Alcohol and Health

Module 2: Alcohol Use Disorder

Engaging and managing patients with alcohol use disorder (AUD) using shared decision-making

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SOLUTIONS TO ADVANCE HEALTH

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What are the Objectives Today?

Module 2: Alcohol Use Disorders

Engaging and managing patients with alcohol use disorders (AUD)

- Learn to comfortably diagnose and engage patients with AUD
- Learn to offer medical advice and shared decision-making about AUD
- Learn to offer AUD medications in an effective manner
- Learn about other effective options for AUD

DIAGNOSING AND ENGAGING PATIENTS WITH ALCOHOL USE DISORDER IN PRIMARY CARE

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

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 to Practically Assess AUD?

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

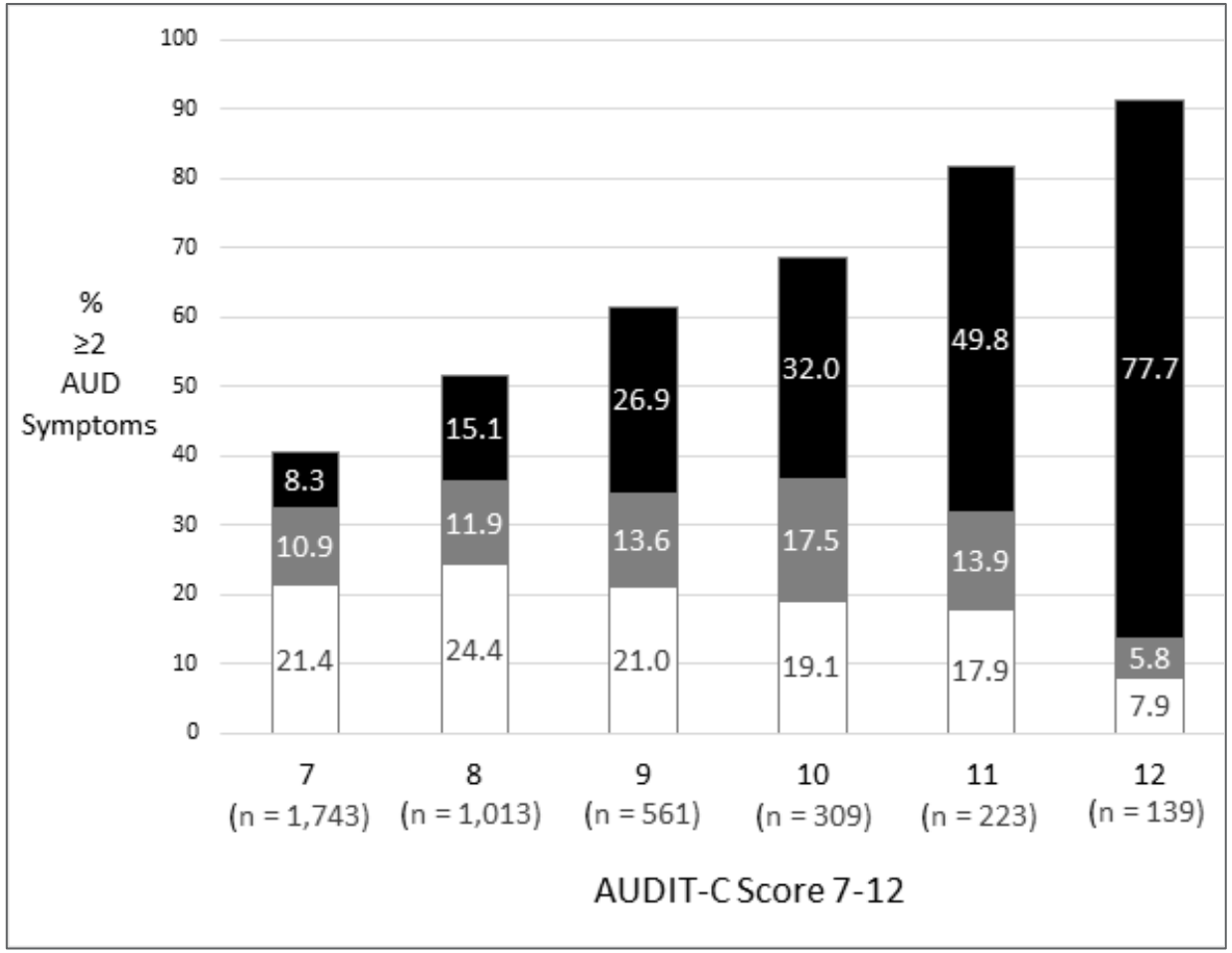
Provider assesses if
symptoms recurrent

- 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

Probability of AUD Symptoms Based on Audit C Score



WHITE: Mild (2-3 AUD symptoms)

