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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Expanding Screening, Improving Treatment Acceptance, and Optimizing Outcomes for Patients with Moderate to Severe Alcohol Use Disorder (AUD)

Announer:
Welcome to CME on ReachMD. This activity, titled “Expanding Screening, Improving Treatment Acceptance, and Optimizing Outcomes for Patients with Moderate to Severe Alcohol Use Disorder (AUD)” is provided by Prova Education.

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Dr. Levesque
This is CME on ReachMD, and I'm Dr. Annie Levesque. Today, I'm here with Dr. Ethan Cowan, and we will be discussing our clinical approach to identifying and managing patients at risk for or diagnosed with alcohol use disorder, or AUD. Welcome, Dr. Cowan.

Dr. Cowan:
Thank you, Dr. Levesque. I’m glad to be here.

Dr. Levesque:
There are high rates of at-risk alcohol use and of alcohol use disorder in all medical settings, whether in primary care, in hospitalized patients, or in emergency departments. Often it may not be the presenting complaint, but it may be contributing to the medical problems that the person is experiencing. So, I think it is useful to screen everyone and to use brief intervention when appropriate, so that we really identify and intervene effectively with those who are at risk of having some health or psychosocial complications from their alcohol use.

I would like to start the conversation with a case. So, it is a 67-year-old man who presented to the emergency department for wrist pain after he fell in his apartment. The x-ray of the wrist shows a distal radius fracture, and the patient reported that he lost balance and tripped while he was going to the bathroom.

Dr. Cowan, how would you approach this patient in terms of screening?

Dr. Cowan:
So, I think this is a good example of the importance of screening. And how we would go about doing this is typically using an SBIRT mechanism, which is screening, brief intervention, and then referral to treatment. In terms of the screening process, there's a number of simple screeners that are available. These could include the NIAAA single-item screener, which asks the patient how many times in the past year have you had 5 or more drinks for a man or 4 or more drinks for a woman in a single day? And that test is scored positive when the response is anything greater than 0. Other than the NIAAA screener, there's a number of other screeners like the AUDIT 10-Question, the AUDIT-C, the DAST-10, the CRAFFT 2.1, and a number of others.

Each of these screeners has their own scoring criteria. For example, if we look at the AUDIT 10-Question screener questions 1 through 8 are scored one way, questions 9 and 10 are scored another way. But at the end, you wind up adding the scores and it tells you sort of

the degree of harmful alcohol use. So, 0 to 7 is somebody who is a low risk, 8 to 14 is somebody who has hazardous or harmful risk, and then greater than 15 points is somebody who probably has alcohol dependence. So, that's sort of where we would start just in terms of the screening questions. And then we would – once we have the answers to the screening questions, we would move on to discussing that with the patient.

And maybe Dr. Levesque, you could talk a little bit about how you would share those types of findings from the screening questions.

Dr. Levesque:
Thank you for this overview of the screening tools. Yes, so if we have an initial screening that is positive I think it warrants usually a more in-depth evaluation. So, there are different ways to go about it. But if we suspect an alcohol use disorder, one way to do it would be to really just go through the list of criteria from the DSM-5 and determine if the patient has an alcohol use disorder.

I'd like to add that in this case, the patient is 67 years old so because of his age, he's at higher risk of complication from alcohol use than a younger patient would be. And there are some tools that are designed specifically for older adults, like the Michigan Alcoholism Screen Test-Geriatric Version. So we could use also this test specifically for older adults.

So as you mentioned, the next step is to communicate the results to the patient and move toward brief intervention if we feel that it's appropriate.

Dr. Cowan, what are some of the key points that we should remember from this case, in your opinion?

Dr. Cowan:
Yeah, I think it's important to remember there's not one single screener that's going to fit all situations. So, the screener that you may use in a primary care setting may be different than the screener that you use in emergency department. And like you said, the screeners may be different depending on the population, whether they're geriatric or pediatric. So, I think it's important to tailor the screening program to your specific setting.

Dr. Levesque:
I agree with you. And I would add that, you know, as you said, there are many validated screening tools. And my suggestion is that everyone finds one that they're comfortable with and that they can memorize it and integrate it in their routine questionnaire with patients.

