The Alcohol Assessment and Intervention - Adult/Pediatric - Inpatient/Ambulatory Clinical Practice Guideline was approved by the Quality Improvement Committee (QIC) on December 12, 2016. Guidelines were previously approved by Unity Health Plan's Clinical Quality Improvement Committee (CQIC) on September 12, 2014; July 20, 2012; May 16, 2008; and September 16, 2005.

This clinical guideline was developed by UW Health's Center for Clinical Knowledge Management (CCKM), a collaborative effort of expert clinicians and quality improvement staff representing area medical systems and payers. The goal is to help ensure that the clinical guidelines are current, evidence-based and meet the needs of our population.

Coverage of services mentioned in this guideline may differ depending on the individual's particular health plan. Please contact Senior Preferred Customer Service to confirm coverage by calling (800) 394-5566.
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Clinical Knowledge Management (CKM) Council (Last Periodic Review: 11/17/2016)

Release Date: November 2016 | Next Review Date: November 2018
Executive Summary
Guideline Overview
The 2005 NIAAA Physician’s Guide, the 2015 VA/DoD Clinical Practice Guideline, as well as the 2016 American Academy of Pediatrics Clinical Report served as the primary outline to this document.\(^1-3\)

Key Revisions 2016 Periodic Review
1. Recommendations removed for patients known to be pregnant
2. Recommendations added for emergency department and hospital inpatient settings

Key Practice Recommendations
1. Screening should take place at least annually in the primary care setting (UW Health Very low quality evidence, weak/conditional recommendation), with each admission in the Emergency Department (UW Health Low quality evidence, weak/conditional recommendation), and with each admission in the inpatient hospital setting.\(^4,5\) (UW Health Low quality evidence, weak/conditional recommendation)
2. Adolescent patients should be screened for alcohol and drug use using Part A of the CRAFFT screening tool (version 2.0).\(^3,6-8\) (UW Health Low quality evidence, strong recommendation) If the patient responds to any question with a number greater than “0,” all 6 CRAFFT questions should be asked. The CAR question should be asked regardless of patient response to Part A.
3. UW Health recommends using the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) to screen for alcohol misuse in non-pregnant adults.\(^9-12\) (UW Health Low quality evidence, strong recommendation)
4. Adult patients who screen positive for unhealthy alcohol use (AUDIT-C score of 3 to 7 for men over 65 years and all adult women; 4 to 7 for men 18 to 65 years) should receive a brief counseling intervention.\(^13-15\) (UW Health Moderate quality evidence, weak/conditional recommendation)
5. Adult patients who are likely to have an alcohol use disorder (AUDIT-C score of 8 or greater) should receive further assessment and/or a referral to treatment with a specialist in alcohol and drug related issues.\(^5,16\) (UW Health Moderate quality evidence, weak/conditional recommendation)

Companion Documents
1. Adolescent Alcohol Screening and Intervention Algorithm
2. Adult Alcohol Screening and Intervention Algorithm
3. Communication Tips for Asking Patients About Alcohol Use
4. Table 1. NIAAA Recommended Drinking Limits
5. Table 2. Pharmacotherapy Options for Alcohol Dependence

Scope
Disease/Condition(s): Risky alcohol use (hazardous drinking), Alcohol Use Disorder (alcohol abuse and/or dependence)

Clinical Specialty: Ambulatory Nursing, Inpatient Nursing, Internal Medicine, Family Medicine, Addiction Medicine, Emergency Department
**Intended Users:** Registered Nurses, Licensed Practical Nurses, Medical Assistants, Social Workers, Behavioral Health Specialists, Health Education Specialists, Pharmacists, Physicians, Advanced Practice Providers

**Objective(s):** To provide evidence-based recommendations on alcohol use screening, brief intervention, referral to treatment, and pharmacotherapy. This guideline does not include recommendations pertaining to alcohol withdrawal.

**Target Population:** Non-pregnant adolescent (10-17 years) and adult (18 years and older) patients without a current diagnosis of alcohol use disorder. Recommendations regarding pregnant patients are not included in this guideline.

**Interventions and Practices Considered:**
- Screening
- Brief intervention
- Referral to treatment
- Pharmacotherapy

**Major Outcomes Considered:**
- Reduction in risky drinking (consumption greater than daily and weekly limits for age and gender)
- Reduction in alcohol abuse and dependence

**Methodology**

**Methods Used to Collect/Select the Evidence:**
Electronic database searches (e.g., PUBMED) were conducted by the guideline author(s) and workgroup members to collect evidence for review. Expert opinion and clinical experience were also considered during discussions of the evidence.

