ALTARUM

SOLUTIONS TO ADVANCE HEALTH

KAISER PERMANENTE®

Kaiser Permanente Washington Health Research Institute

MiSPARC

Michigan Sustained Patient-Centered Alcohol-Related Care

Alcohol and Health

Patient-centered screening, assessing risk, and brief alcohol counseling for unhealthy alcohol use

Background

- Experts at Kaiser Permanente (KP) Washington demonstrated the success of a patient-centered approach to addressing alcohol use as part of patient-centered primary care across 25 primary care sites
- Altarum, supported by KP Washington, is bringing the proven system to 125 small to medium primary care practices across Michigan

What are the Objectives for Participating in the MI SPARC initiative ?

Patient-centered screening, assessing risk, and brief counseling for unhealthy alcohol use

- Understand spectrum of unhealthy alcohol use
- Understand the purpose of brief alcohol counseling: decreasing alcohol-related risks
- Learn a practical way to implement routine alcohol screening and assessment
- Learn how to offer patient-centered advice and feedback: brief alcohol counseling

How Our Understanding of Alcohol Use Has Changed

Old Stereotypes In the past experts thought…	New Knowledge Now experts know…
People who were not "alcoholic" did not need to watch how much they drank.	Drinking can cause problems for anyone. So we focus on preventing these problems by educating everyone about alcohol use.
Alcoholism was due to a lack of will power. It was not generally treated by doctors.	An alcohol use disorder is a brain condition caused by many factors, including how much a person drinks.
Doctors had to wait until people with alcoholism wanted help.	Asking people about their alcohol use and giving them advice about it is part of high-quality health care for everyone.
There was a "one-size-fits-all" approach to alcohol treatment– and we only offered people group treatment based on the 12 steps of Alcoholics Anonymous (AA).	People with alcohol use disorders can choose from several proven treatment options: • Individual or couples counseling • Group counseling • Medications • Mutual help programs like SMART Recovery or AA

The Old Approach to Alcohol

- Stigma led to silence
  - Primary care providers afraid to compromise trusting relationships (lose patients)
  - Patients don't ask questions; don't want to be judged as one of "those" patients

McCormack JGIM 2007

Video: Alcohol and Health

A ReThink of the Way we Drink
https://youtu.be/tbKbq2lytC4

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WHAT IS UNHEALTHY ALCOHOL USE?

What is Unhealthy Alcohol Use?

- Drinking above the recommended limits:
  - Average # of drinks per day (or week)
  - Maximum # drinks per day
- Limits reflect epidemiology – levels associated with adverse health outcomes

Recommended Drinking Limits

	MEN 65 and Younger	WOMEN (all ages) & MEN over 65
Average drinks per day (drinks per week)	No more than 2 (No more than 14)	No more than 1 (No more than 7)
Maximum drinks per day	No more than 4	No more than 3

NIAAA Clinicians Guide revised 2008

What are the recommended limits?*

MEN 65 and younger	WOMEN & MEN over 65
Per day: No more than 2 drinks on average, and no more than 4 drinks on any day	**Per day:** No more than 1 drink on average, and no more than 3 drinks on any day
Per week: No more than 14 drinks total	**Per week:** No more than 7 drinks total

1 Drink =

12 OZ. beer

5 OZ. wine

1.5 OZ. liquor (a standard shot)

Drinking above these limits increases your risk of:

- Weight gain
- Insomnia
- Forgetting medications
- Medication interactions
- Surgical complications
- High blood pressure
- Depression and anxiety
- Liver or pancreatic disease
- Bleeding from the stomach
- Stroke
- Dementia
- Seizures
- Breast, prostate, colon and other cancers
- Heart disease, including heart failure
- Death

*Experts recommend no alcohol use for women who are pregnant, people who have liver disease, or people who have had problems due to drinking in the past.

Standard Drink Sizes (U.S.)

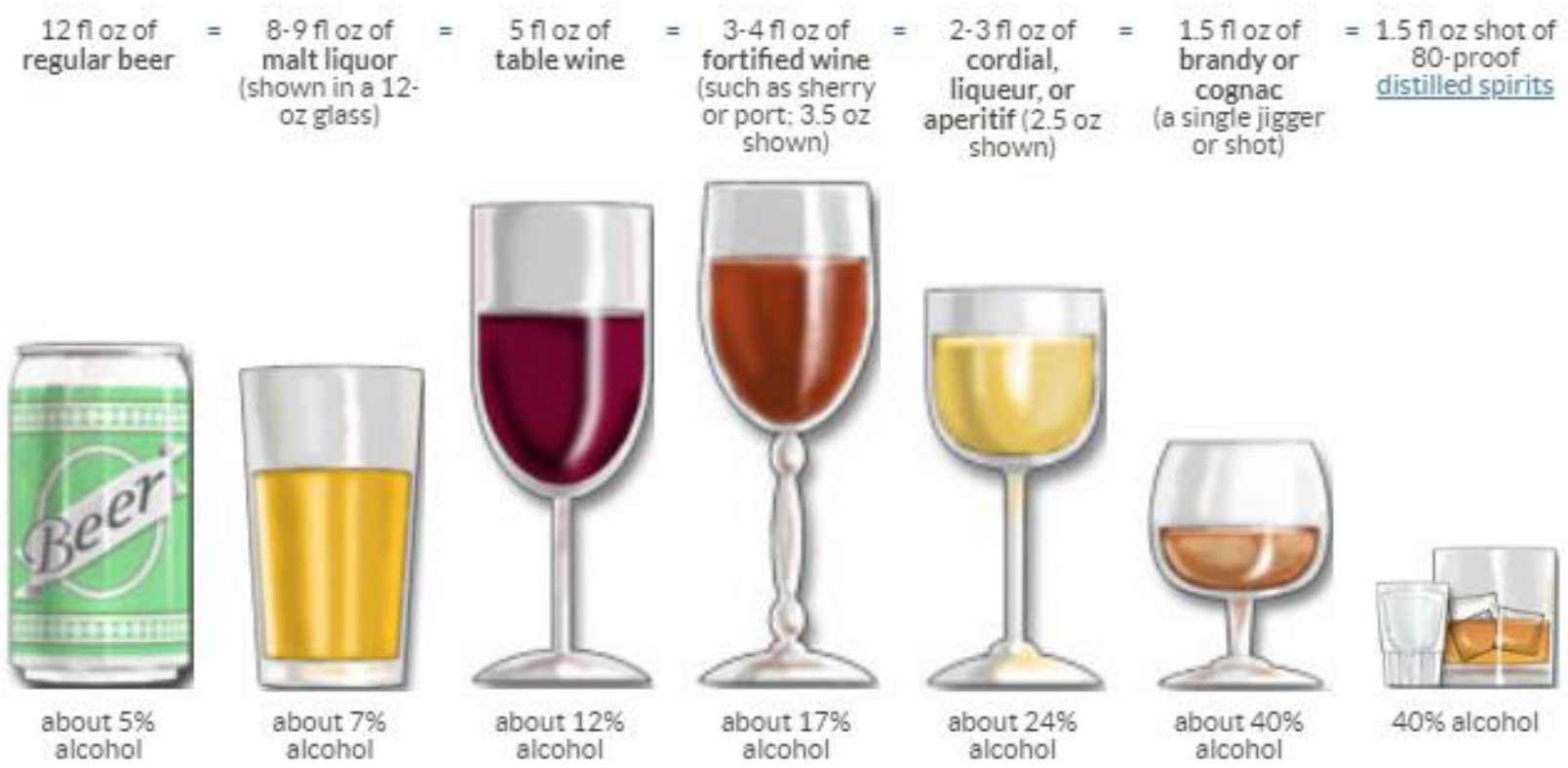
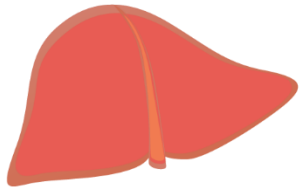
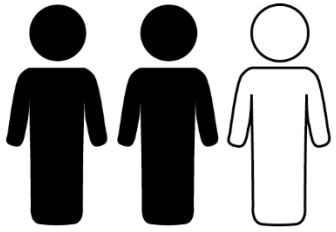