Dr. Cowan:
That's great. Thank you, Dr. Levesque.

Let's move on to Case 2. We'll be talking about brief interventional strategies. So, for patients who have screened in at being at increased risk of alcohol use, or a possible DSM-5 diagnosis of alcohol use disorder, brief interventions can be extremely important and have been shown to help reduce alcohol use. Let's use an example to help illustrate this point. We have Carlos, who is a 54-year-old male who comes to your office complaining of insomnia. On his AUDIT-C, he scores an 8, indicating alcohol misuse.
Dr. Levesque, maybe you could walk us through a stepwise approach about how you might do a brief intervention with this patient.

Dr. Levesque:
Thank you for sharing this case. Yeah, so with this patient, I think the next step would be to share the results of the screening and provide some counseling if the person is receptive. So I would first ask the permission to share some information about safer consumption patterns. And if Carlos is open to it, I would like to review with him what is considered at-risk drinking. The NIAAA considers that it's unhealthy to have more than 14 drinks per week, or more than 4 per occasion for men. And that it is unhealthy to have more than 7 drinks per week, or more than 3 per occasion for women or for adults older than 65.

After sharing the information with the patient, I would like to assess his willingness to change. So, if he doesn't want to change his alcohol use at this time, I would just reinforce that I'm available to help if he changes his mind in the future. And I would also offer to schedule a follow-up visit to continue the conversation. Maybe by then he will have time to think about it a little more, and he may be interested in making some change on a next visit.

If the person is interested in making changes, then I'd like to work together with him to set some personalized goals and to come up with strategies for change, making sure that the goals are reachable. For some people, it makes sense to aim for full abstinence, but for others it may not be realistic and a reduction in alcohol use may be the best goal, or aiming for safer drinking patterns may be a more realistic goal. And then finally, I would plan a follow-up visit with me. Or I would provide an appropriate referral either with a counselor, with an outpatient group program, or with a physician who specializes in the treatment of alcohol use disorder, depending on the specific needs of the patient.

Dr. Cowan, is there anything you would like to add about this case?

Dr. Cowan:
Yeah, I think those are all excellent points. It's very important that we understand what the patient's goals are so that we can tailor our interventions to those goals. I think patients that have more limited motivation probably will need some motivational enhancement techniques. But those who are motivated to change, we can probably begin to talk about treatment options.

And I think it's also important to realize that, you know, a single brief intervention is not going to change things right away. Most patients are going to need to take their own time to develop their own goals and plan to either cut down or stop their drinking.

Dr. Levesque:
Yeah, I agree with you. It is a long-term process and we need to be patient.

I would add one last point. So, I think one important thing to remember with brief interventions is that it is best to use a non-judgmental, non-confrontational style and try to integrate the elements of motivational interviewing. So that means asking open-ended questions and remembering that the patient should set their own goals, not the physician; we're here only to assist them in reaching their goals.

Dr. Cowan:
Yeah, I couldn't agree more. Since you're talking about motivational interviewing, let's move on to the third case, which is an introduction to the motivational interviewing topic.

Dr. Levesque:
So motivational interviewing is a type of counseling that's used to help resolve ambivalence and also to enhance motivation to change a certain set of behaviors. It's patient centered and the goal is to help the person determine why they may want to change and also how to go about it. So, it's helpful to help this patient change all sorts of behaviors that may affect their health. And research shows that it is particularly helpful for reducing alcohol and other substance use.

I would like to start a conversation with a case. So, it is a 23-year-old woman who sees her primary care provider for a health maintenance visit. The primary care provider uses the AUDIT-C as a screening tool, and the patient's score is 8, suggesting unhealthy alcohol use. She reports multiple episodes of binge drinking with her friends and a few blackouts in the last few months.

Dr. Cowan, I'm curious to hear how you would use motivational interviewing strategies with this patient?

