral daily naltrexone. It is available by completing the prior authorization form in ORCHID.
- If transitioning a patient from oral to injectable naltrexone, the patient should immediately stop taking the oral form following the injection.
- Naltrexone Long Acting Injection is associated with an injection site reaction.

Gabapentin or Topiramate

As a second line, for patients who do not tolerate or improve on naltrexone, consider a trial of either:

- Gabapentin at doses of 300-600mg PO TID. Dosing often is titrated by 300mg PO daily every 3-7 days.
- Topiramate at dose of 200-300mg PO daily. Usually start at 50mg PO daily and titrate by 50mg every week.
- If a patient has a contraindication to naltrexone, gabapentin, and topiramate, providers can consider acamprosate or disulfiram. These medications are non-formulary and can be requested through a non-formulary request. An eConsult to the Addiction Medicine portal can be submitted for any questions and for decision support.

Psychotherapy for AUD

Patients with alcohol use disorder should be offered linkage to psychosocial treatment if they are interested in participating in these services, regardless of whether they take a medication for alcohol used disorder. See **LINKAGE AND REFERRAL** for discussion of linking patients to psychosocial treatments for alcohol use disorder. There is no clear benefit of one psychosocial intervention as compared with another, but the intensity of psychosocial treatment offered should match severity of AUD, and patient's readiness to participate in programing in accordance with the ASAM criteria. Self-help referrals like Alcoholic Anonymous (see **Appendix 6**) can be offered alongside medications for alcohol use disorder and referrals to specialty addiction treatment.

Recommended Follow-Up for AUD

- All patients with AUD, at a minimum, should be scheduled for follow-up and monitoring quarterly, even if they are not participating in or interested in any treatment. Monitor frequency of alcohol use with the AUDIT-C.
- Patients who start medications for AUD, should be seen by a coordinator, clinician, or provider no less frequently than monthly for the first three months. Busy clinic settings can use non-licensed community health workers or care coordinators, and/or alternate modalities like telephonic or telemedicine to support visit frequency.
- A patient missing an appointment is not a reason to withhold medications. All efforts should be made to continue medications for a full 3-month trial, as benefits of these medications usually outweigh risks and withholding medications for AUD limits the opportunity to provide treatment to those in need at time of need.
- Maintain a positive therapeutic relationship and encourage reduction of risky drinking and/or abstinence at each visit.

Special Considerations

Contraceptive management is highly recommended for all patients.

- Patient with AUD should be offered contraception. Patients with AUD and planning pregnancy should be informed that any drinking could be harmful to pregnancy, encouraged to plan for abstinence during pregnancy, and prescribed pre-conception prenatal vitamins as appropriate.

Screening for common medical sequela of AUD

- It is not necessary to obtain baseline or trend liver function tests when taking medications for AUD as this may limit the opportunity to provide treatment to those in need at time of need. Naltrexone and disulfiram are associated with a very low risk of medication-induced hepatitis and should not be withheld from patients whose LFT results have not been obtained or are moderately elevated at <5x ULN.
- Patients with symptoms of *medication-induced hepatitis* (such as from naltrexone) should be evaluated for the risk/benefit of the potentially offending medications and for discontinuing of the offending medication if the risk does not outweigh the benefit.
- *Asymptomatic* patients with AUD can be offered a CBC and liver function tests at baseline. Frequency of re-evaluation of asymptomatic patients with normal results depends on ongoing risk factors. Patients with symptoms of *alcoholic peripheral neuropathy*, *alcohol related hepatitis or cirrhosis*, and *alcoholic gastritis* should be evaluated and treated for these conditions.

- *Thiamine and folate deficiency* are rapidly corrected when patients stop drinking and return to FDA recommendations for healthy diet. While no clear evidence exists to support oral repletion in asymptomatic patients, consider thiamine 100mg PO daily for asymptomatic patients with chronic heavy alcohol use. Replete for 1 month for patients who abstain from alcohol, longer if they continue to drink.

Evaluate for co-occurring mental health sequela of AUD

- Patients with AUD are at higher risk of co-occurring mental health conditions that include anxiety, depression, and insomnia. Treatment for these can occur alongside patient's treatment for AUD – even if patient is continuing to use alcohol and has not sustained a long period of abstinence. Patients should be treated for these conditions with behavioral health treatments and providers should avoid the use of narcotic, benzodiazepine, hypnotic, and barbiturate medications in patients with AUD.