Photo: https://www.rethinkingdrinking.niaaa.nih.gov/How-much-is-too-much/What-counts-as-a-drink/Whats-A-Standard-Drink.aspx

Why are AVERAGE Limits so Low?





Outcome	Increases at
Liver disease	≥ 1-2 drinks/day*
Breast Cancer	≥ ½ drink/day
Mortality	≥ 1-2 drinks/day*

*1 drink women, 2 drinks men

Conen 2008; Samokhvalov 2010; Allen 2009; Castelnuevo 2006; Taylor 2009; Lew 2009; Becker 1996; Corrao Prev. Med 2004; Bondy Canadian J Public Health 1999; Holman Med j Aust 1996

Recommended Limits

Some populations are advised to abstain completely from alcohol use:

- Plan to drive or operate machinery, or participate in activities that require skill, coordination, and alertness
- Take certain over-the-counter or prescription medications
- Have certain medical conditions
- Are recovering from alcohol use disorder or are unable to control the amount that they drink
- Are younger than age 21
- Are pregnant or trying to become pregnant

https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

Factors that Increase Risk for AUD

- Increasing average number of drinks/day
- Frequency of heavy episodic drinking
  - For women: 4 or more drinks in a day
  - For men: 5 or more drinks in a day
- Younger age at first use
- Family history (genetics)
- Mental health comorbidity

How does Heavy Episodic Drinking play a role in AUD ?

- Heavy episodic drinking is classified as : ≥ 4 drinks women; ≥ 5 drinks men in any one day
- Is in the causal pathway to alcohol use disorders (AUD)
- As the frequency increases, the risk of AUD increases

Prevalence of Unhealthy Alcohol Use In Michigan

- High rates of heavy episodic drinking (past month):
  - Overall 21% in MI (17% nationally)
  - Ranges 16-25% of MI adults
- 6th highest rate of substance use-related hospitalizations (alcohol most common) in US:
  - 677 alcohol-related stays per 100,000 residents in MI in 2013-2015 (national average 588)
  - Marked variation across counties (highest 1,390)

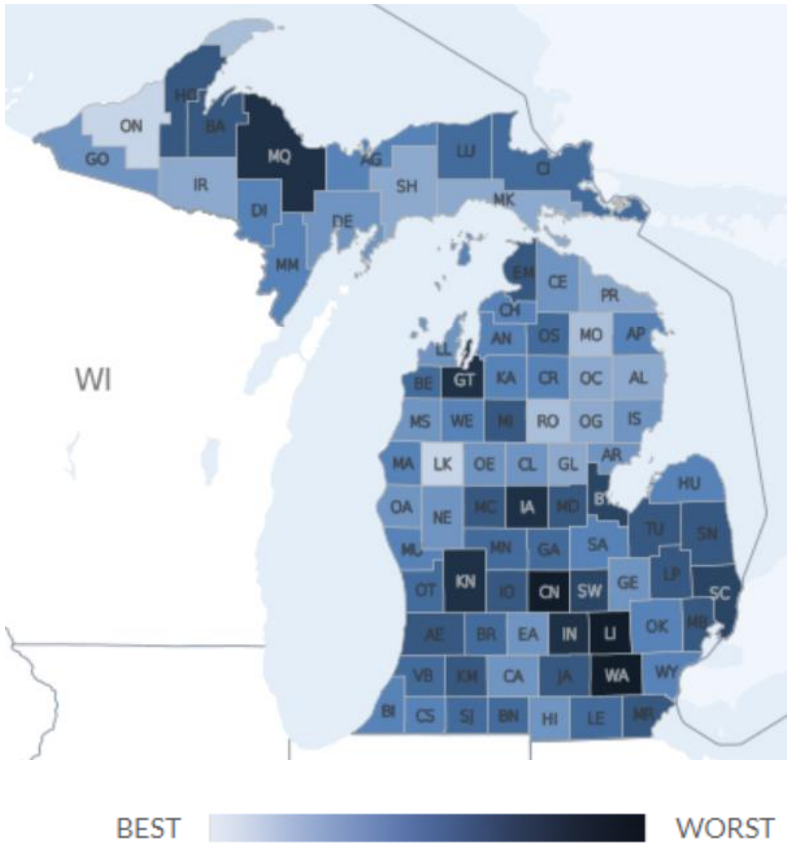


Photo: https://www.countyhealthrankings.org/app/michigan/2018/measure/factors/49/map

WHY AND HOW DO YOU SCREEN FOR UNHEALTHY ALCOHOL USE?

