Alcohol Use Disorder: Expanding Successful Treatment in Primary Care and Beyond

Agenda

8:00-9:00 – Melissa Brewster, PharmD, BCPS
Senior Pharmacy Clinical Coordinator, CareOregon

9:00-9:10 Break

9:10-10:00 – Dr. Amanda Risser, MD, MPH
Senior Medical Director of Substance Use Disorder Services,
Central City Concern

10:00-10:10 Break

10:10-11:10 – Dr. Matthew G. Chan, MD
Assistant Professor of Family Medicine, School of Medicine,
OHSU Scappoose
Kyle Higgins, M.S.W., LCSW, CADC I
OHSU South Waterfront

11:10-11:30 – Stacie Andoniadis
Primary Care Innovations Specialist, CareOregon

11:30-12:00 – Panel Q&A

Learning Objectives

- Understanding of the core competencies related to alcohol use, including knowledge, assessment, and treatment-based competencies.
- Understanding of the pharmaceutical options for treatment of AUD, the importance of medications in the treatment of AUD, and current under-utilization of pharmacology.
- Increase primary care's ability to engage with behavioral health and community resources to assist with the treatment of AUD in a primary care setting.

Alcohol Use Disorder in the U.S.

Melissa Brewster, PharmD, BCPS –

Senior Pharmacy Clinical Coordinator, CareOregon

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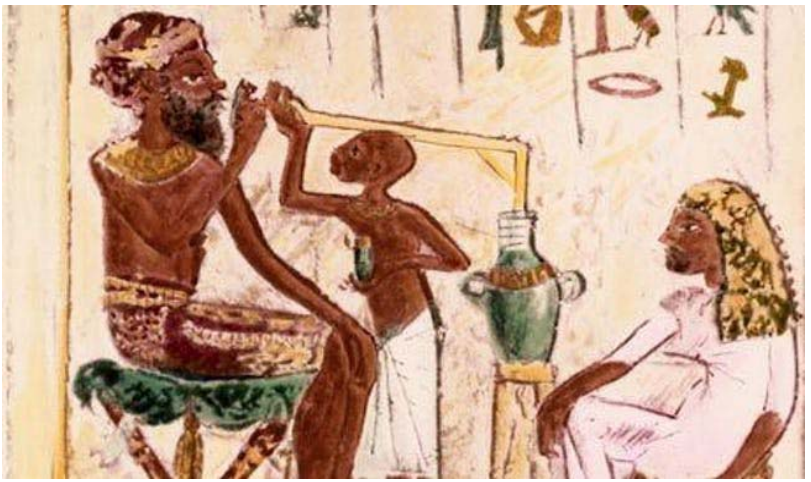
Objectives

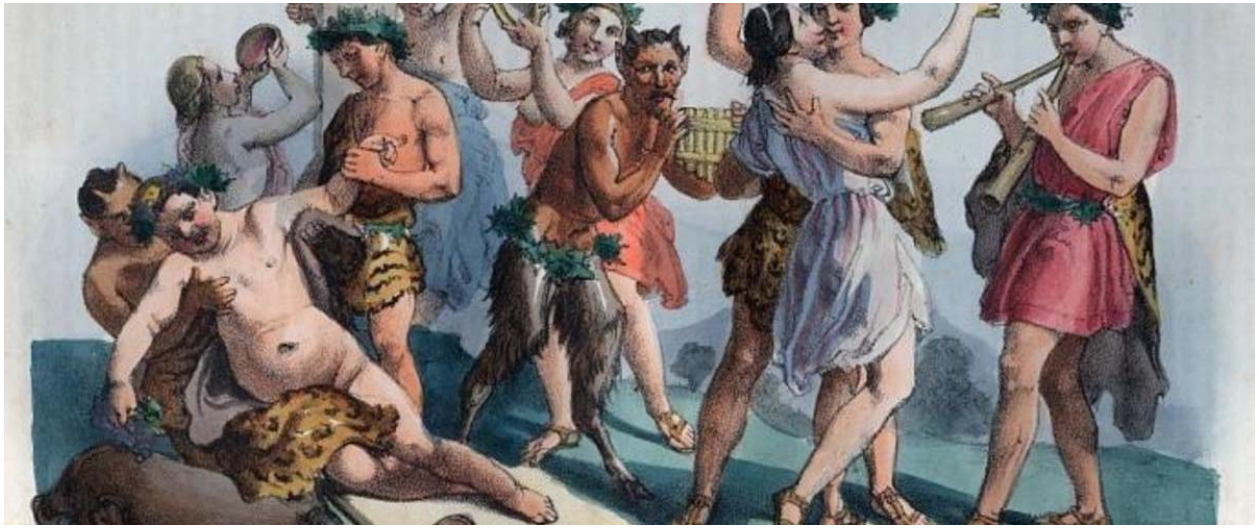
- Describe the history of alcohol in the development of the ancient and modern world
- Identify the impacts of alcohol on the major organs and neurotransmitter systems of the body
- Describe the three FDA approved medications for treating alcohol use disorder