Dr. Cowan:
Yeah, I think it's important to begin with some assumptions that are associated with motivational interviewing. The first assumption is that it's normal for patients to have ambivalence about their own alcohol use. And this tends to be an obstacle to recovery. Patients can also have natural motivations that can help overcome this ambivalence. And the relationship between the patient and the physician is really a collaborative partnership. So, this is a process that you work through together. And what's very important when you're doing motivational interviewing is to have an empathetic, supportive, and directive non-judgmental approach. And this can help lead to change.

In terms of the steps of the motivational interviewing, it tends to fall along five relatively simple steps. The first step is engagement, where you establish rapport if you haven't already done this. The second step is focus and feedback, where you try to have the patient make a connection between their behavior and the consequences of that behavior. So, this is where you would ask them about their alcohol use and what they think the consequences of that alcohol use might be. The third step is to elicit patient motivation, and this can be done through a number of techniques. One of the techniques that we use is by using Readiness Rulers which asks the question on a scale of 1 to 10, how ready they are to change. But you can also ask them specific questions like: What do you think about your drinking? Or what makes you think that you have a problem? Or what worries do you have about your alcohol use? The fourth step is developing practical steps for the patient to follow to implement change. So, this is where we're actually beginning to discuss the plan. And the plan needs to be tailored for what the patient's motivation is. So, for patients that are motivated for complete abstinence, their plan may be different than for someone who's motivated more just to cut down on their alcohol use. And the last step is to set up a follow-up appointment to continue the conversation, or to hand the patient off to somebody who's going to provide specialized care for their alcohol use.

Dr. Levesque, maybe you can talk a little bit about what might happen at one of those follow-up visits, where we're actually handing the patient off to somebody else to continue the treatment.

Dr. Levesque:
Yes, thank you, Dr. Cowan. That was a great overview of motivational interviewing.

So, at a follow-up visit I would inquire about the progress of the patients toward their goals. I would like to explore what strategy worked and what didn't work. I think it's really important to provide affirmation for the progress that was made. And we can also explore if we need to adjust our goals and strategies. And this, as you mentioned earlier, should all be done in a patient-centered way, where our role is simply to guide the patient and help them set their own goals.

And then before the patient leaves, I would like to schedule a follow-up visit to continue the conversation, because as we said before, changing a behavior takes time, and it may require multiple visits.

Dr. Cowan, is there anything that you would like to add about using motivational interviewing with this patient?

Dr. Cowan:
Yeah, you know, I couldn't agree more. I think one of the things that we need to keep in mind is that there's going to be bumps in the road, and people are going to have a little bit of backsliding. And that, you know, they may be motivated to change, you may have a plan in place, but they may not reach the planned goals that you've set, and that's okay. That's the time when you bring somebody back and you basically have the discussion again, and you repeat the process, and you develop a new plan. And as I said before, this is not something that's going to change overnight. It's something that we have to continue to work with the patient in order to get them to where we think they need to be.

Dr. Levesque:
I completely agree. It is not always a linear path, and it's a long-term effort. Thank you so much.

For those who are just tuning in, you're listening to CME on ReachMD. I'm Dr. Annie Levesque, and here with me today is Dr. Ethan Cowan. Our focus today is to offer strategies to more confidently identify and manage patients at risk for or diagnosed with alcohol use disorder, or AUD.

Let's move on to Case Number 4. I would like to start with the case of a 40-year-old woman, who sees her primary care provider for a follow-up visit. On her last visit 3 months ago, she reported drinking 3 to 4 glasses of wine on most days, and at the time, she met criteria for moderate alcohol use disorder. Her goal on last visit was to limit her alcohol use to 3 days per week with no more than 1 glass of wine each time. But when we see her today, unfortunately, her alcohol use has not changed, and she's still drinking the same amount as before, and it has an impact on her family life, on her work, and on her socialization.

So, from my perspective, the first step would be to make sure that she doesn't require acute management for alcohol withdrawal and make sure that it is safe to continue treating her in an outpatient setting. And once that's established, I think the next step would be to discuss pharmacotherapy as a treatment option for her. So I would start by reviewing with her the different treatment options, and make sure that she has no contraindications to any of the medication and determine together what would be the best fit for her.