Why Screen for Unhealthy Alcohol Use?

- Multiple rigorous trials in primary care settings show that brief patient-centered alcohol counseling decreases drinking compared to alcohol screening alone
- USPSTF therefore recommends alcohol screening and counseling all adults (class B recommendation)
- The National Commission on Prevention Priorities ranked screening and counseling as the 4th highest prevention priority, above breast and cervical cancer screening

USPSTF JAMA 2018; O'Connor JAMA 2018; Maciosek 2017

How Do You Screen for Unhealthy Alcohol Use?

Ideally…

- As part of whole-person care
- Annually, all patients (80% target)
- By self-report: on paper (or tablet/online)
- Staff enter results in medical record before provider visit
- Alcohol screening can be efficiently combined with other USPSTF screening recommendations (e.g. depression and other drug use)

https://www.uspreventiveservicestaskforce.org/uspstf/
Williams JGIM 2015; Williams JSAT 2016; Williams JGIM 2018; Bradley JGIM 2011

Why We Use AUDIT-C

- AUDIT-C scores reflect severity
  - Average drinks/day
  - Probability of active alcohol use disorders
- Supports assessing risks
- Tells us a lot about medical risks: for use with feedback
- Useful for measuring change over time

AUDIT-C **Questions**

In the past year…

1. How often did you have a drink containing alcohol?
2. How many drinks containing alcohol did you have on a typical day when you were drinking?
3. How often did you have 5 or more drinks on one occasion?

AUDIT-C Scoring

- 3 Questions
- 0-4 points each item
- Score (0-12 points) extensively validated
- AUDIT-C scale becomes clinically meaningful over time, although initially abstract like for blood pressure, HA1C, PHQ-9

Bush Arch Intern Med 1998; Bradley Arch Intern Med 2003; Johnson Alcohol Clin Exper Res 2013;
Dawson DAD 2012; Rubinsky Alcohol Clin Exper Res 2013; USPSTF JAMA 2018

Recommend: 7-item Screen to Streamline Workflow

Depression (PHQ-2)

Alcohol use (AUDIT-C)

Cannabis and other drug use

An alternate strategy might be to add the AUDIT-C to your social history (with tobacco assessment).

Over the past 2 weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
2. Feeling down, depressed, or hopeless?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3

In the past year…

3. How often did you have a drink containing alcohol in the past year?	Never 0	Monthly or less 1	2 to 4 times a month 2	2 to 3 times a week 3	4 or more times a week 4	
4. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?	None 0	1 or 2 drinks 0	3 or 4 drinks 1	5 or 6 drinks 2	7 to 9 drinks 3	10 or more drinks 4
5. How often did you have 5 or more drinks on one occasion in the past year?	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4	
6. How often in the past year have you used marijuana?	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4	
7. How often in the past year have you used an illegal drug (not marijuana) or used a prescription medication for non-medical reasons?	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4	

Use the AUDIT-C score to trigger counseling and assessment

- **Brief preventive alcohol counseling**: at 3 or more points for women or 4 or more points for men
- **Add assessment** with Alcohol Symptom Checklist for anyone scoring 7 or more points
- AUDIT-C questions #1-2 can under-estimate drinking
- Patients with AUDIT-C scores of 3-4 can *report* drinking below limits but validation studies show they often drink above limits due to
  - Drink sizes > than standard size drinks
  - Alcohol content > than standard alcohol beverage per volume
  - Under-estimation

How to Practically Assess AUD?

Alcohol Symptom Checklist
(when AUDIT-C scores ≥ 7)