A History of Alcohol

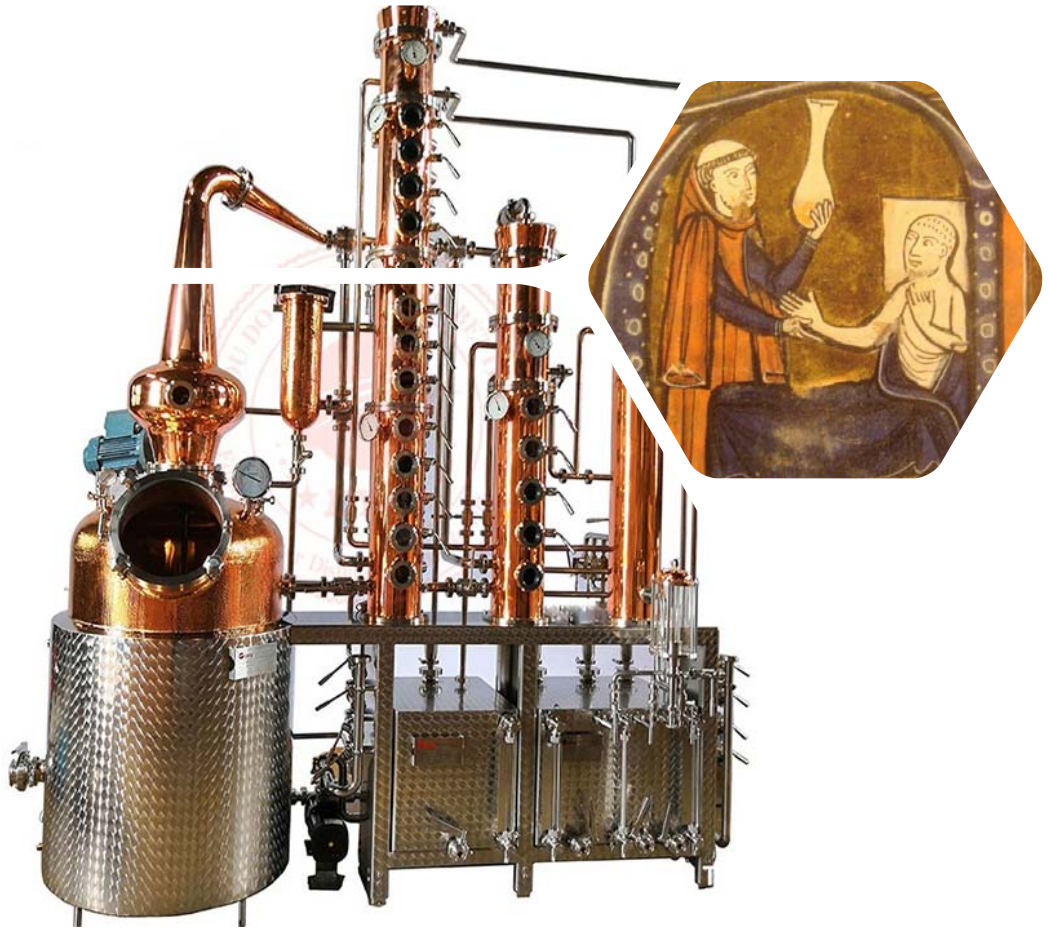
Alcohol in Ancient Egypt



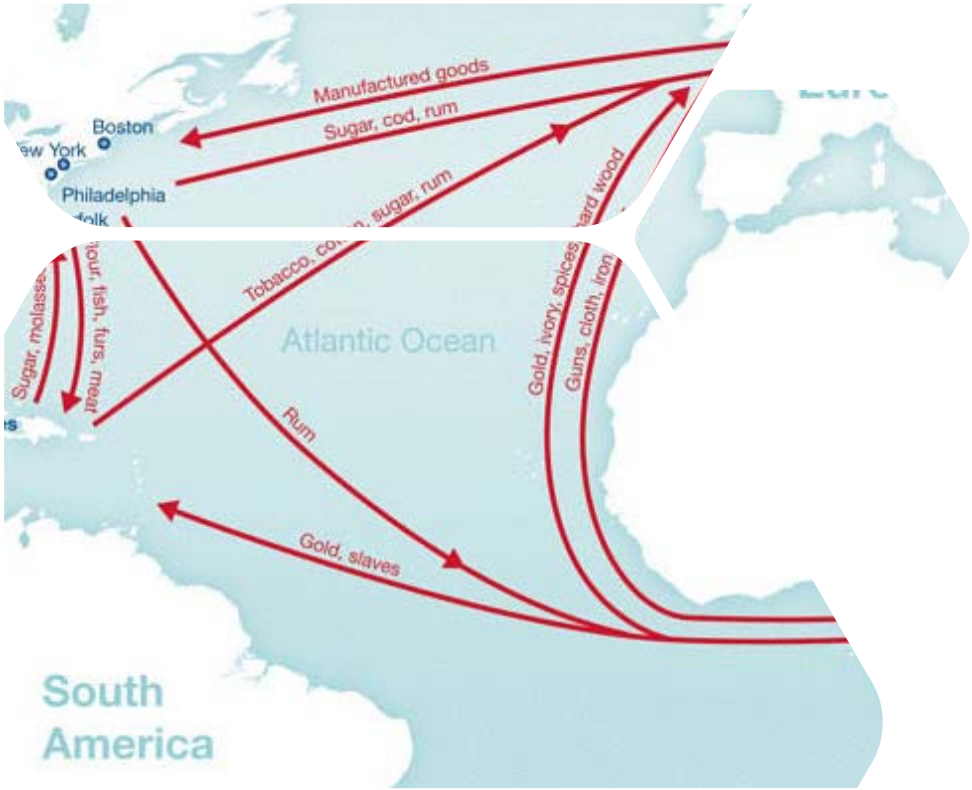
Alcohol in Ancient Greece and Rome



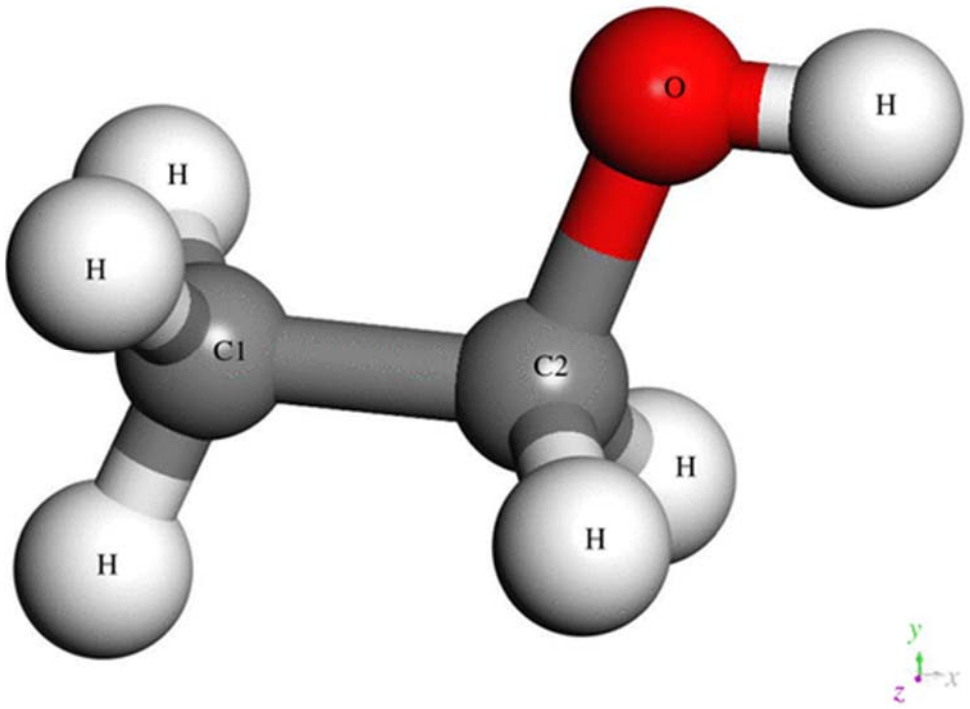
The Invention of Distillation



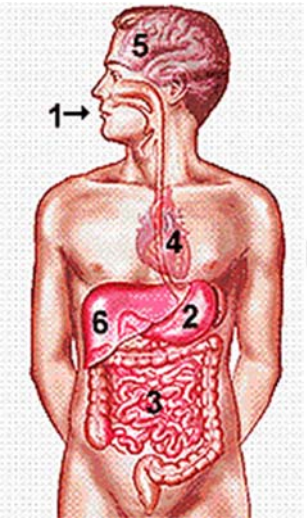
The Dark Side of the Spirits in Trade

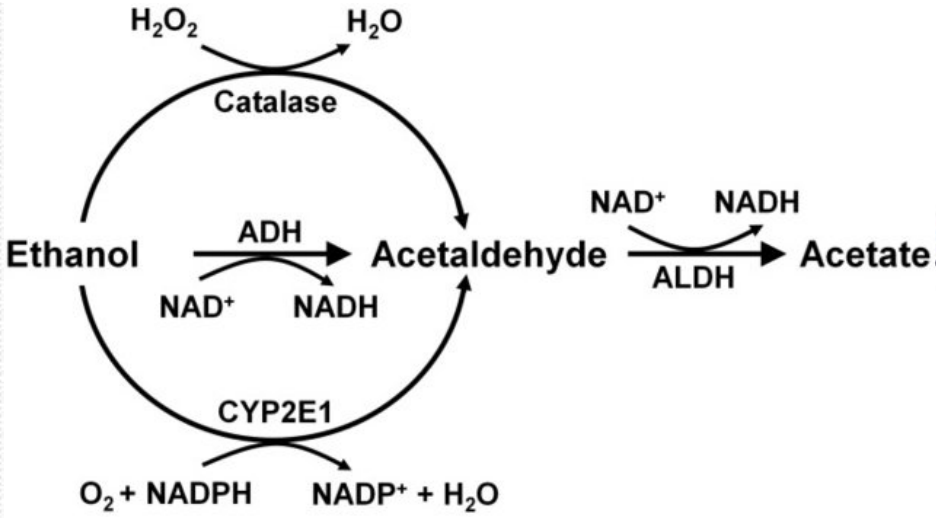


Ethanol

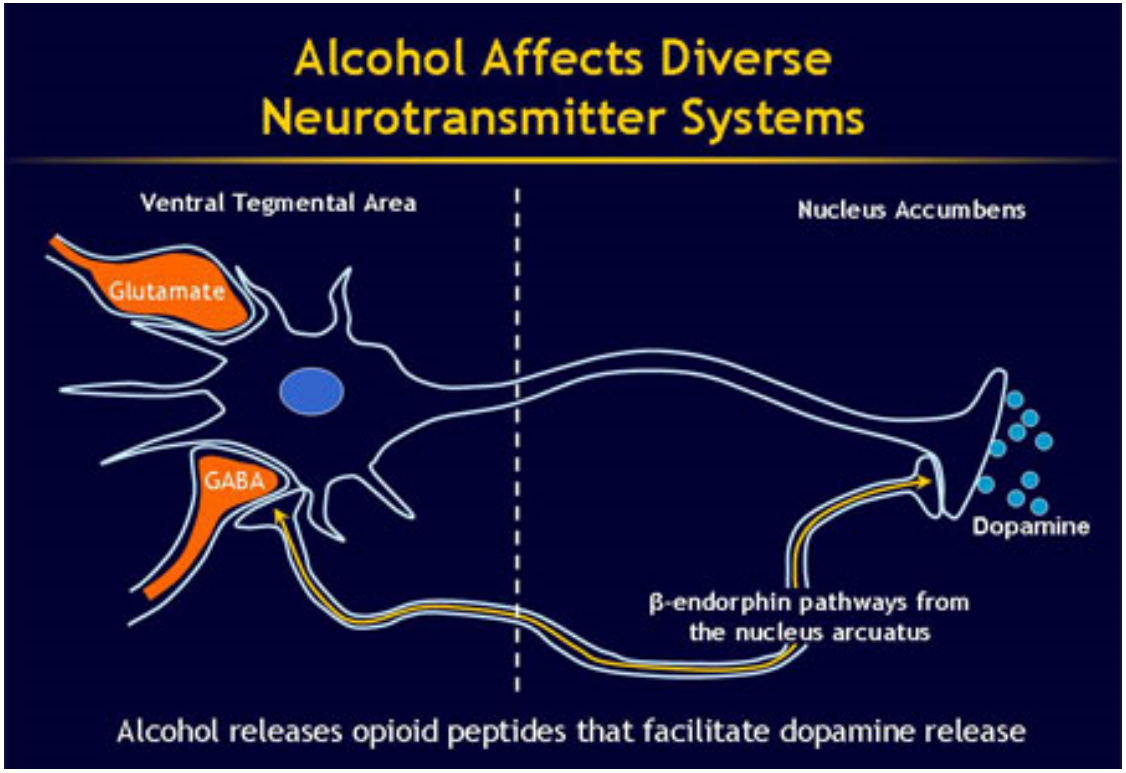


Alcohol's Journey Through the Body

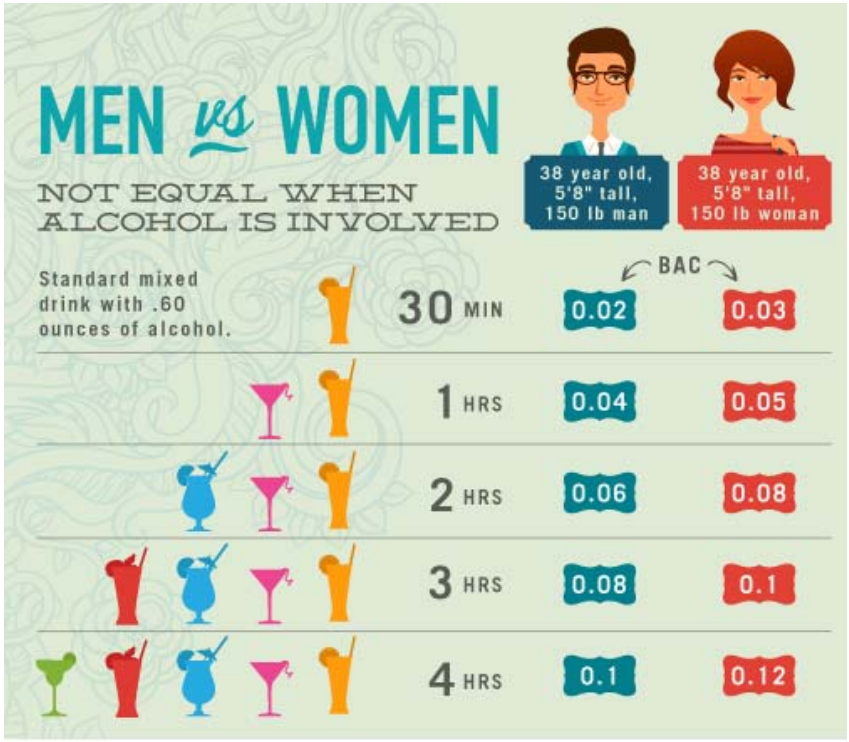




Alcohol in the Brain



Gender Differences in Alcohol Effects



Alcohol Metabolism

- On average, one standard drink is metabolized per hour (0.02 BAC)
- Hence, BAL of 0.30 will take approximately 15 hours to metabolize to zero
- People with alcohol tolerance start to develop withdrawal 6 hours from last drink
- Withdrawal will develop long before the BAL reaches zero

BLOOD ALCOHOL CONTENT (BAC)
Table for Male (M) / Female (F)

Number of Drinks		Body Weight in Pounds								Driving Condition
		100	120	140	160	180	200	220	240	
0	M	.00	.00	.00	.00	.00	.00	.00	.00	Only Safe Driving Limit
	F	.00	.00	.00	.00	.00	.00	.00	.00	
1	M	.06	.05	.04	.04	.03	.03	.03	.02	Driving Skills Impaired
	F	.07	.06	.05	.04	.04	.03	.03	.03	
2	M	.12	.10	.09	.07	.07	.06	.05	.05	
	F	.13	.11	.09	.08	.07	.07	.06	.06	
3	M	.18	.15	.13	.11	.10	.09	.08	.07	
	F	.20	.17	.14	.12	.11	.10	.09	.08	Legally Intoxicated
4	M	.24	.20	.17	.15	.13	.12	.11	.10	
	F	.26	.22	.19	.17	.15	.13	.12	.11	
5	M	.30	.25	.21	.19	.17	.15	.14	.12	
	F	.33	.28	.24	.21	.18	.17	.15	.14	

Subtract .01% for each 40 minutes of drinking.
1 drink = 1.5 oz. 80 proof liquor, 12 oz. 5% beer, or 5 oz. 12% wine.
Fewer than 5 persons out of 100 will exceed these values.

Standard Drinks

- 12 oz regular beer (5% alcohol)
  - Light beer contains slightly less (4.2%)
  - Malt beverages contain around 7%
- 5 oz table wine (12% alcohol)
- 1.5 oz 80 proof spirits (40%)
- Multiply oz by % = 60

A Review of Measures

- 1 cup= 8 oz = 5.3 drinks
- 1 pint = 2 cups = 16 oz = 10.6 drinks
- 1 quart = 2 pints = 32 oz = 21.3 drinks
- 1 gallon = 4 quarts = 128 oz = 85.3 drinks

- Assuming 80 proof spirits

Additional Terminology

- Nip/mini bottle (airplane size) = 50 mL = 1.7 oz
- Fifth = fifth of a gallon = 750 mL = 25.4 oz = 17 drinks
- Handle = about half a gallon = 1.75 L = 59 oz = 39.3 standard drinks

Risk Levels of Drinking

- Binge drinking = 4 drinks in one sitting for women or 5 drinks for men on at least 1 day in the past month
- Heavy alcohol use = binge drinking 5 or more days in the past month
- Low risk drinking
  - Women: no more than 3 drinks in one sitting or 7 in a week
  - Men: no more than 4 drinks on a single day or 14 in a week
- No such thing as NO RISK Drinking

So…Does a Glass of Wine Reduce Heart Disease Risk?