GREY: Moderate (4-5 AUD symptoms)

BLACK: Severe (≥ 6 AUD symptoms)

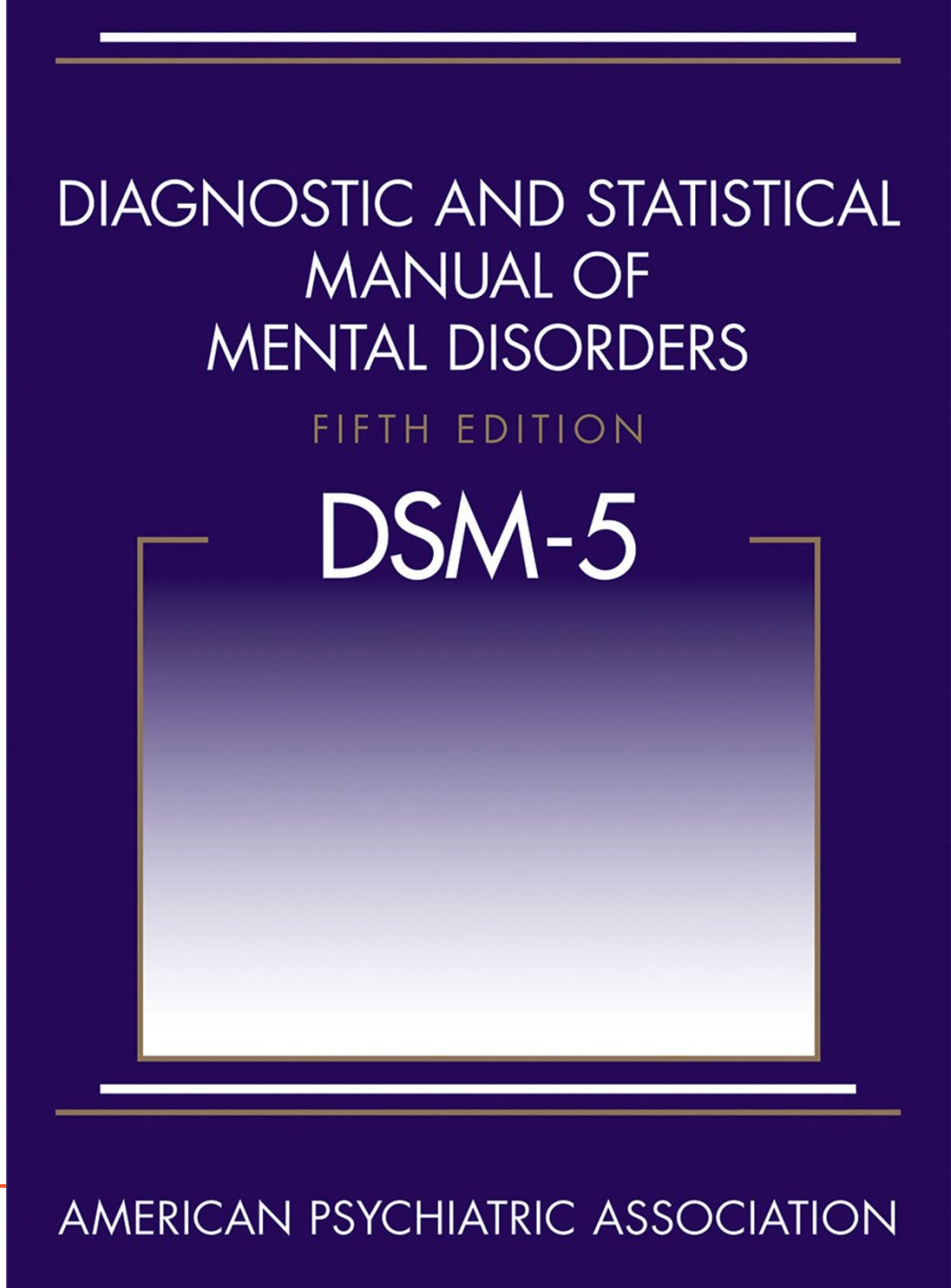
Sayre JGIM 2020

Diagnosing AUD

Use the Alcohol Symptoms Checklist to:

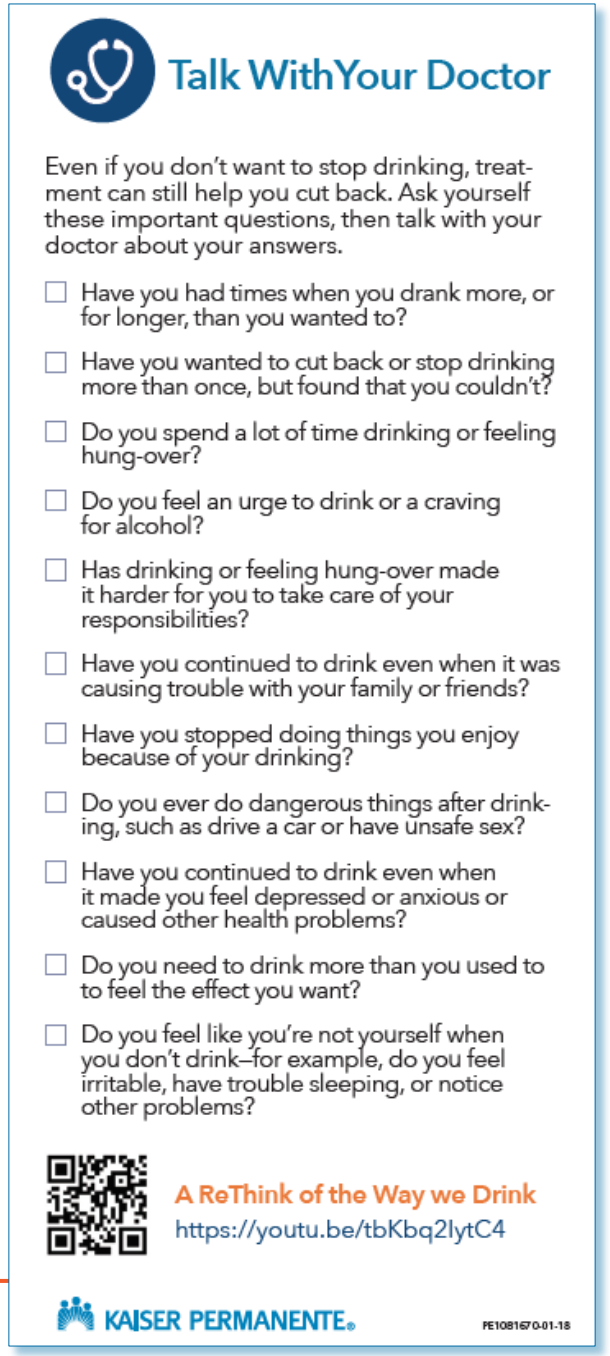
- Engage: “You indicated [insert symptom from checklist] can you tell me about that?”
- Assess whether symptoms are recurrent: “How often does that occur?”
  - 2-3 symptoms → Mild AUD
  - 4-5 symptoms → Moderate AUD
  - ≥ 6 symptoms → Severe AUD

Dawson ACER 2012



Using the Alcohol Handout During Engagement

- Handout also has AUD symptoms
- Helpful for patients with an AUDIT-C score ≥7 and reporting no symptoms on Alcohol Symptom Checklist
  - Brief preventive alcohol counseling



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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PE108167-0-01-18