Provider assesses if
symptoms recurrent

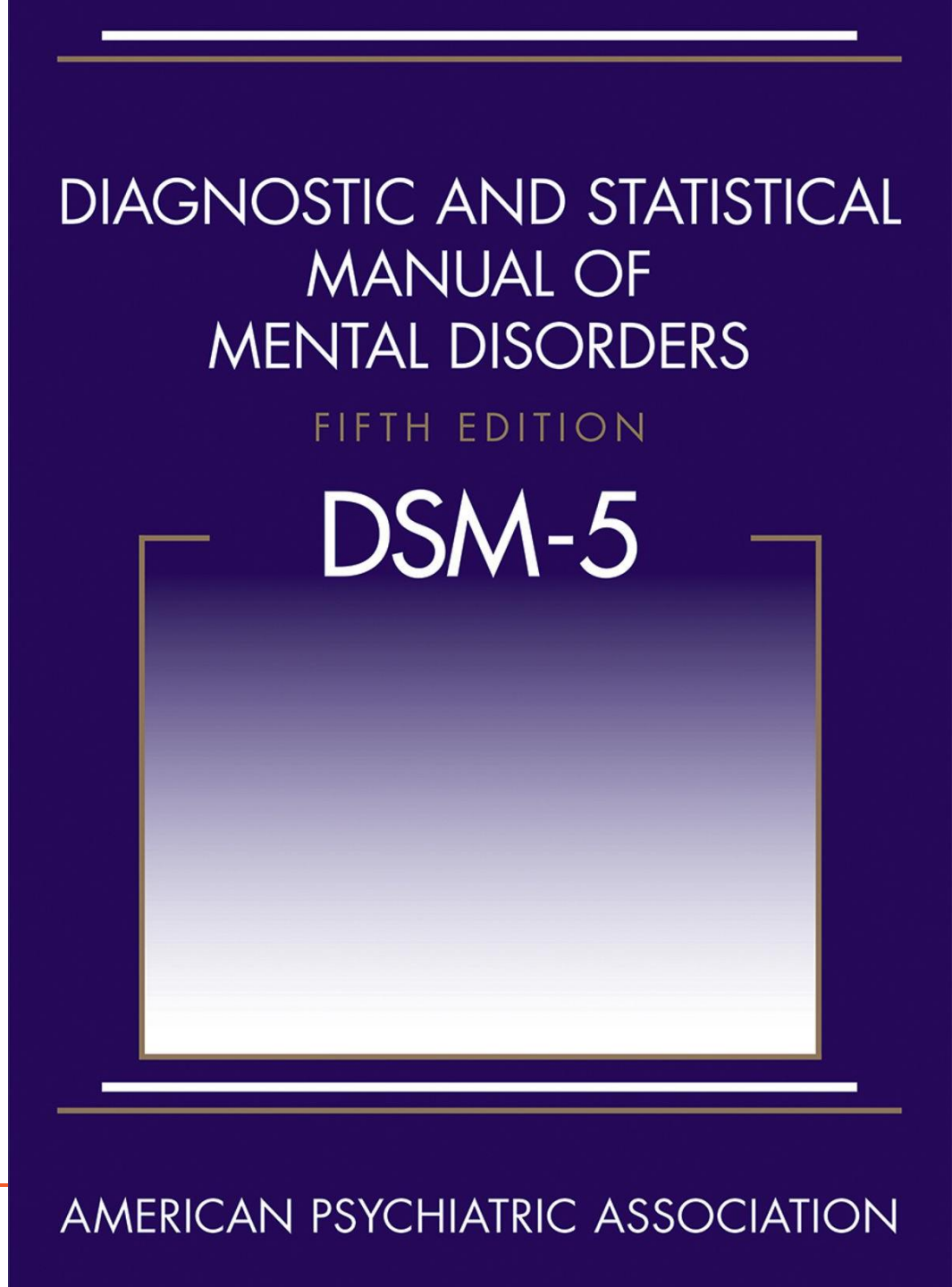
- Mild: 2-3 AUD symptoms
- Moderate: 4-5 AUD symptoms
- Severe: ≥ 6 AUD symptoms

In the past 12 months…

1. Did you find that drinking the same amount of alcohol has less effect than it used to or did you have to drink more alcohol to get intoxicated?	No	Yes
2. When you cut down or stop drinking did you get sweaty, nervous, have upset stomach or shaky hands? Did you drink alcohol or take other substances to avoid these symptoms?	No	Yes
3. When you drank, did you drink more or for longer than you planned to?	No	Yes
4. Have you wanted to or tried to cut back or stop drinking alcohol, but been unable to do so?	No	Yes
5. Did you spend a lot of time obtaining alcohol, drinking alcohol, or recovering from drinking?	No	Yes
6. Have you continued to drink even though you knew or suspected it creates or worsens mental or physical problems?	No	Yes
7. Has drinking interfered with your responsibilities at work, school, or home?	No	Yes
8. Have you been intoxicated more than once in situations where it was dangerous, such as driving a car or operating machinery?	No	Yes
9. Did you drink alcohol even though you knew or suspected it causes problems with your family or other people?	No	Yes
10. Did you experience strong desires or craving to drink alcohol?	No	Yes
11. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	No	Yes

Definition of Alcohol Use Disorder (DSM-5)

- Have had 2 or more recurrent symptoms:
  - Drinking larger amounts or longer than intended
  - Loss of control
  - Use when hazardous
  - Social/interpersonal problems
  - Withdrawal
  - Physical/psychological problems
  - Craving; strong desire or urge to use
  - Large amount of time spent drinking
  - Tolerance
  - Neglect or fail responsibilities
  - Give up activities to use