So, naltrexone, acamprosate, and disulfiram are the three medications that are FDA approved for the treatment of alcohol use disorder. And there are also a number of other medications that we sometimes use as off-label treatment. So, for example, gabapentin or topiramate. In order to decide which is the most appropriate option for her, the first step, in my opinion, is to determine what her goals are. Because medications like naltrexone or acamprosate can work for both patients who want to completely stop drinking and also for those who want to reduce their alcohol use. On the other hand, medication like disulfiram can only be used with patients who want, or for whom the goal is full abstinence. So, that would be the first thing to determine with her.

Naltrexone is often the first line of treatment. It helps reduce craving for alcohol and it also helps decrease the rewarding and pleasurable effect of alcohol. It's an easy-to-use medication because people only need to take one tablet a day. And there's also an intramuscular long-acting formulation that lasts a full month. So, that's really helpful for people who struggle with taking a medication every day. Because it is an antagonist of the mu receptors, it cannot be prescribed to someone who takes opioids. So, for example, someone who has chronic pain and takes a daily opioid would not be a good candidate, or someone who is treated for opioid use disorder with buprenorphine or methadone could not take naltrexone. Another contraindication is in patients with severe liver disease because there is possible liver toxicity with naltrexone.

So, for someone who would have contraindication to naltrexone, acamprosate is a good treatment option as well. The mechanism of action is less clear. We believe that it works by modulating the glutamate receptors. But because it doesn't target the opioid receptors, it can be used when patients are taking opioids, and it's metabolized by the kidneys, so it's a good option for people with significant liver impairment. The main downside with acamprosate is that patient needs to take 2 tablets 3 times per day. So, it's 6 tablets per day. It's not ideal for people who struggle with medication adherence.

And then finally, I'd like to briefly talk about the last FDA approved medication, so it's disulfiram. It's an inhibitor of the enzyme aldehyde dehydrogenase, so it works really as a deterrent to drinking because if someone was to drink alcohol after taking disulfiram there would

be an accumulation of the toxic metabolite, acetaldehyde, and that would cause unpleasant effects like flushing, sweats, nausea, vomiting, palpitations. There is also a risk of hepatotoxicity with disulfiram, so it's not the best option for people with liver dysfunction. And it's also not recommended for people with myocardial disease or those with a history of psychosis.

So, coming back to our case, given that our patient voiced a goal to reduce her alcohol, not to stop completely, and because she doesn't have any major contraindications I think that naltrexone would be a first choice to begin with. But we could also consider acamprosate as an alternative depending on her preference.

Dr. Cowan, I would be curious to hear your thoughts about this case.

Dr. Cowan:
Yeah, I definitely would agree that we need to tailor our pharmacological interventions to what the patient is ready for. And in my practice, generally we'll start with oral naltrexone but acamprosate, like you said, is a perfectly acceptable option for most patients.

Dr. Levesque:
Thank you. And last thing I would say is that after starting a medication, whether that's naltrexone or acamprosate I would really want to schedule a close follow-up with her to see if the medication is helping and also to adjust if there's side effect and troubleshoot if there is any and adjust the treatment if needed.

Dr. Cowan:
That's a good point, Dr. Levesque.

Let's move on to the next case, where we're going to talk about the approach to alcohol use disorder in the emergency department setting. Now the emergency department is quite a bit of a different setting than other outpatient settings; it focuses predominantly on acute care. But we should remember that it still can be an important place for screening, brief interventions, and referral for treatments for those with alcohol and other substance use disorders. A significant portion of the traumatic injuries and medical complications of chronic disease that we see in the emergency department are actually associated with alcohol misuse and other substances.