- Polyphenols in grape skins are antioxidants
- May improve vascular tone – but…
- Acetaldehyde causes cell damage and can cause cancer
- Also raises estrogen levels which is thought to be the cause of breast cancer risk
- Women over 55 who drink 3 glasses of wine a week or less may receive some cardiovascular benefit

Alcohol Use Disorder in the U.S.

- Alcohol use disorder (AUD) is highly prevalent, highly comorbid, disabling, and often goes untreated
- 88,000 annual deaths
- Only 1 in 6 adults reports ever being asked about their alcohol use
- Around 14% of adults have AUD in any given year
- Lifetime prevalence is over 29%
  - Only around 1 in 11 of these receive any treatment
  - Only 9% of patients who could use treatment with medication receive them

JAMA 2020.

Alcohol Use Disorder in the Oregon

- Five Oregonians die from alcohol use each day, more than double that of overdose deaths
- Untreated SUD costs Oregon $5.9 billion dollars every year
- Alcohol dependence cost Oregon $3.2 *billion* in 2006, compared to $3.95 *million* in revenue from alcohol sales
- Excessive drinking costs the United States $2.05 per drink
- According to the CDC, Oregon ranks 28th in the nation in binge drinking with 18.4% of adults engaging in a binge in the previous year (2019)

United Health Foundation 2020. MMWR 2019.

Risk Factors for AUD

White

Younger

Native American

Poverty

Experiencing Disability

MDD

Bipolar Disorder

Antisocial Personality Disorder

PTSD

JAMA Psychiatry, 2015.

Gray Area Drinking

- Female
- Well-educated
- Professional
- High functioning
- The wealthier the country, the more women drink
- Moderation is easier to maintain for gray area drinkers than abstinence
- The concept of abstinence is a MAJOR contributor to treatment hesitation

Medication Treatment for Alcohol Use Disorder

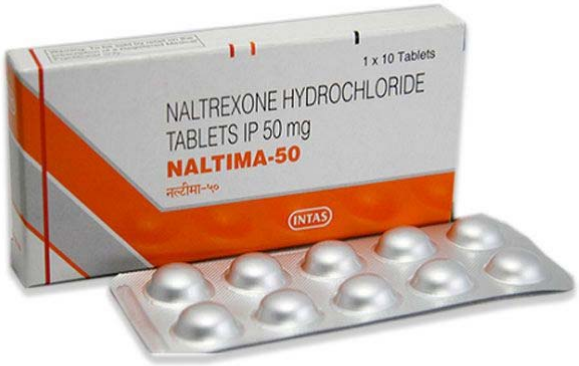
- All individuals with moderate to severe alcohol use disorder who are:
  - Currently drinking
  - Recently abstinent and experiencing cravings or at risk for return to drinking
  - Prefer medication along with or instead of a psychosocial intervention

Management of AUD: Beyond Withdrawal

- Medically managed withdrawal “detoxification” is not treatment
- Brief intervention
- Treatment
  - Psychosocial counseling
  - Pharmacotherapy
- Self (online, books), mutual help (e.g. AA, Smart Recovery)
- Peer support services
- Manage comorbidity (medical and psychiatric)

Medications Used for Alcohol Use Disorder

- FDA Approved
  - Naltrexone (1st line)
  - Acamprosate
  - Disulfiram
- Non-FDA Approved
  - Topiramate
  - Gabapentin
  - Baclofen



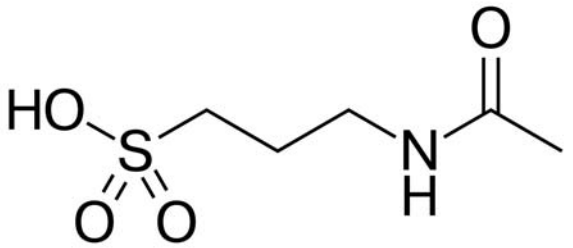
Oral Naltrexone

- 50 mg daily
- Consider starting if
  - Currently drinking
  - LFTs < 5x upper limit normal and no liver failure
  - At least 3 days since last opioid
- Monitor LFTs periodically
- Common side effects include nausea, vomiting, headache, and dizziness
- Timing of dosing is critical! One hour before drinking

Adapted from slide by Richard Saitz MD, MPH, FACP, DFASAM. The Immersion Training in Addiction Medicine Programs from Boston University School of Medicine

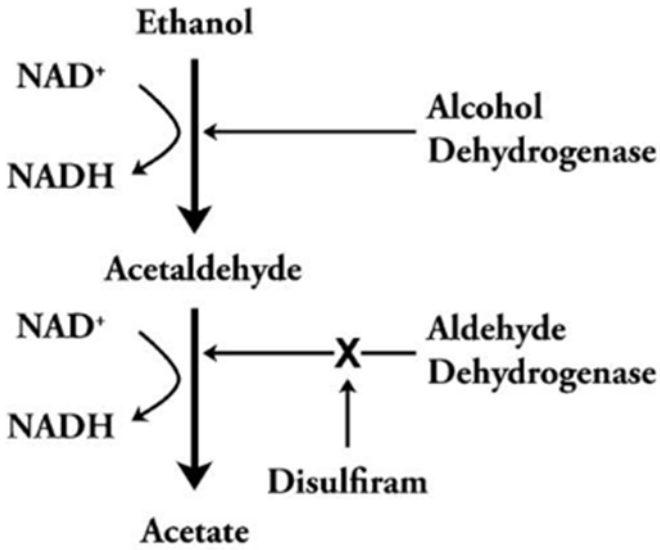
Acamprosate

- GABA analogue
- 666 mg TID
  - Reduced return to any drinking, NNT 12
  - Reduced % drinking days,
  - Reduced % heavy drinking days



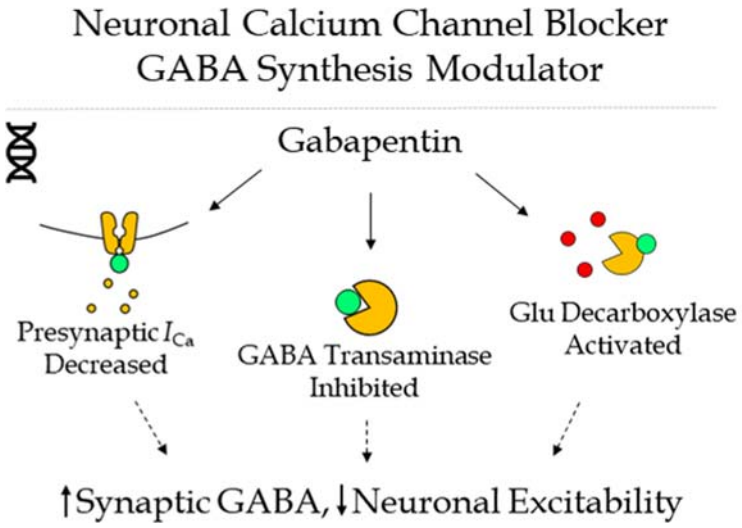
Disulfiram

- FDA approved for alcohol dependence in 1949: 250 mg/day
- Not very effective unless administration is supervised
- Irreversibly inhibits aldehyde dehydrogenase
- Disulfiram Ethanol Reaction
  - Flushing
  - Headache
  - Palpitations
  - Dizziness
  - Nausea
  - Hypotension



Gabapentin for AUD

- Gabapentin resulted in higher sustained abstinence rates compared with placebo
  - 11.1% for gabapentin 900 mg
  - 17% for gabapentin 1800 mg; NNT = 8
- Gabapentin resulted in higher rates of no heavy drinking
  - 29.6% for gabapentin 900 mg
  - 44.7% for gabapentin 1800 mg; NNT 5
- Improved mood, fewer cravings, and improved sleep.



Mason, Barbara J., et al. JAMA internal medicine 174.1 (2014): 70-77.

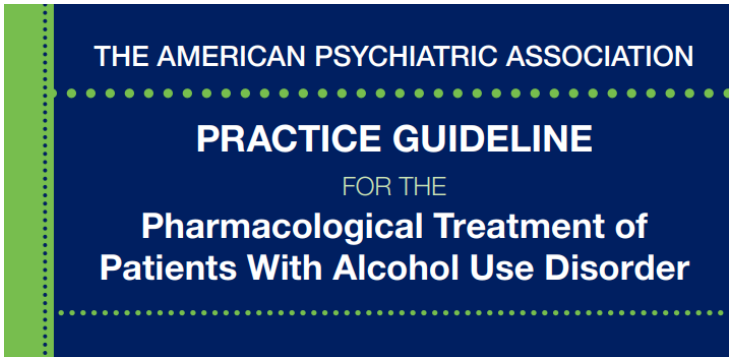
AUD Guidelines

- Guideline update in 2018 by American Psychiatric Association

  https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969

- CPNP: Pharmacist Toolkit

  https://cpnp.org/guideline/aud



College of Psychiatric & Neurologic Pharmacists

cpnp

Thank You!

10 minutes

Alcohol Use Disorder

Diagnosis, Medications, Ambulatory Withdrawal Management

Dr. Amanda Risser, MD, MPH –

Senior Medical Director of Substance Use Disorder Services,
Central City Concern

careoregon.org

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

CareOregon

Nothing To Disclose

(I find alcohol use disorder hard to treat!)

AUD Treatment Opportunities

- Patients with AUD present in all care settings: Withdrawal Management, ED, inpatient, behavioral and physical health outpatient.
- Creates many opportunities to initiate a conversation about AUD.
- Engagement tends to be higher in behavioral health setting, likely due to motivation and expertise and referrals from criminal justice.
- Withdrawal management initiates treatment then there is difficulty continuing engagement without community experts in both physical and behavioral health and patient pathways.

Oregon liquor stores see record March sales

Updated Apr 15, 2020; Posted Apr 14, 2020

Dustin Anderson wears gloves while working at the Cedar Mill Liquor Store in Portland, on March 26, 2020, amid the coronavirus pandemic and Oregon Gov. Kate Brown's stay-home order. Liquor stores were deemed an essential business and have remained open. Brooke Herbert/The Oregonian/Ore

"…during the coronavirus crisis, people are putting in place patterns of heavier drinking that will show up in future higher rates of alcohol use disorders."