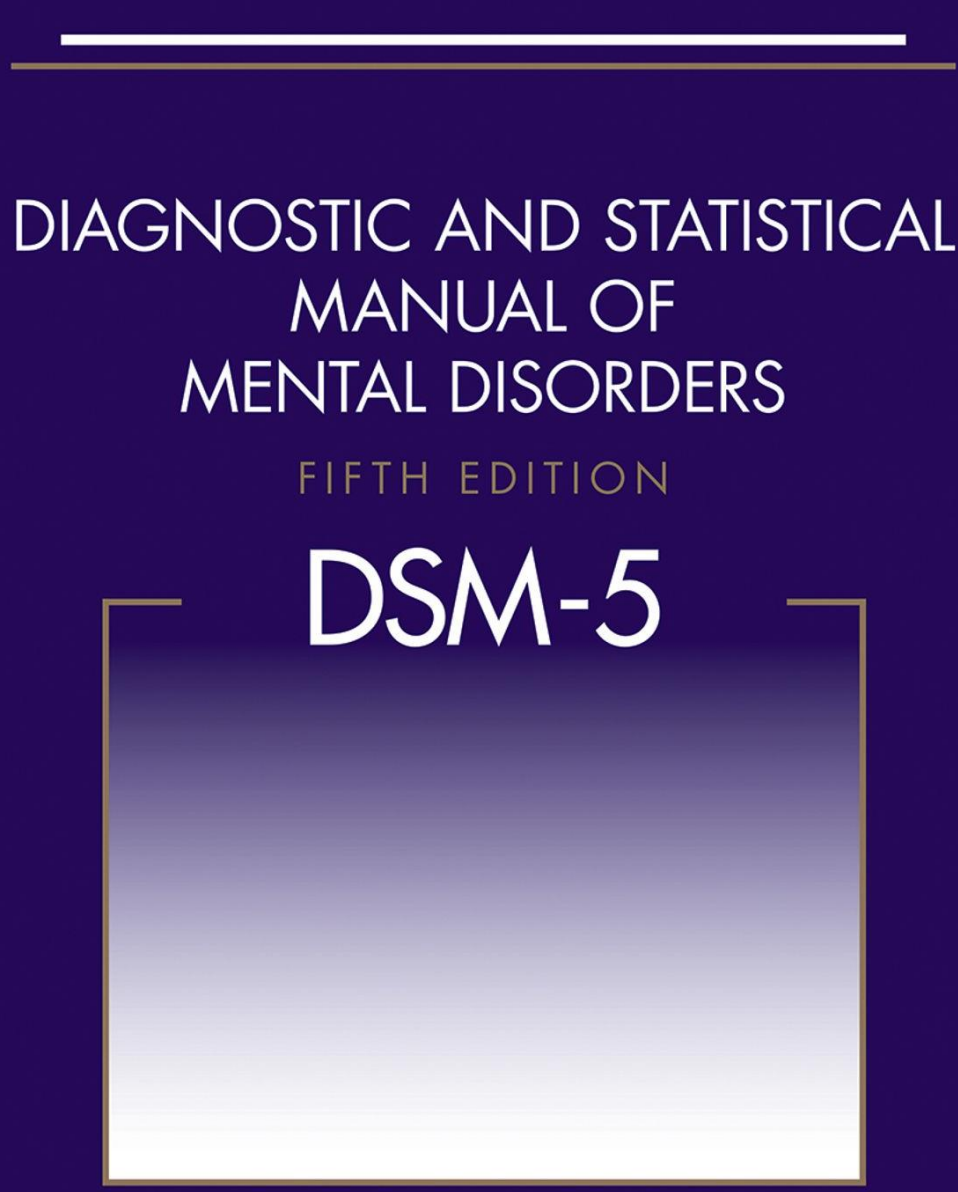


Diagnosing AUD

Use the Alcohol Symptoms Checklist to:

- Engage with patient: “You indicated [insert symptom from checklist] can you tell me about that?”
- Assess whether symptoms are recurrent: “How often does that occur?”
  - 2-3 symptoms → Mild AUD
  - 4-5 symptoms → Moderate AUD
  - ≥ 6 symptoms → Severe AUD

Dawson ACER 2012



DSM-5 AUD: Prevalence

Past year AUD	U.S. Prevalence %
18-29 years	26.7
30-44 years	16.2
45-64 years	10.0
65+ years	2.3
Total AUD	13.9

Grant JAMA Psychiatry 2015

Making a New AUD Diagnosis

- Ask permission: "Do you mind if we talk about your alcohol use…"
- State diagnosis clearly
- Expect emotion, as for any new, serious medical diagnosis, but especially given the shame and guilt associated with AUD due to stigma
  - Pause, listen, reflect; allow patient to express emotions, thoughts, concerns
- Ask the patient what that means to them
  - Pause, listen, reflect

Steps to Implementing Screening and Assessment

1. Find AUDIT-C in your EHR or decide where to enter results.
2. Decide how screening will be prompted and how often
3. Define roles: give screen, enter in EHR, assess, prompt counseling (with alcohol handout)
4. Stock forms for screening and assessment
5. Screening tool (AUDIT-C alone or recommended combination screener with PHQ-2)
    1. Alcohol handout
    2. Alcohol Symptoms Checklist
    3. Optional: substance use symptom checklist and suicide risk assessment
6. Test on 1-2 patients, debrief, refine, repeat

COUNSELING AND BRIEF INTERVENTION

Brief Alcohol Counseling: General Approach

- Non-judgmental empathy: critical to supporting any behavioral change
  - Reflect on something you love and how it would feel to be asked to change it
- Patients need to drive change for successful behavior change
  - The choice to make a change is totally up to the patient
  - The patients' values and preferences need to guide their decision and goals
  - Asking about how alcohol use fits into patients' lives can help engage
  - Asking the good things about drinking for them; The not so good things
- Support self-efficacy: elicit prior successful behavior change

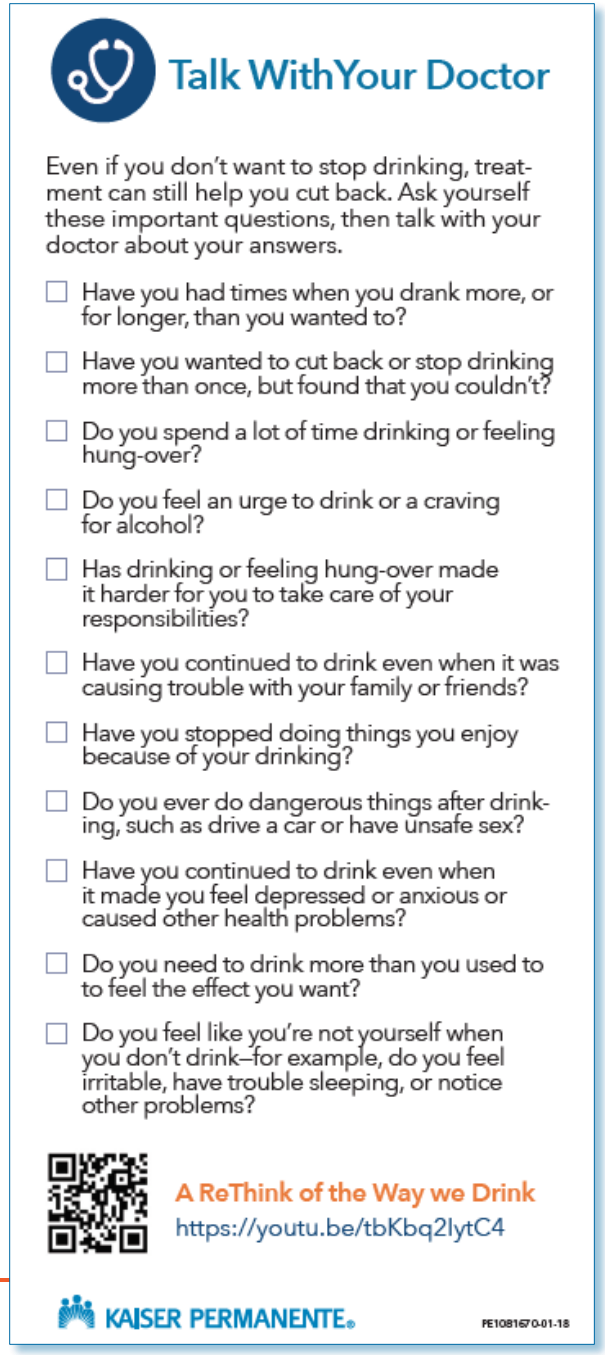
AUD Treatment: Beginning Shared Decision-making