To help illustrate this point, let's use a case. We have John, who's a 61-year-old male, who was brought into the emergency department by ambulance after being involved in a slow-speed single-vehicle accident, where his car rammed into a pole. John comes into the emergency department. He's responsive but sleepy on arrival. He has slurred speech, but is able to follow commands, and he does have the smell of alcohol on breath. The most important thing when we're approaching a patient like this in the emergency department is to first rule out life-threatening injuries and address any urgent needs like breathing problems or bleeding that the patient might be having either secondary to the accident or secondary to the alcohol use. We know that very heavy alcohol use in patients can reduce their breathing and actually cause them to stop breathing. It can cause a number of other problems like vomiting, dehydration. For patients who are alcohol dependent, sometimes when they stop drinking, they'll have seizures. But the main things for us in the emergency department are to make sure that we are protecting the patient's airway, that their breathing is okay, and that if they're involved in some sort of traumatic injury, that there's no active bleeding going on, whether that's intraabdominal bleeding or bleeding into the brain.

Now, once the patient has been ruled out for injury, like in this case, John went through a thorough emergency department evaluation and no acute traumatic injuries were found and he was held overnight in observation to see how he was in the morning. So the patient now is awake and alert, and with regard to discussing the patient's alcohol use, you can use some of the same techniques that we already discussed. We can try and get John to understand or at least come to some conclusions about how their alcohol use may have contributed to them winding up in the emergency department. We can assess their motivations for behavior change, and then refer them to appropriate services. Now, some emergency departments have social workers who might do this. Others might have trauma services that help in coordinating this type of follow-up care. But at many emergency departments, these interventions will likely fall on the clinician.

For patients who are highly motivated, the clinician can begin to discuss pharmacologic options for alcohol use disorder in the emergency department. Although I will say that it is quite rare for us to actually begin these in the emergency department, but we might begin the discussion of these types of pharmacological interventions and then hand the patient off to somebody who will follow up with that conversation and potentially start them on pharmacologic treatment.

When possible, it's best to arrange for a warm handoff between the emergency department and the follow-up clinic so that the clinic is aware that the patient will be coming and can reach out to them. This warm handoff is very important to make sure that there's both continuity of care and that the patient doesn't get lost in the process.

In terms of discharge, after we've made sure that the patient is safe and has no significant injuries, we want to make sure that they have

the appropriate follow-up appointment and in the discharge instructions, we should also include general resources for the patient on the alcohol use disorder resources that are available in the local community.

Dr. Levesque, do you have anything else you'd like to add to this case?

Dr. Levesque:
I completely agree with everything you said. I think emergency department providers are in a very unique position as healthcare providers because they may be the first person to actually discuss alcohol use and offer treatment to a patient, so their role is actually critical. And I completely agree with you about the importance of warm handoff. So, I think it's so important for a provider in the emergency department to be familiar with the resources in their area and be able to assure a proper continuation of care and a proper referral. So thank you very much for sharing those points.

Dr. Cowan:
Great. Thank you, Dr. Levesque. And let's go on just to wrap up some of the cases that we've talked about today. I think for me, some of the final takeaway points are that, you know, we have many different techniques that have been shown to be effective at helping people reduce their alcohol use or abstain from alcohol. These include things like SBIRT, like screening, brief intervention, and referral for treatment. They include things like motivational interviewing. And then for patients who are motivated and willing to initiate treatment, we can consider pharmacological treatment, which is generally underused in this patient population. But it is something that I think that it's worth to discuss with patients, and for those who are interested, to initiate with patients.

Dr. Levesque, do you have anything you'd like to say about any takeaways from today?

Dr. Levesque:
Yeah, I think some of the takeaways for me is that, while drinking and alcohol use disorders are very common, but they're not always the presenting problem so it is really important to provide universal screening to our patients. And then we should when the screening is positive, it's important for us to provide brief intervention. That includes advising patients on safer practices, assessing the patient readiness to change, assist them in determining their goals and treatment, and finally help them arrange a treatment plan or a referral. As you mentioned, for some patients, providing counseling and behavioral treatment is sufficient, but for others pharmacotherapy may be indicated.

And then some final key elements when discussing alcohol use are to be empathic and non-judgmental with the patients and try to integrate motivational interviewing strategies. Not everyone has the same goals, and there is no one treatment that works for everyone, so we really want to remain patient centered.

That's all the time we have today. So, I want to thank our audience for listening in. And thank you, Dr. Cowan, for joining me and sharing your valuable insights. It was great speaking with you today.

Dr. Cowan:
Thank you, Dr. Levesque.

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