- America is drinking its way through the coronavirus crisis, April 8, 2020, David H. Jernigan

By Ted Sickinger| The Oregonian/OregonLive

Comprehensive, Strategic Approach

- Health Systems- Incentivizing the use of evidence based treatment, encouraging adoption of low-barrier access to treatment and increasing rate of screening and referral
- Build capacity among culturally specific organizations and communities disproportionately impacted by alcohol industry targeting
- Maintain Oregon's state alcohol beverage control; Increase the price of alcohol by 10%
- Increase the number of jurisdictions covered by alcohol marketing, promotion and retail restrictions such as limiting outlet density, price promotions, and limits on days or hours of sale and point of purchase interventions

Oregon Health Authority State Health Improvement Plan 2020-2024

DSM-5 diagnosis criteria for alcohol use disorder*

1. Alcohol is often taken in larger amounts or over a longer period than was intended
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects
4. Craving or strong desire, or urge to use alcohol
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
8. Recurrent alcohol use in situations in which it is physically hazardous
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect

b. A markedly diminished effect with continued use of the same amount of alcohol

11. Withdrawal or taking alcohol to relieve withdrawal

(At least of 2 symptoms in past 1 year; mild disorder:2-3; moderate:4-5; severe disorder≥6)

Initiation and Engagement in Alcohol or Other Drug Use Treatment:

Overview

Initiation and Engagement reported separately; must meet both for quality pool

Initiation: ***Members who received AOD Treatment within 14 days of index episode start date*** / ***Members with a new AOD dx***

Engagement: ***Members who received AOD Treatment within 34 days of initiation event*** / ***Members with a new AOD dx***

IET by Index Payer and Drug: Alcohol Abuse and Dependence

Diagnosis Category	IndexVisitT..		CareOregon	Kaiser	Legacy Health PacificSource	OHSU Health	Providence	Grand Total
Alcohol Abuse and Dependence	Detox	IET denominator	137	23	1	4	15	180
		Initiation rate	27.7%	21.7%	0.0%	25.0%	13.3%	25.6%
		Engagement rate	8.0%	0.0%	0.0%	0.0%	0.0%	6.1%
	ED	IET denominator	898	178	10	18	111	1,215
		Initiation rate	14.5%	5.6%	30.0%	0.0%	12.6%	12.9%
		Engagement rate	2.8%	1.1%	0.0%	0.0%	1.8%	2.4%
	Inpatient	IET denominator	368	65	4	12	78	527
		Initiation rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		Engagement rate	4.1%	6.2%	0.0%	0.0%	2.6%	4.0%
	Outpatient BH Payer	IET denominator	1,341	295	18	48	197	1,899
		Initiation rate	53.6%	58.0%	66.7%	41.7%	54.8%	54.2%
		Engagement rate	41.8%	44.1%	55.6%	37.5%	40.1%	42.0%
	Outpatient PH Payer	IET denominator	1,438	121	20	35	226	1,840
		Initiation rate	12.2%	12.4%	5.0%	8.6%	7.5%	11.5%
		Engagement rate	3.1%	4.1%	0.0%	2.9%	1.8%	2.9%
	Total	IET denominator	4,182	682	53	117	627	5,661
		Initiation rate	34.2%	39.0%	37.7%	30.8%	34.9%	34.8%
		Engagement rate	15.7%	20.7%	18.9%	16.2%	13.9%	16.1%

This Table Shows:

We are not doing a great job at either initiation or engagement in treatment services for alcohol use disorder.

Table 3: Mechanism of Action of Medications Used in the Treatment of AUD and Their Adverse Effects

Medication	Adult Dosing	Mechanism of Action	Common Adverse Effects	Contraindications
Acamprosate	Oral: 666 mg (two 333-mg tablets) 3 times per day	Modulates hyperactive glutamatergic n-methyl-d-aspartate receptors	• Anxiety • Diarrhea • Vomiting	Severe renal impairment[a]
Naltrexone	• Oral: 50 to 100 mg per day • Intramuscular: 380 mg per month	• Opioid antagonist that competitively binds to opioid receptors and blocks the effects of endogenous opioids such as β-endorphin • Decreases the craving for alcohol	• Dizziness • Nausea • Vomiting	• Liver failure • Acute hepatitis and precautions for other hepatic disease
Disulfiram	Oral: 250 to 500 mg per day	• Expectation or experience of an adverse response to alcohol consumption • Inhibits ALDH2, causing accumulation of acetaldehyde during alcohol consumption, which, in turn, produces various adverse effects such as nausea, dizziness, flushing, and changes in heart rate and blood pressure	• Drowsiness • Metallic or garlic taste in mouth	• Severe myocardial diseases • Psychoses • Liver failure • Hypersensitivity to thiuram derivatives
Topiramate[b,c]	Oral: 25 to 400 mg per day	Blocks voltage-dependent sodium channels, augments the activity of the neurotransmitter γ-aminobutyrate, antagonizes certain subtypes of the glutamate receptor, and inhibits the carbonic anhydrase enzyme	• Paresthesia • Anorexia • Dizziness • Somnolence • Psychomotor slowing • Abnormal vision • Fever	None

[a]Dose adjustment for moderate renal impairment.
[b]This medication has not been approved by the FDA for the treatment of alcohol dependence, alcohol abuse, or AUD.
[c]The prescribing information sheet for topiramate lists warnings for several serious adverse effects. These include warnings for acute myopia and secondary angle closure glaucoma, suicidal behavior and ideation, and fetal toxicity. Clinicians are advised to refer to the prescribing information sheet for additional information on adverse effects.
ALDH2 = aldehyde dehydrogenase 2

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U.S. Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

Effective Health Care Program

Pharmacotherapy for Adults With Alcohol Use Disorder (AUD) in Outpatient Settings

CLINICIAN SUMMARY | February 16, 2016

Data Supports:

Acamprosate- NNT 12

Naltrexone- NNT 20

Ambulatory Alcohol Withdrawal Management

ASAM guidance relevant for current times

Case Presentation:

- 40-year-old woman presenting to alcohol withdrawal management services at Hooper.
- She drinks 2 bottles of wine a day – started drinking when her outpatient program went remote.
- Her presenting CIWA was 12 and her last drink was the night before.
- She lives with her elderly mother who has COPD and is oxygen-dependent.
- She's hoping to leave withdrawal management to a residential treatment where she can eventually parent her child who is currently in foster care.
- She develops a fever of 101 on the first day of admission with a mild sore throat, we sent her to urgent care and she got a COVID-19 PCR test.

The ASAM
CLINICAL PRACTICE GUIDELINE ON

Alcohol Withdrawal Management

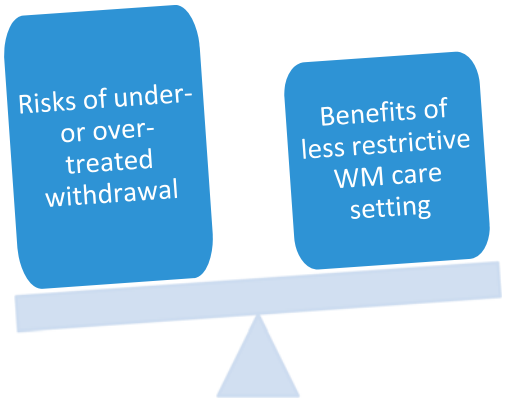
Alvanzo, A., Kleinschmidt, K., Kmiec, J.,
Kolodner, G., Marti, G., Milio, L., Murphy, W.,
Tirado, C., Waller, C., Nelson, L.

These slides prepared by:
David Lawrence MD
OHSU DGIMG, Section of Addiction Medicine
Assoc. Medical Director, Hooper DSC, Central City Concern

Who Isn't Appropriate for Ambulatory WM?

Pattern of use

- 17+ daily standard drinks
- Concurrent benzodiazepine dependence or withdrawal



Recovery capital

- Unable to obtain transportation or housing
- Family/friends not supportive of WM process
- Low level of cooperation, reliability, or commitment
- Significant risk of imminent return to use

Current & Historic Withdrawal severity

- Severe withdrawal
- Withdrawal seizure or delirium in past year

Comorbid medical issues

- Active or potentially destabilizing medical or psychiatric problem
- Cognitive impairment
- Suspected head injury
- Unable to take oral medication
- Pregnancy
- Other inpatient indication

Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence. NICE. 2011.

Who Isn't Appropriate for Ambulatory WM?

Supportive care instructions including:

- Followup schedule
- Symptoms to expect, how to monitor them, when to seek on-call care
- Creation of a low-stimulation, reassuring environment
- Hydration with non-caffeinated drinks
- Multivitamin, thiamine
- WM medication administration instructions

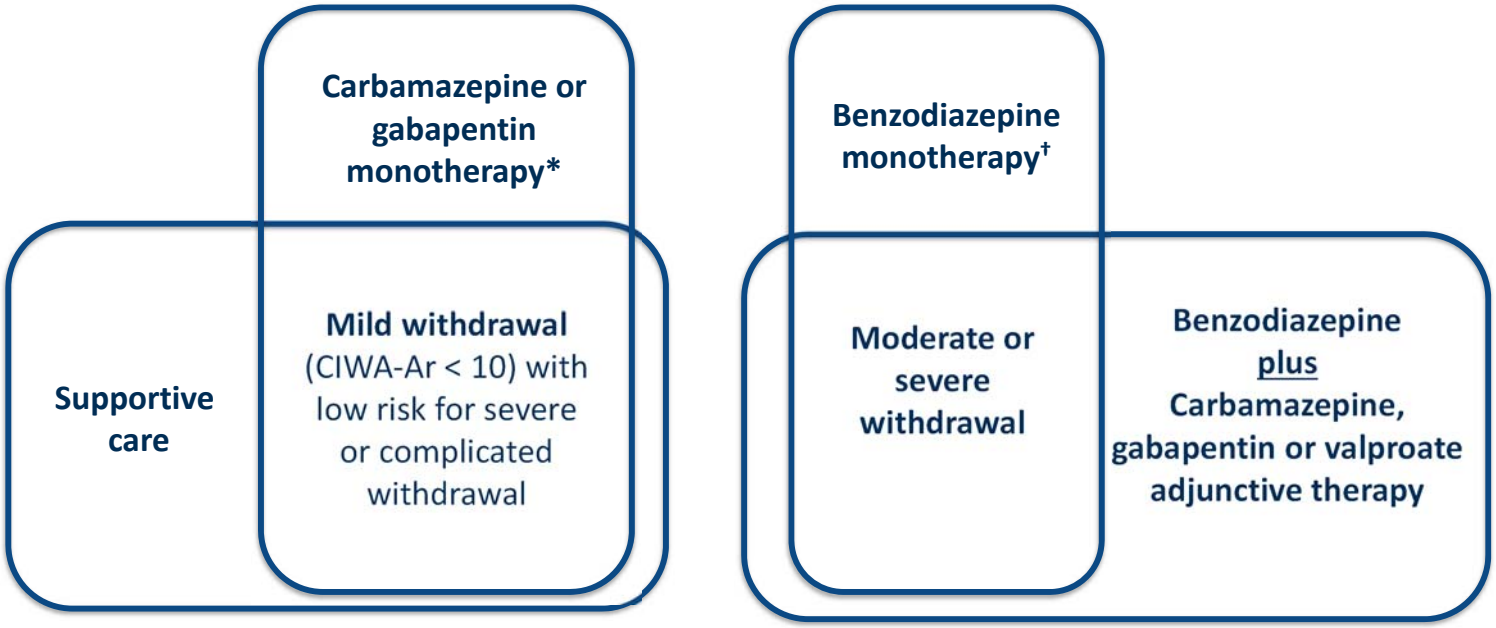
Treatment of alcohol use disorder:

- Naltrexone, acamprosate, gabapentin, disulfuram
- SUDs treatment resources
- Mutual support resources

Daily in-person (may alternate with virtual) monitoring (x5 days) should include:

- General condition, vitals, hydration, orientation, sleep and emotional status, substance use
- Blood alcohol concentration (if available)
- Objective withdrawal scale assessment (e.g. CIWA, SAWS)
- Indications for higher level of care:
  - Severe and un-resolving tremor despite multiple doses of medication
  - Persistent vomiting, hallucinations, confusion, seizure, agitation
  - Worsening underlying medical or psychiatric conditions
  - Over-sedation
  - Return to alcohol use
  - Syncope or unstable BP or HR

Which WM Medication to Offer?