- Stress that any decision to change is totally up to the patient
- Express optimism that if they decide to change, they can be successful
- Indicate that you are here to help them decide:
    1. Whether to stop drinking, cut-down, or make no changes
    2. If they want to change, what kind of help they want
- Note that their choices will often change over time

Using the Alcohol Handout During Engagement

- Handout also has AUD symptoms
- Also helpful for patients with an AUDIT-C score ≥7 but reporting no symptoms on Alcohol Symptom Checklist
  - Duration of counseling does not appear important

- Ask permission to discuss what we now know about alcohol use
- Advise about recommended limits (on handout)
- Personalized feedback: link alcohol use to health (handout)
- Support goal setting if appropriate: keep a record; decrease to limits, etc.
- Plan follow-up including next visit
- Elicit patient input after each step



Talk WithYour Doctor

Even if you don't want to stop drinking, treatment can still help you cut back. Ask yourself these important questions, then talk with your doctor about your answers.

- ☐ Have you had times when you drank more, or for longer, than you wanted to?
- ☐ Have you wanted to cut back or stop drinking more than once, but found that you couldn't?
- ☐ Do you spend a lot of time drinking or feeling hung-over?
- ☐ Do you feel an urge to drink or a craving for alcohol?
- ☐ Has drinking or feeling hung-over made it harder for you to take care of your responsibilities?
- ☐ Have you continued to drink even when it was causing trouble with your family or friends?
- ☐ Have you stopped doing things you enjoy because of your drinking?
- ☐ Do you ever do dangerous things after drinking, such as drive a car or have unsafe sex?
- ☐ Have you continued to drink even when it made you feel depressed or anxious or caused other health problems?
- ☐ Do you need to drink more than you used to to feel the effect you want?
- ☐ Do you feel like you're not yourself when you don't drink–for example, do you feel irritable, have trouble sleeping, or notice other problems?

A ReThink of the Way we Drink
https://youtu.be/tbKbq2lytC4

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PE108167O-01-18

Talking to your patients about AUD

- Alcohol use—like any addictive substance—can lead to brain changes: "high-jacking" reward circuits of the brain leading to AUD
- A person with AUD may not feel good (or "normal") without alcohol
- That can make it hard to change, even when people want to
- The good news is there are things that can help: 5 general options
- Shared decision-making ensures patient-centered care
- Opens the door to effective treatments many patients are not aware of
- Increases engagement (80% don't follow through after simple referral)
- All treatments require active patient participation
- Helps empower patients to change

AUD Treatment in Primary Care for patients who are ready to make a change

- Provide information about AUD and treatment options
- Prescribe medications with medical management
- Help link patients to resources for AUD: have a resource sheet
  - Counseling, peer support, specialty addiction treatment, online support
- Follow up to assess decision(s) and treatment response
- Repeat shared decision-making if goals or treatment choices change
- Monitor over time using AUDIT-C and Alcohol Symptom Checklist

Decision 1: Stop, Cut-down or No Change in Drinking?

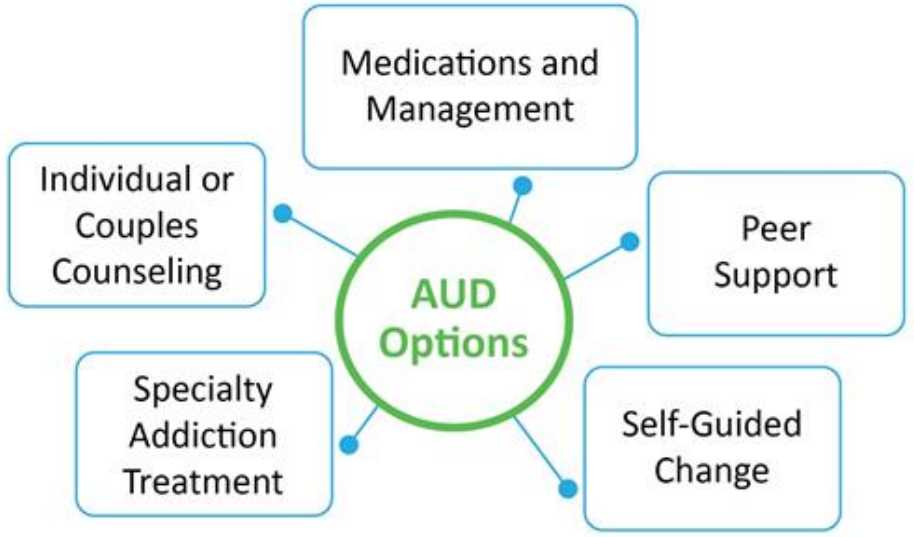
- Support patients in deciding the best option for them
- Many patients recover from AUD without stopping drinking
- However, the probability of sustained recovery is better for people who stop drinking
- Although patients decide if they want to stop drinking or cut down (or make no change), primary care providers can provide key information…

  For U.S. adults who have resolved an AUD, the probability of having a sustained recovery 3 years later is:

  - 94% if they have stopped drinking entirely
  - 78% if they have cut down < recommended limits
  - 60% if they have cut down but drink > recommended limits

Decision 2: Choosing Among 5 Options for AUD

- Patients and providers often share the false perception that group-based addiction treatment programs are the only option, however, there are 5 options for recovery from AUD…
  1. Medications that address brain changes of AUD
  2. 1:1 or couples counseling
  3. Peer support
  4. Specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking



OPTION 1:

MEDICATIONS THAT ADDRESS BRAIN CHANGES OF AUD

Medications for AUD

- Medications for AUD are effective without specialty counseling or treatment
- They help people with AUD:
  - Stop drinking or
  - Decrease heavy drinking days in those who continue drinking
- They should be provided with “medical management” (next slide)
- RN or Social Worker can also provide “medical management”