Linkage and Referral

In clinics staffed with social workers, substance use disorder counselors, and case workers, patients with AUD can be offered a specialty consult to social work, and the social worker or SUD counselor can offer further assessment using the ASSIST (see http://www.who.int/substance_abuse/activities/assist_test/en/) and a comprehensive alcohol use disorder assessment using the ASAM Criteria.

In clinics without this staffing, patients can be referred to the Department of Public Health Substance Abuse Prevention and Control system of care using the DPH-SAPC Service and Bed Availability Tool: https://sapccis.ph.lacounty.gov/sbat. The patient can also be provided the 24/7 call-in number for the Substance Abuse Service Helpline (SASH): 844-804-7500
Patients meeting eligibility for Whole Person Care can be assisted in their referral to substance use disorder services as described via http://dhs.lacounty.gov/wps/portal/dhs/wpc.

WHEN TO REFER TO SPECIALTY SUD TREATMENT

Factors Supporting Referral to Specialty SUD Treatment:

- History of delirium tremens
- History of withdrawal seizures
- Acute illness
- Severe cognitive impairment (acute or chronic)
- Inability to take oral medications
- Serious psychiatric condition (suicidal ideation, psychosis)
- Pregnancy
- Absence of a support network or inability to commit to frequent visits
- Severe alcohol withdrawal symptoms (SAWS > 16 or CIWA-Ar $\geq$ 20)
- Profound derangements in laboratory studies
- Concomitant benzodiazepine use

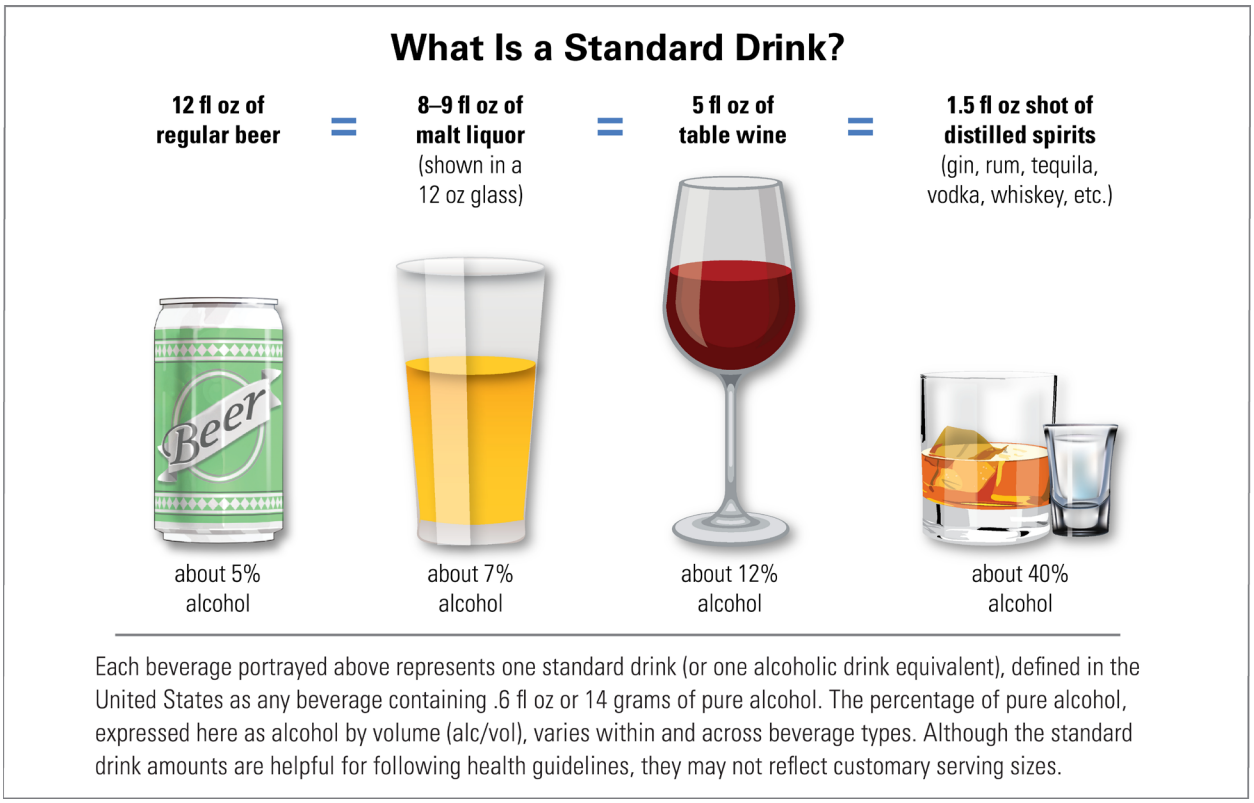
When to submit an eConsult to Addiction Medicine:

- Any clinician with questions related to using medication for alcohol use disorder. Please note that this is an advice-only portal.

APPENDIX

Appendix 1: Standard Drink

The definition of a standard drink is available via https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/what-standard-drink



Appendix 2: FRAMES

F = feedback of personal risk, e.g. that drinking may contribute to medical problem such as hypertension;
R = responsibility of the patient, i.e. emphasizing that drinking is by choice, and the patient has personal control;
A = advice to change, e.g. to stop drinking or reduce drinking to safe levels;
M = menu of alternative goals and strategies to reduce drinking;
E = empathic counseling style is more effective than confrontation;
S = self-efficacy; encourage patients' optimism that the chosen goals can be achieved.

Fleming MF, Manwell LB. Brief intervention in primary care settings: a primary treatment method for at-risk, problem, and dependent drinkers. *Alcohol Res Health* 1999;23(2):128-137.

Appendix 3: 5As

Ask: About alcohol use
Advise: Advise eliminating hazardous alcohol use
Advising the patient to change their alcohol consumption should be offered in a clear, strong, and personalized manner. Expect ambivalence. Be willing to listen non-judgmentally to his/her concerns about changing alcohol use.

Assess: Determine willingness to make changes in alcohol use

Assess how ready the patient currently is to change alcohol use. Readiness rulers (i.e., "On a scale of 1 to 10, where 10 is very ready, how ready are you to cut down your drinking?") are useful in addressing the extent to which a person is ready to change, which can change from visit to visit.

Assist: Provide help to move the individual toward a change attempt. Offer medications for alcohol use disorder treatment. Offer a specialty consult to social work so a behavioral health clinician can discuss further with the patient. Offer the patient the Substance Abuse Service Helpline (SASH): 844-804-7500 if they want to pursue intensive alcohol use disorder treatment outside of DHS.

Arrange: Follow-up contact. Follow-up is most helpful to do it within the first weeks of a brier intervention and can be either in person or via telephone

Appendix 4: Diagnostic Criteria for Alcohol Use Disorder:

In the past year, have you:

- Had times when you ended up drinking more, or longer, than you intended?
- More than once wanted to cut down or stop drinking, or tried to, but couldn't?
- Spent a lot of time drinking? Or being sick or getting over other aftereffects?
- Wanted a drink so badly you couldn't think of anything else?
- Found that drinking – or being sick from drinking – often interfered with taking care of your home or family? Caused job troubles? Or school problems?
- Continued to drink even though it was causing trouble with your family or friends?
- Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
- More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
- Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
- Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
- Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

The presence of 2 or more symptoms indicates a diagnosis of alcohol use disorder.	
Mild:	2-3 symptoms
Moderate:	4-5 symptoms
Severe:	6 or more symptoms

Appendix 5: Symptoms of Alcohol Withdrawal

Symptoms of Alcohol Withdrawal

- Autonomic hyperactivity (diaphoresis, tachycardia)
- Increased hand tremor
- Insomnia
- Nausea or vomiting
- Transient visual, tactile, auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Seizures

Appendix 6: Los Angeles Area Alcoholics Anonymous Resources

Los Angeles Central Office, Alcoholics Anonymous
Main: (323)963-4343
FAX: (323)936-8729, Toll Free: (800)923-8722
www.LACOAA.org

Oficina Central Hispana Alcoholicos Anonimos
Main: (323)750-2039
https://hispanaaala.org/

Oficina Intergrupal del Este de Los Angeles de Alcoholicos Anonimos
Main: (323) 722-1044
http://aaintergrupalestedelosangeles.org/

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