*If risk for worsening withdrawal while away from the treatment setting, benzodiazepine monotherapy also appropriate

† If BZD contraindicated, CBZ or GABA monotherapy are appropriate alternatives

- **Generally, protocols follow a 4-6 day dose taper schedule**

Ambulatory Alcohol Withdrawal Management

CASE PRESENTATION:

- Our patient went to her mother's house and isolated herself in her room.
- She had some phone recovery supports to sustain her.
- Because of her risk profile and drinking patterns, we started her on chlordiazepoxide- 25 mg po QID.
- We called her twice daily.
- She did well for 24 hours but struggled.
- Her upper respiratory symptoms resolved and her COVID test came back negative.
- She returned to drinking, we brought her back to Hooper for withdrawal management a few hours after her first few drinks.

What You Can Incorporate Into Your Organization Today

1. Use specific exclusion criteria to feel more confident in offering ambulatory WM
2. Use virtual or telephone visits to minimize burden of frequent follow-up
3. Employ gabapentin and carbamazepine WM protocols as either monotherapy or adjuncts to benzodiazepines

Thank You!

10 minutes

Alcohol Use Disorder in Primary Care

Kyle Higgins, LCSW
Behavioral Health Consultant
OHSU Family Medicine

Dr. Matt Chan, MD
Assistant Professor
OHSU Family Medicine

careoregon.org
twitter.com/careoregon

OHSU

CareOregon

Disclosures

There are no disclosures

“Primary care providers are the most likely to have contact with patients who are struggling with substances, yet we have traditionally avoided that responsibility.”

Miriam Komaromy, M.D.
Associate Director
University of New Mexico’s Project ECHO

Alcohol Use Disorder

- Previously viewed as Abuse vs Dependence in DSM IV
- Defined as a problematic pattern of use causing clinically significant impairment or distress
- AUD exists on a continuum of severity, which with proper assessment can better inform treatment

In Order to Confirm a Diagnosis of AUD, at Least **Two** of the Following Should be Observed Within a 12-Month Period

- Alcohol is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol , or recover from its effects
- Craving, or a strong desire or urge to use alcohol
- Recurrent alcohol use despite having persistent or recurrent social/interpersonal problems caused/exacerbated by the effects of alcohol

In Order to Confirm a Diagnosis of AUD, at Least **Two** of the Following Should be Observed Within a 12-Month Period

- Important social, occupational or recreational activities are given up/reduced due to alcohol
- Recurrent alcohol use in situations in which it is physically hazardous
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have caused/exacerbated by alcohol
- Tolerance as defined by either of the following;
  - A need for markedly increased amount to achieve intoxication or desired effect
  - A markedly diminished effect with continued use of the same amount of alcohol

By the Numbers

- Among adults 18 yrs. and over 25.5% reported engaging in binge drinking and 6.6% reported heavy drinking in past month

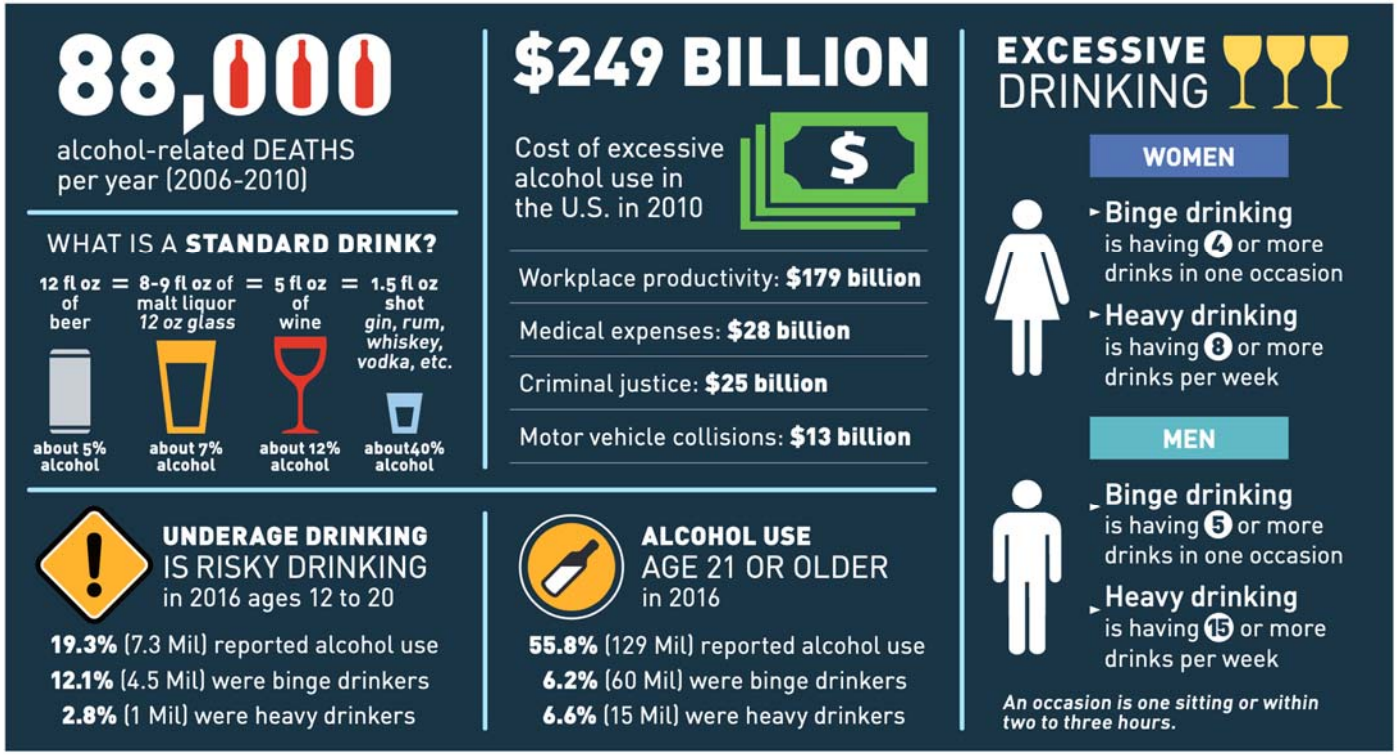
- 5.8% (14.4 mil) of respondents surveyed met criteria for AUD

- Estimated 88,000 people a year die from alcohol related causes, the third leading preventable cause of death in US (this number has more than doubled since 1999) and is twice the number of opioid related overdose deaths

- 4th leading cause of death in U.S.

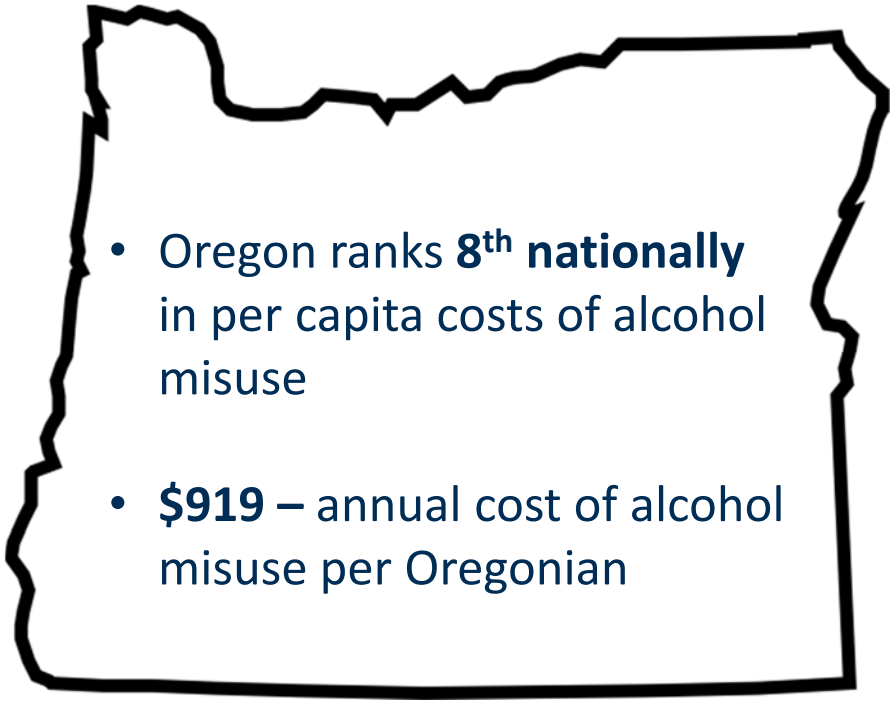
SAMSHA

By the Numbers



SAMSHA

Oregon



- Oregon ranks **8th nationally** in per capita costs of alcohol misuse
- **$919 –** annual cost of alcohol misuse per Oregonian

Treatment Works

Treatment works but can be a slow process:

- Currently 15 mil Americans over age 18 living with AUD*
- Only 6.7% of those received the treatment they need*
- Those surveyed and dx with SUD found that they were more willing to enter treatment within primary care setting (37.2%) than special treatment center (24.6%)*

*2015 & 2016 National Survey on Drug and Health

Treatment Works

Levels of treatment:

- 0.5 Early Intervention
- 1.0 Outpatient (OTP)
- 2.1 Intensive Outpatient (IOP)
- 3.5 Residential
- 4.0 Medical Detox

Primary Care Role

- Often front-line to screening and referral (SBIRT*), you are already seeing these patients
- Utilize in-clinic integrated team based partners (BHC, Pharm)
- Can treat co-morbid health conditions, the toll of alcohol use on the body is increasing the need for chronic disease management
- Also able to treat co-occurring mental health conditions

* Screening, Brief Intervention, and Referral to Treatment

Case

- 39-year-old man, new to establish care
- Comes into office wanting to discuss recurrent gout
- Reports no other medical history
- Part way through the conversation, you ask him about his alcohol intake
- He reveals that he drinks upwards of 6 beers per night

Case

- You suspect he might have underlying alcohol use disorder (AUD), and would like to investigate further
- How do you go about screening for unhealthy/risky use or alcohol, or AUD?

How People Present to Care

- Acute intoxication
- Co-occurring mental health disorders
- Medical complications of acute use
- Medical sequelae of chronic use
- **Somatic complaints**
- **Pain**
- Asking for help

USPSTF

Recommendation Summary

Population	Recommendation	Grade
Adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B
Adolescents aged 12 to 17 years	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. See the Clinical Considerations section for suggestions for practice regarding the I statement.	I

- A positive test is 82 percent sensitive and 79 percent specific for unhealthy alcohol use
- Validated in a two-site cross-sectional study of 459 adult primary care patients

McNeely, et al., 2015

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Patient name: _____

Date of birth: _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

(For the health professional)

Scoring and interpreting the USAUDIT:

Each answer receives a point ranging from 0 to 6. Points are added for a total score that correlates with a zone of use that can be circled on the bottom left corner of the page.