Medical Management as the Behavioral Support

Components of proven “medical management” for AUD

- ***Weekly x 4, biweekly x 2, then monthly***
- Clear explicit medical advice that abstinence is recommended
- Monitor ***medication adherence and side effects***
- Encourage “sober” support (AA or another peer support)
- Monitor the urge to drink, consider increasing dose (e.g., naltrexone)
- Assess and manage mental health and other substance use disorders

Evidence-based Medications for AUD

- Naltrexone 1st line – once a day makes it preferable (FDA approved)
- Acamprosate 1st line – equally effective; 3 times a day (FDA approved)
- Topiramate 2nd line (or if has other reason to be on, e.g., anti-epileptic)
- Gabapentin 3rd line (evidence less robust)
- Disulfiram works by making people sick if they drink alcohol: generally, prescribe only if patient requests (FDA approved)

First-line Treatment: Naltrexone

- Available as daily (oral) or monthly (injectable)
- Start 50mg daily, increase to 100mg daily if urge to drink persists
- Supports decreased heavy drinking and abstinence
- IMPORTANT: Opioid antagonist – don't use if patient takes or might need opioids (gout, pancreatitis, impending surgery, etc.)
- Side effects: headache, dizziness, nausea, vomiting
- Injectable monthly improves adherence; may avoid GI side effects
- Baseline labs: check LFTs first: < 5x normal is OK, but monitor

Jonas JAMA 2014
Anton JAMA 2006; Oslin JGIM 2014

First-line Treatment: Acamprosate

- 2 x 333mg pills (666mg) three times daily
- May be most useful for supporting abstinence; safe while drinking
- Thought to act on gabaminergic pathways
- Side effects: Anxiety, diarrhea, vomiting
- NSD from Naltrexone
- Check CrCl first: adjust dose CrCl 30-50ml/min, avoid in stage 4-5 CKD (CrCl <30ml/min)

Jonas JAMA 2014;
Anton JAMA 2006; Oslin JGIM 2014

Decision Guide for First-line Medications

	Naltrexone	Acamprosate
Form	PO (or IM)	PO
Frequency	Once daily (or IM monthly)	2 pills, three times daily
Safe with Active Alcohol Use?	Yes	
Optimal outcomes	Period of abstinence optimal (not required)	
Baseline labs: LFTs ,renal	Check LFTs OK if LFTs < 5x normal Monitor if abnormal	Check renal function Contraindicated in severe renal disease
Added benefit: treats Opioid Use Disorder (OUD) also	Injectable naltrexone effective for OUD	No additional benefit for OUD
Current or possible opioid use	Avoid (precipitates opioid withdrawal)	Preferred if will use opioids

Second-line Treatment: Topiramate

- Off-label use supported by systematic review
- Decreases heavy drinking especially
- Start 25mg daily, increase over 2 weeks to 75mg daily (max 300mg)
- Side effects (nausea, memory difficulties) minimized by slow taper
- Must be tapered to discontinue (to avoid seizures)

Johnson Lancet 2003; Johnson JAMA 2007; Jonas JAMA 2014

Third-line Treatment: Gabapentin

- Off-label use: weaker evidence than for others
- Decreases heavy drinking days
- Initiate at 300mg daily (increase by 300mg every 1-2 days to a target of 600mg three times daily)
- Potential for misuse in patients with other substance use disorders
- Renal dosing required, avoid if CrCl < 30mL/min

Kranzler Addiction 2019

Disulfiram

- Works by making people sick if they drink alcohol
- 250 mg daily; FDA approved
- Shown to have benefit if supervised (e.g., directly observed by family or friend)
- Usually used only if patients request (does not address brain changes of AUD)
- Not included in evidence reviews of placebo-controlled trials because patients must know they are taking it for benefit, so cannot be evaluated in those trials
- Patients must avoid any alcohol: mouthwash etc.
- Proven effective when supervised

Saitz JAMA 2014
Jonas JAMA 2014

OPTION 2:

1:1 OR COUPLES COUNSELING

Behavioral Treatments for AUD

- Evidence-based counseling:
  - Cognitive behavioral therapy (CBT): 1:1 or couples counseling
  - Community reinforcement approach (CRA): 1:1 counseling
  - Motivational enhancement therapy (MET): 1:1 counseling
  - Twelve step facilitation (TSF): 1:1 counseling
  - Mindfulness-based relapse prevention (MBRP): 1:1 counseling
- Potentially less stigmatized than specialty treatment
- Also addresses mental health and substance use conditions, pain, insomnia
- Motivational enhancement therapy: helpful if no decision to change
- Some options offer more privacy: EAPs, self-pay

Azrin Behav Res Ther 1976; Kelly Recent Dev Alcohol 2008; McCrady Addiction 2013; Carroll Addiction 2012; NICE UK2010

OPTION 3:

PEER SUPPORT

Peer Support

- Free, typically anonymous, can fit different schedules
- Offers positive, supportive, and non-judgmental environment
- Also offers sponsors, role models and thereby optimism and hope
- All offer online meetings, in addition to in-person meetings
- Can help people who want to cut down or stop drinking

Anton JAMA 2006; Oslin JGIM 2014

Peer Support

Program	Goal	In person meetings?	12-step	Spiritually-based	Comment
Alcoholics Anonymous (AA)	Abstain	> 110,000 Nationwide	Yes	Yes	Work 12 steps; diverse groups (starter; women, etc.); sponsors; 24 hour support; www.aa.org
SMART Recovery	Abstain	> 1000 nationwide	No	No	Aligned with CBT & MET; based on research; supports medication use www.smartrecovery.org
LifeRing	Abstain	> 100 nationwide	No	No	Aligned with CBT; focuses self-empowerment and personal recovery plan; www.lifering.org
Women for Sobriety	Abstain	~100 nationwide	No	Yes	For women by women; positive emotional growth & self esteem; www.womenforsobriety.org
Moderation Management	Cut-down	Yes	No	No	Emphasis on self control/choice; Online>>in person www.moderation.org