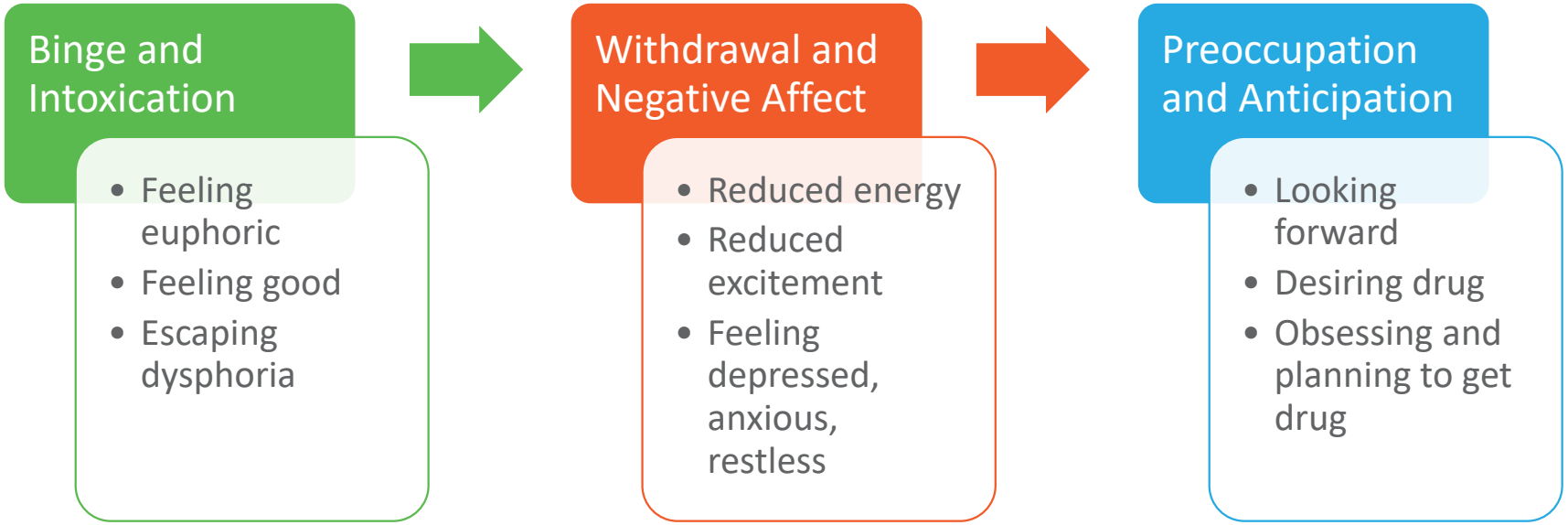
Making a New AUD Diagnosis

- 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 AUDs due to stigma
  - Pause, listen, reflect; allow patient to express emotions, thoughts, concerns
- Ask the patient what that means to them
  - Pause, listen, reflect

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

Stages of Addiction/Shifting Drivers



Volkow 2006

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

AUD and Shared Decision-making

- 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

Barry NEJM 2012
Bradley & Kivlahan JAMA 2014

AUD Treatment: Primary Care Provider Roles

- 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

MEDICAL ADVICE AND INFORMATION TO SUPPORT SHARED DECISION-MAKING FOR AUD

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

- Support patients in deciding the best option for them
- Many patients recover from AUDs 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…

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

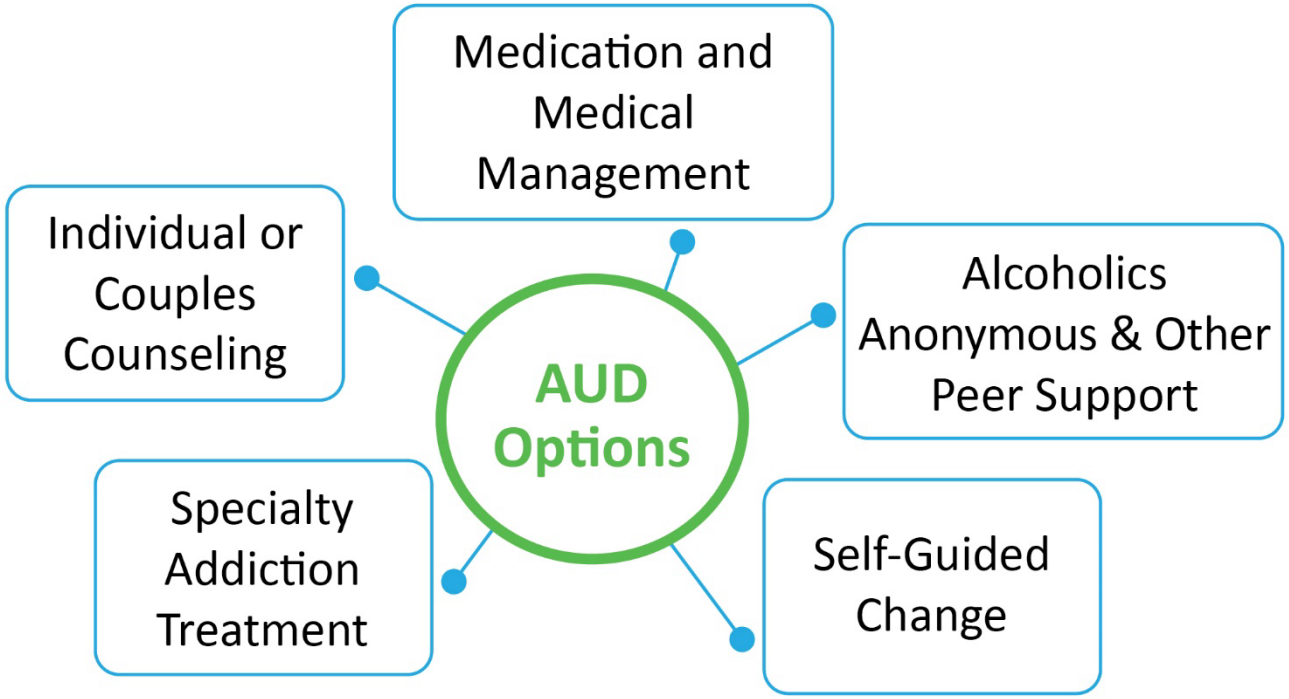
For U.S. adults who have resolved an AUD, the probability of having a sustained recovery 3 years later is:

- 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 including online options
  4. Group-based specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking

5 Options for Patients with AUD



OPTION 1:

MEDICATIONS THAT ADDRESS BRAIN CHANGES OF AUD

Option 1: Medications

- 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 including online options
  4. Group-based specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking

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”

Jonas JAMA 2014; Saitz JAMA 2014
Anton JAMA 2006; Oslin JGIM 2014

Medical Management as the Behavioral Support

Components of proven “medical management” for AUDs

- ***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 other peer support)
- Monitor the urge to drink, consider increasing dose (e.g., naltrexone)
- Assess and manage mental health and other substance use disorders

Jonas JAMA 2014; Saitz JAMA 2014
Anton JAMA 2006; Oslin JGIM 2014

Evidence-based Medications for AUDs

- 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 (Antabuse) works by making people sick if they drink alcohol: generally, prescribe only if patient requests (FDA approved)

Jonas JAMA 2014; Saitz JAMA 2014
Kranzler Addiction 2019

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 Medication

	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

Option 2: 1:1 Couples Counseling

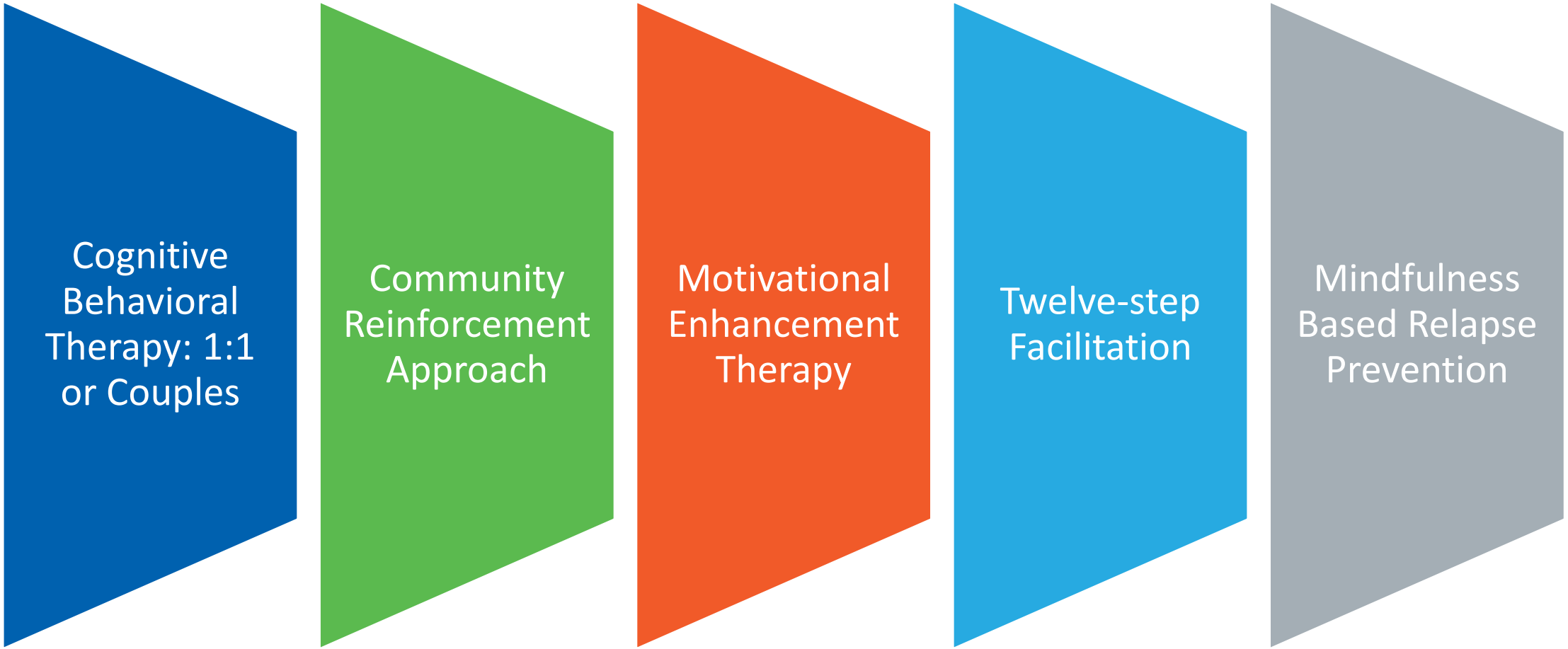
- 5 options for recovery from AUD…
  1. Medications that address brain changes of AUD
  2. 1:1 or couples counseling
  3. Peer support including online options
  4. Group-based specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking

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

Evidence-based Behavioral Treatments (EBT) for AUD



OPTION 3:

PEER SUPPORT INCLUDING ONLINE OPTIONS

Option 3: Peer Support

- 5 options for recovery from AUD…
  1. Medications that address brain changes of AUD
  2. 1:1 or couples counseling
  3. Peer support including online options
  4. Group-based specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking

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:

GROUP-BASED SPECIALTY ADDICTION TREATMENT

Option 4: Group-based specialty treatment

- 5 options for recovery from AUD…
  1. Medications that address brain changes of AUD
  2. 1:1 or couples counseling
  3. Peer support including online options
  4. Group-based specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking

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

Option 5: Self Guided Change

- 5 options for recovery from AUD…
  1. Medications that address brain changes of AUD
  2. 1:1 or couples counseling
  3. Peer support including online options
  4. Group-based specialty addiction treatment
  5. Self-guided change: as above with Rethinking Drinking

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 SHARED DECISION-MAKING AUD

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

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

Finding Local Resources for AUDs

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 (e.g., Librium): 200mg QD decrease by 25 mg QD
    - Liver disease: consider oxazepam 120mg decreasing by 10mg per day

Kathy tell Amy ref here

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

WHAT ARE THE CME AND MOC DATA REQUIREMENTS?

Project Measurements: Measure 1 (Module 1)

Aligns with QPP measure #431

Screening and brief counseling for unhealthy alcohol use.

A. Patient Count: # of unique adults (age 18+) seen at in person or telehealth appointment.

B. Screening: # (from A) who had an AUDIT- C score documented.

C. Positive: # (from B) who had an AUDIT-C score, ≥ 3W, ≥4 M.

D. Counseled: # (from C) who had brief counseling documented.

For CME/MOC credit we are applying a target of screening at least 50% of eligible patients and counseling at least 10% of those with a positive AUDIT-C score.

Project Measurements: Measure 2 (Module 2)

Aligns with QPP measure #305

Treatment of AUD:

A. New AUD diagnoses: # of unique adults (age 18+) with a new diagnosis of AUD out of all patients seen (during the measurement period)

B. AUD Follow-up: # (from A) who had follow-up for AUD within 2 weeks of new diagnosis

- Modality: AUD addressed by phone, video, or in-person visits; prescribed AUD treatment medication; referral to treatment
- Location: Primary care, specialty addiction treatment, mental health

For CME/MOC credit we are applying a target of achieving follow-up within 2 weeks for at least 50% of eligible patients

Meaningful Participation: Timeline

- **Month 1:** Trainings 1 & 2, office changes, obtain baseline data and begin implementation.
- **Month 2 & 3:** Continue implementation.
- **Month 4:** Submit midway data, review with practice facilitator and – make workflow adjustments as indicated
- **Month 5:** Continue to improve on implementation
- **Month 6:** Continue to improve on implementation
- **Month 7+:** Submit and review final data, reflect and make plans for future improvements and sustainability.
- **Attestation!** (Only necessary for those eligible for CME and/or MOC credit)

Facilitated Data Collection Process

1. Determine how documentation and quality data will be tracked within your EHR

2. Determine how the CME and MOC Part IV data will be pulled and discussed

3. Determine who will participate in the touch bases with your practice facilitator.

Next Steps

- Turn in your post survey!
- Support the Office Champion and build staff engagement.
- Become familiar with DSM-5 symptoms/Alcohol Symptom Checklist; making AUD diagnoses, offering shared decision-making, and the 5 effective options for AUD
- Create process for Alcohol Symptom Checklist utilization and documentation; AUD diagnosis and follow-up documentation.
- Begin collecting CME/MOC Part IV baseline data.

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THANK YOU!

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