Score*	Zone of use	Suggested action
0 - 6: Women 0 - 7: Men	**I – Low risk** (low risk of health problems related to alcohol use)	Brief education
7 - 15: Women 8 - 15: Men	**II - Risky** (increased risk of health problems related to alcohol use)	Brief intervention
16 - 19	**III - Harmful** (increased risk of health problems related to alcohol use and a possible mild or moderate alcohol use disorder)	Brief intervention or referral to specialized treatment
20+	**IV - Severe** (increased risk of health problems related to alcohol use and a possible moderate or severe alcohol use disorder)	Referral to specialized treatment

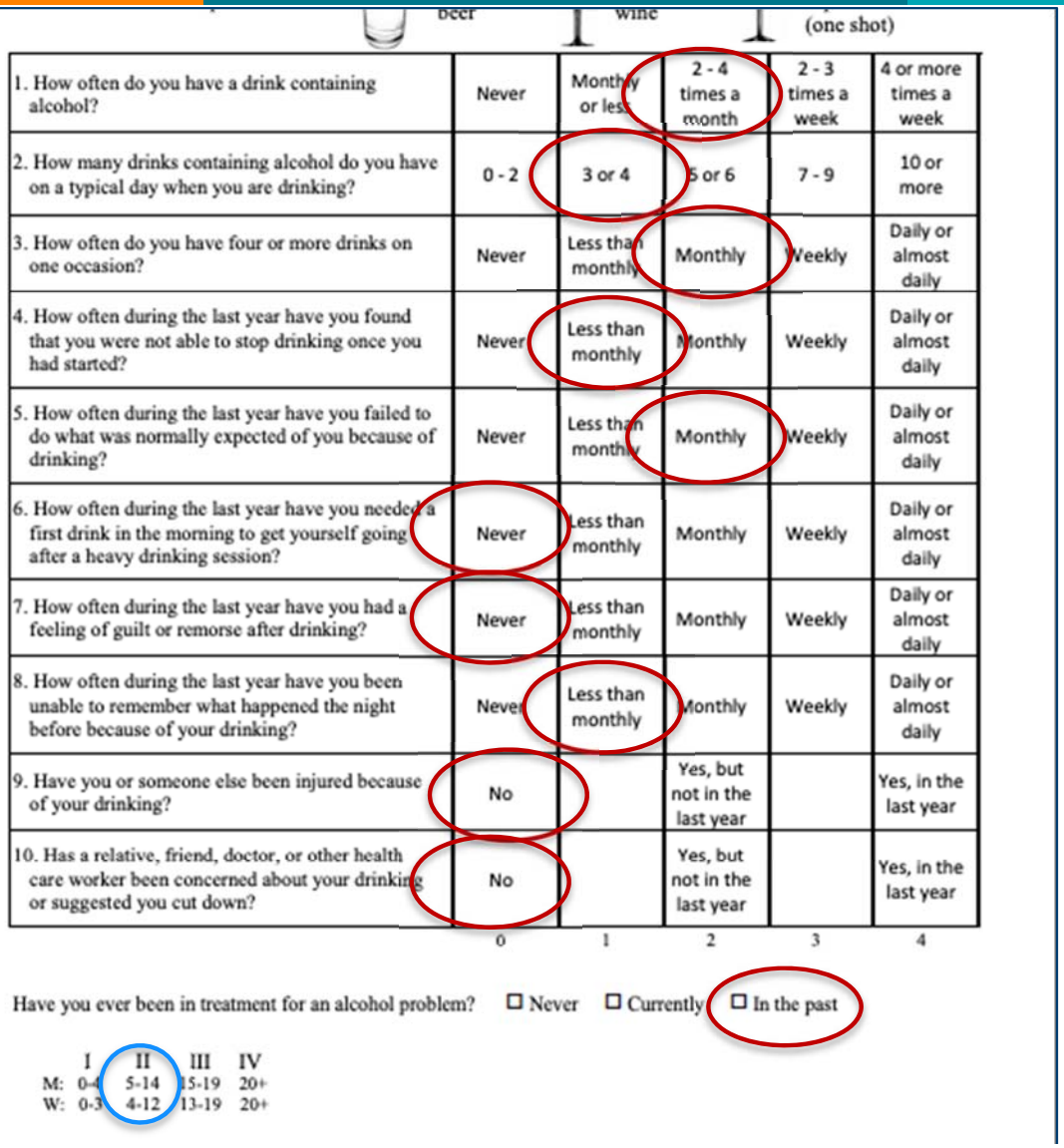
Brief education: An opportunity to educate patients about low-risk consumption levels and the risks of excessive alcohol use.

Brief intervention: Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of their substance use and enhancing their motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are shown to be more effective than a one-time intervention.

Referral to specialized treatment: A proactive process that facilitates access to specialized care for individuals who are likely experiencing a substance use disorder. Patients who are ready to accept treatment are referred to experts for more definitive, in-depth assessment and, if warranted, treatment. Referrals to treatment should be delivered using the brief intervention model.

More resources: www.sbirtoregon.org

* USAUDIT - The Alcohol Use Disorder Identification Test, Adapted for Use in the United States: A Guide for Primary Care Practitioners. Thomas F. Babor, John C. Higgins-Biddle, Katherine Robaina. Substance Abuse and Mental Health Services Administration (SAMHSA). 2016.



1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

AUDIT

USPSTF

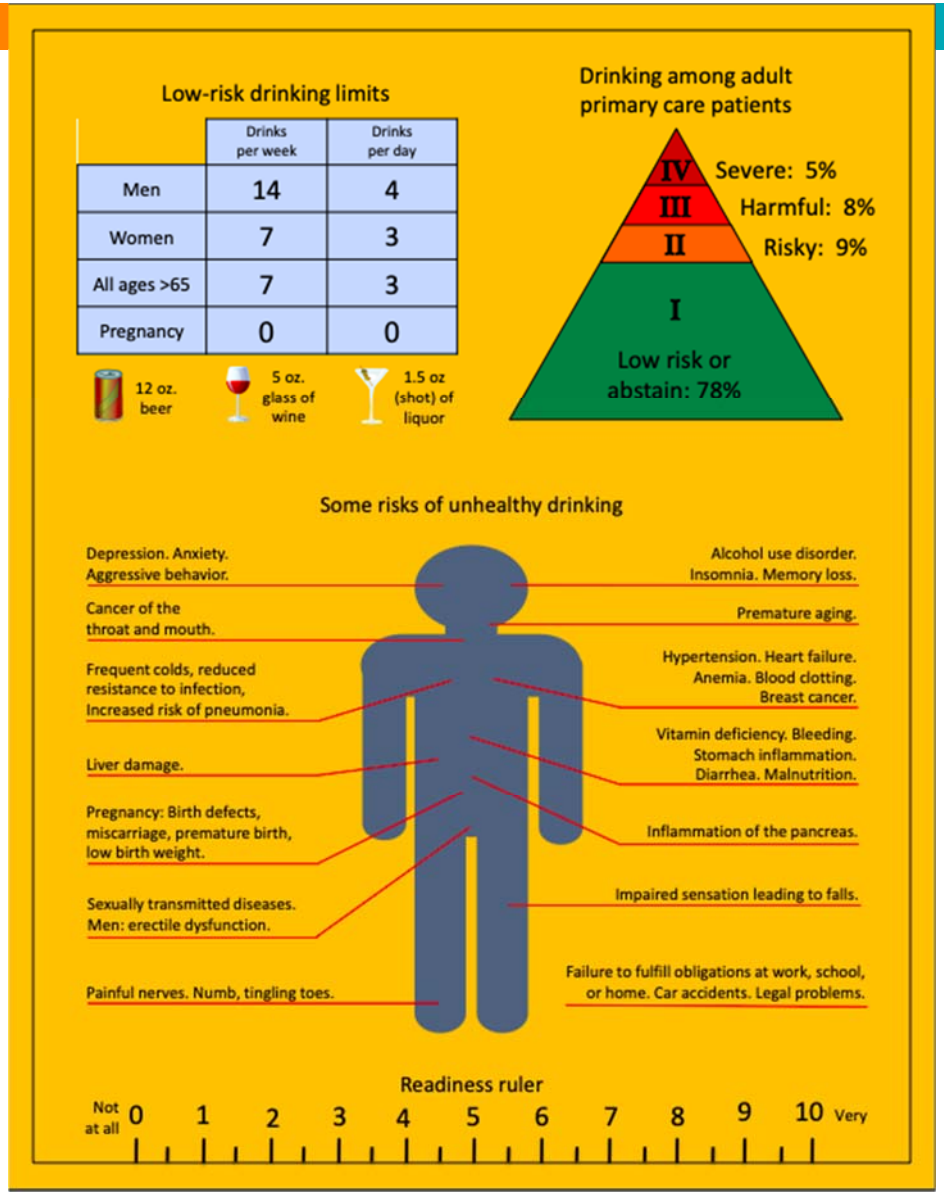
- For adults, brief (1-3 items) screeners commonly reported sensitivity and specificity between 0.70 and 0.85, typically having better sensitivity than the full AUDIT for identifying the full spectrum of unhealthy use

- AUDIT tended to have higher specificity, particularly at the standard cutoff of ≥8

SBIRT

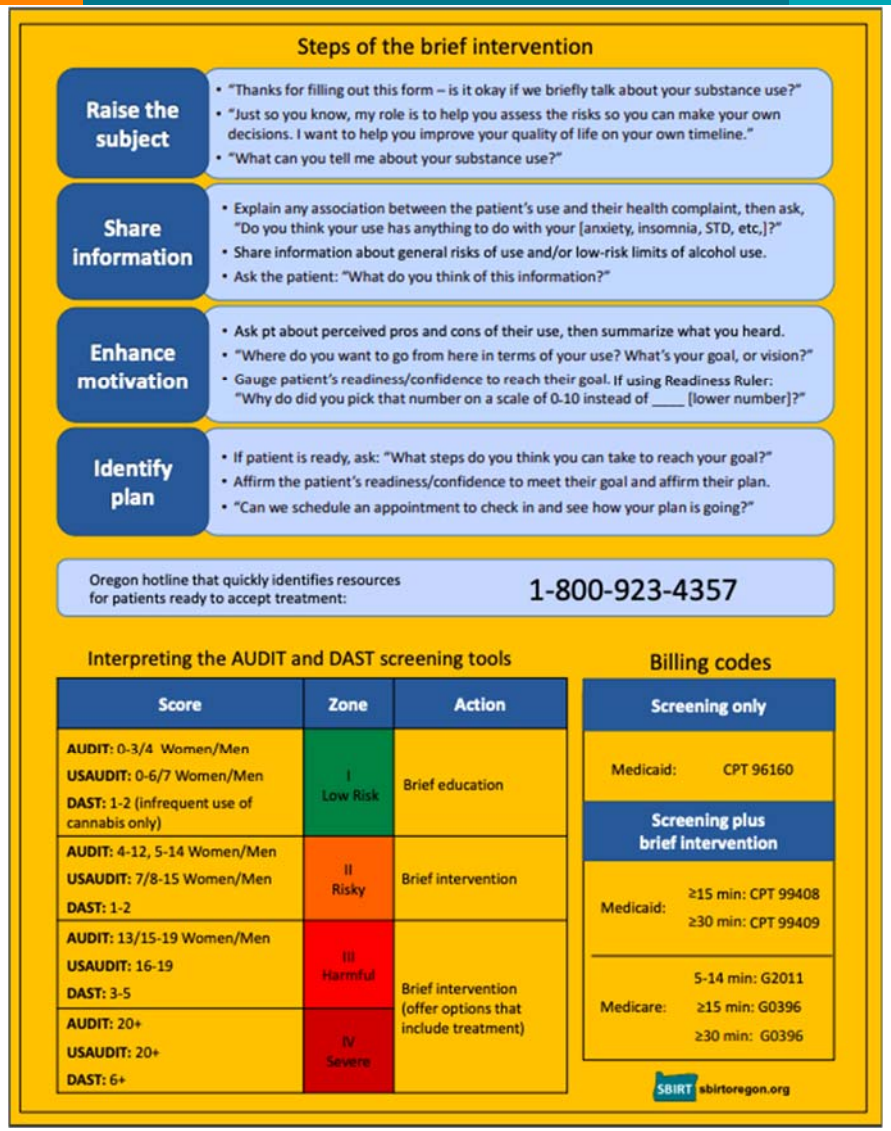
- How do you fit in a full motivational interview discussion with 15-20 minute office visit?
- Enter the SBIRT
- Clinical framework to guide discussion around reducing unhealthy drinking, or identify dependence
- Allows clinician to provide objective consequences in non-judgmental manner

- Based on their total AUDIT score, can match their risk category
- Review recommendations for safe drinking limits
- Review the long term sequelae of alcohol use
- Assess readiness to change with Readiness Ruler



careoregon.org Sbirtoregon.org

- Framework of phrases to help guide the brief intervention
- Prompts you for discussing next step in treatment



Steps of the brief intervention

Raise the subject

- "Thanks for filling out this form – is it okay if we briefly talk about your substance use?"
- "Just so you know, my role is to help you assess the risks so you can make your own decisions. I want to help you improve your quality of life on your own timeline."
- "What can you tell me about your substance use?"