OPTION 4:

SPECIALTY ADDICTION TREATMENT

Group-based Alcohol Treatment Programs

Also called “rehabilitation programs” or “rehab”

- Most focus on stopping drinking, often using 12-step approach of AA
- Three main types of group-based treatment programs:
  - Outpatient (usually weekly visits)
  - Intensive outpatient (usually several times a week)
  - Residential (inpatient), where patients stay overnight
- Many led by chemical dependency professionals who may have personal experience with alcohol use disorders

Group-based Alcohol Treatment Programs

- Some programs offer other types of counseling (1:1, couples, family)
- Some programs offer, or are supportive of, medication treatment for alcohol use disorder and related mental health
- Once treatment programs end, counseling, peer support programs or “aftercare” programs with less frequent visits can be helpful
- Outpatient treatment works just as well or better than inpatient treatment

OPTION 5:

SELF-GUIDED CHANGE

Self Change

Rethinking Drinking can help (online or free booklets available): https://www.rethinkingdrinking.niaaa.nih.gov/

- Use calculator to count drinks per day: https://www.rethinkingdrinking.niaaa.nih.gov/Tools/Calculators/Default.aspx
- Patient selects a small change they are confident they can make
- Patient records drinks daily for next appointment
- Can be combined with peer support, counseling (e.g., for depression/anxiety/insomnia/pain), medications

SUMMARY OF

SHARED DECISION-MAKING

Option Grid: Part 1

Patient wants…	Counseling	Medications	Group-based treatment	Peer support	Changes on own
To cut down	√	All except disulfuram		Moderation Management	√
To stop drinking	√	√	√	√	√
To keep thinking about it	√			√	√
Options that are easy to find	In some places	√	√	√	√
Low-cost or free options	If Employee Assistance Program (EAP)			√	√
Options covered by health insurance	Typically	√	Typically		
Not to have to go to meetings or appointments		Fewer in-person appointments		Some available online	√

Option Grid: Part 2

Patient wants…	Counseling	Medications	Group-based treatment	Peer support	Changes on own
Options that won't go in the medical record	Some, including EAP		Sometimes	√	√
Options that the insurance company wouldn't know about	If self pay or EAP		If self pay	√	√
To meet others with similar experiences			√	√	
Options led by someone with personal experience	Sometimes	Sometimes	Often	√	
Options led by a health professional	√	√	Sometimes		
Options shown to work by research	√	√	Not yet certain	AA (others not yet certain)	Not yet certain

Summary of Shared Decision-Making

- Clear medical advice to abstain
- Elicit patient preferences
- Shared decision-making: offer 5 options and combinations of them
  - Cut-down, stop or no change
  - Which of 5 options of interest to help make change (if any)
- Arrange return visit in next 2 weeks
- Prescribe and/or refer based on local resources
- Medical management if treating with medications

Finding Local Resources for AUD

Local alcohol resources sheet

- **Peer Support**
  - AA: ask alcohol treatment specialists for recommendations of "starter meetings"
  - Online peer support
- **Alcohol counselors** in community and large employers with employee assistance programs (EAPs)
- **Alcohol treatment specialists: programs & addiction psychiatrists**
  - NIH Alcohol Treatment Navigator: https://AlcoholTreatment.niaaa.nih.gov
  - SAMHSA: https://findtreatment.gov (tel:+1-800-662-4357)

Links to Resources

For Patients

- **Rethinking drinking**: https://www.rethinkingdrinking.niaaa.nih.gov/
- **Drink Calculator:** https://www.rethinkingdrinking.niaaa.nih.gov/tools/Calculators/Default.aspx

For Providers

- **NIAAA Clinicians Guide:** https://www.integration.samhsa.gov/clinical-practice/Helping_Patients_Who_Drink_Too_Much.pdf
- **Implementing Care for Alcohol and Drug Use:** https://www.thenationalcouncil.org/wp-content/uploads/2018/03/021518_NCBH_ASPTReport-FINAL.pdf

OUTPATIENT MANAGEMENT OF ALCOHOL WITHDRAWAL

DSM-5 Alcohol Withdrawal

- Cessation of (or reduction in) heavy and prolonged alcohol use
- Two (or more) of the following, within several hours to a few days after the cessation of (or reduction in) alcohol use:
  - Autonomic hyperactivity
  - Increased hand tremor
  - Insomnia
  - Nausea or vomiting
  - Transient visual, tactile, or auditory hallucinations or illusions
  - Psychomotor agitation
  - Anxiety
  - Generalized tonic-clonic seizures

Short Alcohol Withdrawal Scale (SAWS)

A total score ≥ 12 points = moderate to severe withdrawal requiring medical management
A total score < 12 points = mild withdrawal; < 6 after treatment indicates adequate symptom control

SAWS Question	Day													
(0= none; 1 mild; 2 moderate; 3 severe)	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Anxious														
2. Feeling confused														
3. Restless														
4. Miserable														
5. Problems with Memory														
6. Tremor (shakes)														
7. Nausea														
8. Head pounding														
9. Sleep disturbance														
10. Sweating														
TOTAL Score (0-30)														

Managing Alcohol Withdrawal: Outpatient

- Outpatient often safe
- Assess SAWS and labs (LFTs, renal panel, CBC with platelets)
- Benzodiazepines first line for moderate-severe
  - Fixed and symptom-triggered dosing are both safe
  - Fixed regimen:
    - Chlordiazepoxide 200mg QD decrease by 25 mg QD
    - Liver disease: consider oxazepam 120mg decreasing by 10mg per day

Managing Alcohol Withdrawal: Inpatient

Inpatient withdrawal management is often needed when…

- History of delirium tremens or withdrawal seizures
- Multiple prior withdrawal episodes
- Inability to tolerate oral medications
- Absence of a support person and housing
- Uncontrolled chronic medical conditions
- Serious psychiatric comorbidity (e.g., suicidal ideation, psychosis)
- Older age
- Other substance use
- Urine drug screen positive for other substances
- Severe alcohol withdrawal symptoms

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THANK YOU!

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