Share information

- Explain any association between the patient's use and their health complaint, then ask, "Do you think your use has anything to do with your [anxiety, insomnia, STD, etc,]?"
- Share information about general risks of use and/or low-risk limits of alcohol use.
- Ask the patient: "What do you think of this information?"

Enhance motivation

- Ask pt about perceived pros and cons of their use, then summarize what you heard.
- "Where do you want to go from here in terms of your use? What's your goal, or vision?"
- Gauge patient's readiness/confidence to reach their goal. If using Readiness Ruler: "Why do did you pick that number on a scale of 0-10 instead of ____ [lower number]?"

Identify plan

- If patient is ready, ask: "What steps do you think you can take to reach your goal?"
- Affirm the patient's readiness/confidence to meet their goal and affirm their plan.
- "Can we schedule an appointment to check in and see how your plan is going?"

Oregon hotline that quickly identifies resources for patients ready to accept treatment: **1-800-923-4357**

Interpreting the AUDIT and DAST screening tools

Score	Zone	Action
AUDIT: 0-3/4 Women/Men **USAUDIT:** 0-6/7 Women/Men **DAST:** 1-2 (infrequent use of cannabis only)	I Low Risk	Brief education
AUDIT: 4-12, 5-14 Women/Men **USAUDIT:** 7/8-15 Women/Men **DAST:** 1-2	II Risky	Brief intervention
AUDIT: 13/15-19 Women/Men **USAUDIT:** 16-19 **DAST:** 3-5	III Harmful	Brief intervention (offer options that include treatment)
AUDIT: 20+ **USAUDIT:** 20+ **DAST:** 6+	IV Severe	

Billing codes

Screening only	
Medicaid:	CPT 96160
Screening plus brief intervention	
Medicaid:	≥15 min: CPT 99408 ≥30 min: CPT 99409
Medicare:	5-14 min: G2011 ≥15 min: G0396 ≥30 min: G0396

SBIRT sbirtoregon.org

SBIRT

- Promotes open ended questioning, and patient-driven change
- Aids to help clinicians to avoid imparting “medical advice” and implicit bias
- OARS:
  - Open-ended questions
  - Affirmations
  - Reflective listening
  - Summaries

Referral to Treatment

- OHA has compiled directory based on county for clinicians to make appropriate referrals for substance use disorders

- **https://www.oregon.gov/oha/HSD/AMH/publications/provider-directory.pdf**

Role of Integrated Behavioral Health

- Support screening, intervention and referral (SBIRT)
- If nothing else can be done, introduce patient to clinic based Behavioral Health Consultant
- Clarify goals/Treatment planning
- Build motivation for change (however: essential for all roles in patient care team)
- Promote harm-reduction principles
- Counseling/Psychotherapy
- Refer out/Build relationship with community partners

Social Determinants of Health

Important to assess SDH to identify potential barriers to successful outcomes:

- Transportation
- Housing/ Utilities
- Access Healthcare
- Food insecurity
- Social Supports
- Childcare
- Literacy/Health Literacy
- Intimate Partner Violence

Trauma-Informed Care Approach

- Asking permission before exploring/assessing for AUD in more detail
- Explaining what is to be expected and why it is important to their care (transparency)
- Approach all patients as if they have a trauma history
  - Understand the role of ACES in the development of substance use disorders
- Summarize what you hear from patient and validate feelings of fear and uncertainty (creating safety)
- Collaborate on treatment planning

Trauma-Informed Care Approach

Examples of what to say:

Open with –
"I would like to spend some time today discussing the results of this questionnaire, is that okay?"

Follow up with–
"We know that alcohol use has several impacts on our mind and body that is important to discuss"
and/or

"Based on what we have discussed about your recent alcohol use there are some concerns (recommendations, ideas, ways I can help, etc.) I have" *and/or*

"I see you are worried about how this is impacting your life, this is why it is important that we explore together what is happening and different treatment options"

Trauma-Informed Care Approach

Outdated language	Person-first, affirming language
Injection Drug Users (IDU)	People who inject drugs (PWID)
Drug abuse, dependence, drug habit	Substance use disorder
Drug abuser, addict, alcoholic	Person with a substance use disorder
Clean and sober	Person in recovery
Dirty or clean needles	Used or new needles
Dirty or clean urine	Positive or negative urine drug screen
Medication-Assisted Treatment (MAT)	Medication Treatment
High risk	Individuals at risk of acquiring HIV, Hep C, etc.

SbirtOregon.org, Office of National Drug Control Policy, 2017.

The Pre-Contemplative Patient

Drink in safe places

- Avoid being overheated during the summer, or stay warm during the winter
- Drink with people you trust in case of emergencies

Track your drinks

- Hold on to the can pull-tabs
- Mark your bottles or pour out specific amounts

Cutting back

- See how much you're drinking on average, and can consider making a goal to drink less per day
- Before stopping, talk with healthcare provider about withdrawal

Eastside Illicit Drinkers Group for Education (EIDGE) Vancouver

The Pre-Contemplative Patient

Focus on harm reduction and safer use strategies

Be prepared before you drink

- Take your meds, eat something, have a glass of water before your first drink of the day
- Let your friends and family know where you'll be drinking

Eastside Illicit Drinkers Group for Education (EIDGE) Vancouver

The Pre-Contemplative Patient

Mixing and diluting your drinks

- Pre-mix with juice or soda to dilute the EtOH

Hydrate well before and after each drink

Know your limits

- Count your bottles or cans
- Stick to the alcohol type that you tolerate the best

Eastside Illicit Drinkers Group for Education (EIDGE) Vancouver

Check Your Biases

- Is your approach to care being influenced by someone's gender, race, age, or spirituality?
- How is alcohol viewed differently in different cultures?

What About Non-English Speakers?

AUDIT created by WHO, and validated in other cultures and languages

- Original sample included subjects from Australia, Bulgaria, Kenya, Mexico, Norway, and the United States

- **https://auditscreen.org/translations/**

What About Non-English Speakers?

ASSIST

- Developed by the World Health Organization (WHO) as a culturally neutral tool for use in primary and general medical care settings

CAGE

- Shorter, and easier to translate into other languages
- Two affirmative responses are 77% sensitive and 79% specific for more severe alcohol use disorder, but drops to 53% and 70% sens/spec for unhealthy alcohol use

Return to the Case

- Patient recognized some of his medical issues were related to his drinking habit
- Did not want to stop drinking completely
- Agreed to maybe reducing intake to 3 beers per night
- Other harm-reductive approaches?

ANTECEDENT

pArtNerships To Enhance alCohol scrEening, treatment, anD intErveNTion

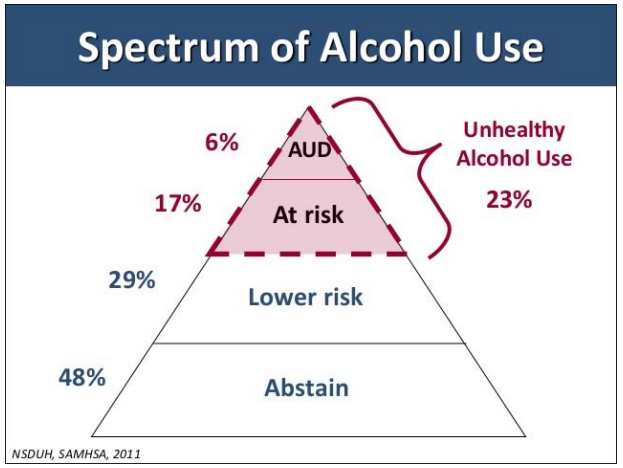
- **Why:** Oregon ranks 8th nationally in per capita costs of alcohol misuse. Study addresses unhealthy alcohol use by supporting primary care clinics in their SBIRT utilization and EHR reporting.
- **Who is eligible:** All family medicine and internal medicine clinics in Oregon
- **What:** The ANTECEDENT team will support 150 primary care clinics for 15 months with data reporting and clinical workflows and integrating SBIRT into routine care.
- ***Highlight:*** *Aligned with CCO incentive metric for SBIRT*
- **When:** Recruiting now through February 2021
- **To get involved:** Please contact: **ANTECEDENT@ohsu.edu** or 503-494-4365
- **Partners:** ORPRN, SBIRT Oregon, OHA Transformation Center
- **Principal Investigators:** Melinda Davis, PhD and John Muench, MD, MPH

What is ANTECEDENT?

ANTECEDENT is aligned with the CCO SBIRT metric and addresses unhealthy alcohol use in primary care clinics.

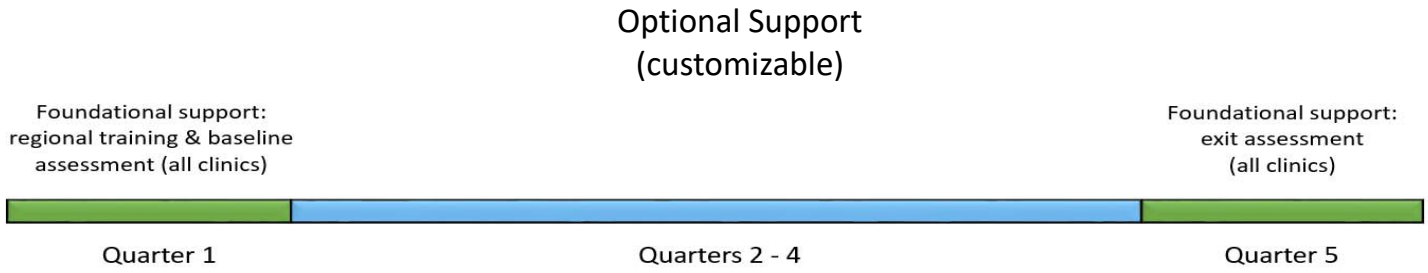
Features

- Free for all clinics
- Customizable participation
- Flexible start dates
- Promotes patient-centered care



pArtNerships To Enhance alCohol scrEening, treatment, anD intErveNTion

What to Expect from ANTECEDENT



Foundational Support:

- Baseline assessment (to tailor/select optional support offerings)
  - HIT query
  - Workflow assessments
  - Baseline clinic data
- Exit assessments

Supplemental Support (Optional)

- Monthly practice facilitation (QI coaching) for up to 12 months
- Access to Oregon ECHO Network substance misuse tele-mentoring program
- Academic detailing (e.g. expert consultation/training)
- Access to HIT support for EHR functionality and metric reporting
- Access to motivational interviewing training

References

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- USPSTF. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions
- SAMHSA, Medication for the Treatment of Alcohol Use Disorder: A Brief Guide. https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4907.pdf
- SBIRT Oregon. http://www.sbirtoregon.org/

How Your CCO Can Support the Work

Stacie Andoniadis – Program Manager,
Medication for Addictions – CareOregon

careoregon.org
twitter.com/careoregon

CareOregon

Objectives

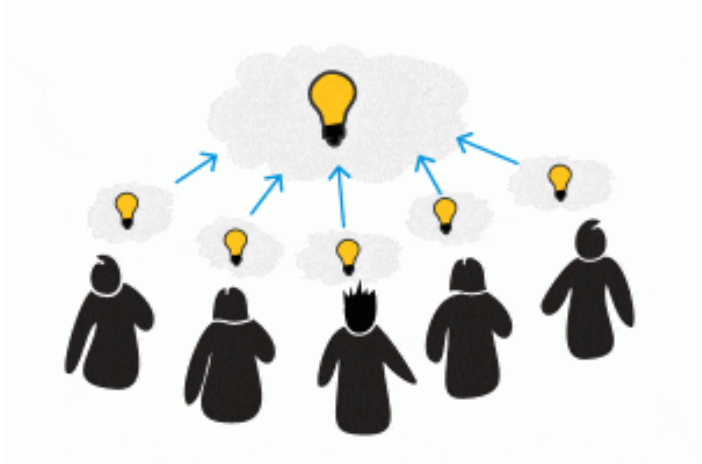
- Review how CareOregon supports a continuum of evidence based SUD services
- Understand options for implementing the ideas you've heard today to best support patients with AUD
- Review the opportunity population health data provides for better patient care

Working Together To Address AUD and Substance Use Disorders

- Learning Collaboratives and learning opportunities
- Partnering with the community to improve the capacity of services to match the need
- Strengthen partnerships and referral pathways between care settings.
- 1:1 targeted technical assistance
- Population health data – data for action
- Care Coordination – Regional Care Teams

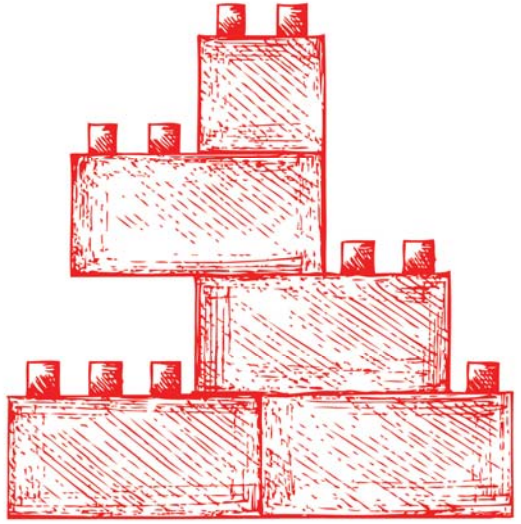
Shared Vision and Goals

- Build capacity to treat AUD within physical and behavioral health settings
- Support providers and programs through:
    - Training and education
    - Consultation
    - Patient pathways
- Articulate a regional network of SUD and AUD access points and recovery supports
- Attention to transitions of care across provider continuum, and process improvement to increase retention in services
    - Regional Care Teams
    - County care teams



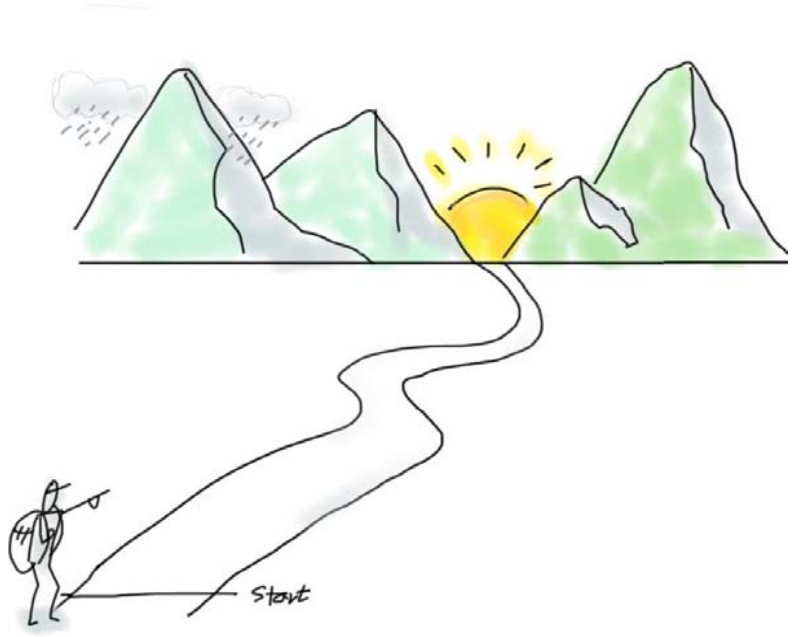
Understanding the Community Need

- Building the foundation – Evaluate and listen, what is happening in our region and why?
- Resourcing our community – Upskilling providers, offering learning opportunities and 1:1 TA
- Environmental assessment – Population data, change driven by analytics
- Connecting the dots – Developing and supporting a continuum of care.
- Ensuring access and availability of culturally competent services
- Understand the impacts of SDoH, particularly housing, on AUD and SUD



Organized Expansion of Services

- In collaboration with public health and providers: **develop and convene regional Learning Collaborative series around SUD expansion across care settings**
- Develop and support **focused relationships** between Primary Care and Specialty Behavioral Health providers who offer SUD treatment, to support **patient-sharing, care coordination, and transitions of care**
- Offer other **community education events** that are responsive to provider, patient, and organization needs



Population Health Data and Electronic Tools

Data-driven decision:

- Using data for action
- Identification of underutilized medications
- Analysis of diagnose and follow-up care to identify and address potential gaps in care and opportunities for improvement

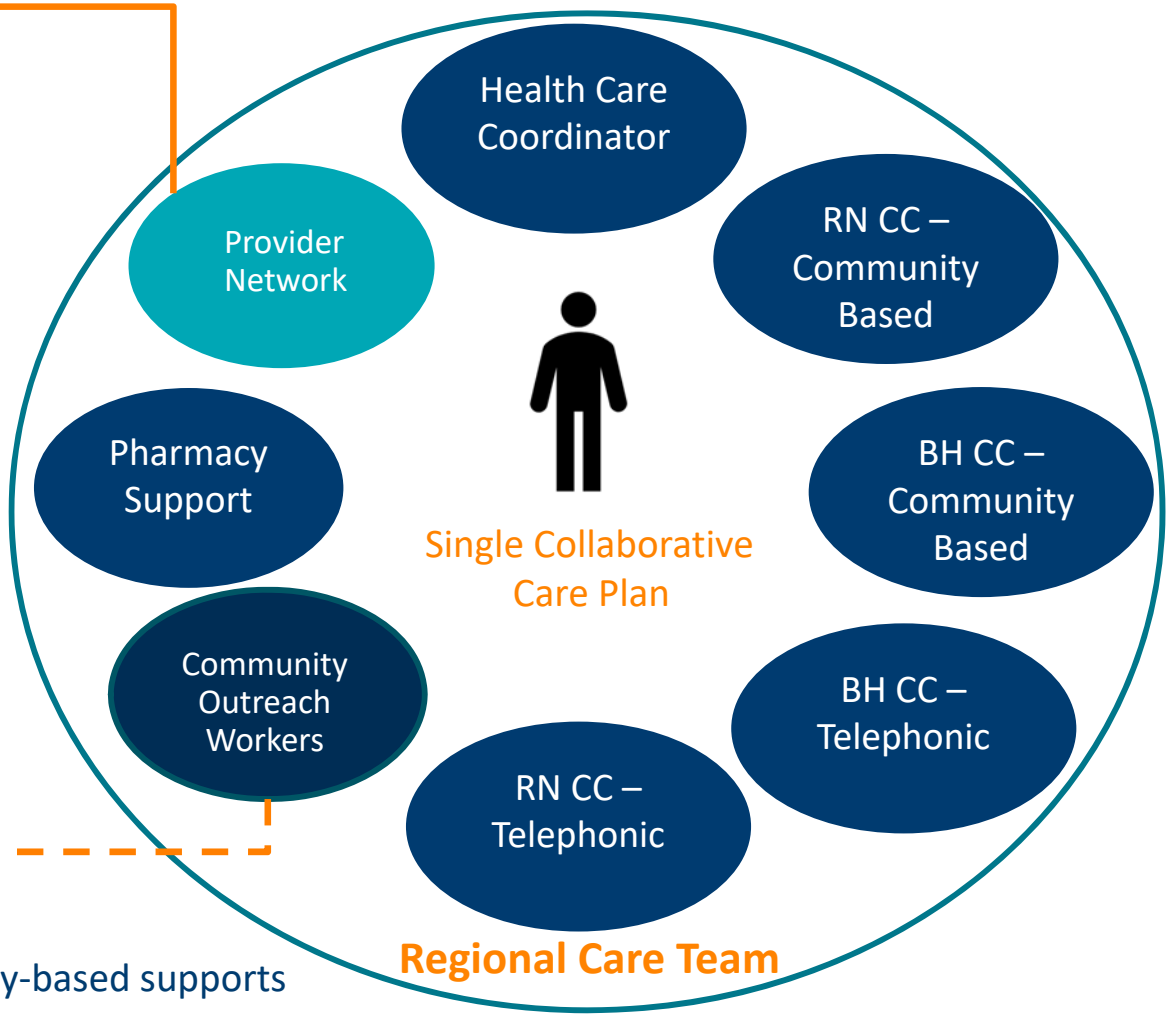
- Collective Medical – Providing technical assistance to support the adoption of Collective Medical.
  - Provides clinics with tools to see in-the-moment ED, inpatient care and discharge.
  - Creation of cohorts/group to track patient care
  - Notification to PCP
- Electronic Health Record – Technical assistance to support the adoption of effective tools for evaluation, diagnosis and referral
  - SBIRT – Imbedding process for warm handoff and referral into EHR

CareOregon offers technical assistance and implementation support for SBIRT and optimization of the Collective platform.

- **Tools to implement change**: How to diagnose, clinic culture, policies, workflow, reduce bias and become trauma informed
- Deepen your understanding of **team-based care** and role optimization and how both support AUD
- Ability to **use data and electronic tools to drive improvements**
- Structure to **screen, diagnose, and refer** through team-based culture and practice

Primary Care, Specialty, & Community Mental Health:

- ✓ Case managers
- ✓ Clinic Care coordinators
- ✓ Social workers
- ✓ Nursing/MA team
- ✓ Transitions care coordinator
- ✓ Peer mentors
- ✓ Clinic manager
- ✓ Engagement specialist



Regional Care Teams are Patient-focused multidisciplinary teams, dedicated to working with clinical partners to **coordinate services and resources** for patients and providers.

*Care Oregon community-based supports

Next Steps:

- Assess the need for upskilling –
  - Do clinician and clinician teams need support diagnosing, understanding medication and treatment options, “grey area”
- SBIRT – Review clinic workflow for SBIRT
  - Maximize use of BHC, team based care
- Understanding your population and clinic resources-
  - Who needs outreach, when and why?
  - Outreach to your CCO for analytic support
- Continuum of Care-
  - Engage with you community behavioral health network,
  - Understand referral options for medically managed withdrawal, treatment, and other chronic conditions
  - Document who to contact for care coordination or technical assistance

Thank You!

Panel Questions & Answers

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Thank You!
Join Our Upcoming Session:

Maternal Health: Challenges in Primary Care

Date TBD

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