**Methods Used to Formulate the Recommendations:**
The workgroup members agreed to adopt recommendations developed by external organizations and/or arrived at a consensus through discussion of the literature and expert experience. All recommendations endorsed or developed by the guideline workgroup were reviewed and approved by other stakeholders or committees (as appropriate).

**Methods Used to Assess the Quality of the Evidence/Strength of the Recommendations:**
Recommendations developed by external organizations maintained the evidence grade assigned within the original source document and were adopted for use at UW Health.

Internally developed recommendations, or those adopted from external sources without an assigned evidence grade, were evaluated by the guideline workgroup using an algorithm adapted from the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology (see Figure 1 in Appendix A).

**Rating Scheme for the Strength of the Evidence/Recommendations:**
See Appendix A for the rating scheme(s) used within this document.

**Recognition of Potential Health Care Disparities:**
Studies show variable differences between ethnic and racial groups in the amount of alcohol consumption and associated health burden, including risk for injury and deaths attributable to alcohol. Studies consistently show Native Americans carry the greatest burden with over 20% of deaths attributable to alcohol. Asians appear to carry the lowest burden. In studies which show greater levels of alcohol-related harm in Hispanics and Blacks as compared to Whites, the differences can be often be accounted for by socioeconomic status. Racial and ethnic disparities have been noted in outpatient and residential substance use disorder treatment completion, with Hispanics and Blacks completing treatment less often than Whites. Again, differences are mitigated when level of economic resources are taken into account.

Definitions

<table>
<thead>
<tr>
<th>Table 1. NIAAA Recommended Drinking Limits¹</th>
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<tbody>
<tr>
<td><strong>For healthy men up to age 65</strong></td>
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<tr>
<td>• No more than 4 drinks in a day AND</td>
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<tr>
<td>• No more than 14 drinks in a week</td>
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<tr>
<td><strong>For healthy women, and healthy men over age 65</strong></td>
<td></td>
</tr>
<tr>
<td>• No more than 3 drinks in a day AND</td>
<td></td>
</tr>
<tr>
<td>• No more than 7 drinks in a week</td>
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</tbody>
</table>

- **Standard drink**: A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents. These are approximate, since different brands and types of beverages vary in their alcohol content.

One standard drink = 12 oz. regular beer = 8-9 oz. malt liquor = 5 oz. table wine = 1.5 oz. 80-proof hard liquor.¹

**Figure 2. NIAAA Standard Drink Chart¹**

- **Alcohol Use Disorder**: A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria occurring within a 12-month period.²⁰ (See Appendix E)
• **At Risk Use:** Consuming the equivalent of more than 4 standard drinks in a day or more than 14 in a week, for men and the equivalent of more than 3 standard drinks in a day or more than 7 in a week for women who do not meet criteria for alcohol dependence or abuse. Some literature also uses the term “hazardous drinking” for drinking that runs the risk of causing serious problems.

• **Harmful Drinking (Alcohol Abuse):** Drinking amounts that *cause* serious problems. These problems include motor vehicle crashes, physical health and/or mental health problems, violence, injuries, unsafe sex, and serious issues in areas of life such as work, school, family, social relationships, and finances.

**Introduction**

Excessive alcohol consumption accounted for nearly 1 in 10 deaths and over 1 in 10 years of potential life lost among working-age adults in the United States between 2006-2010. In 2015, it was estimated that 24% of U.S. adolescents aged 12-17 years used alcohol or drugs within the previous year, and 5.0% met criteria for a substance-related disorder. According to the 2015 Dane County Youth Report, 34.8% of high school youth and 8.1% of middle school youth said they drank alcohol in the past 12 months.
Recommendations

Screening for Alcohol Use
Screening of alcohol use status is the first critical step in determining problem drinking. For tips on how to approach alcohol screening with a patient, see Appendix D. Screening should take place at least annually in the primary care setting (UW Health Very low quality evidence, weak/conditional recommendation), with each admission in the Emergency Department (UW Health Low quality evidence, weak/conditional recommendation), and with each admission in the inpatient hospital setting. Universal screening for alcohol use and an intervention for those who screen positive is required for all injured patients at Level I trauma centers. Patients with a current diagnosis of alcohol use disorder (AUD) or who are exhibiting symptoms highly indicative of an AUD do not need to be screened. (UW Health Low quality evidence, strong recommendation)

Adolescents and Alcohol Use
The CRAFFT (Car, Relax, Alone, Forget, Family/Friends, Trouble) is a validated tool to screen adolescents for risky drinking and drug behaviors. Adolescent patients should be screened for alcohol and drug use using Part A of the CRAFFT (version 2.0). If the patient responds to any question with a number greater than “0,” all 6 CRAFFT Part B questions should be asked. The CAR question should be asked regardless of patient response to Part A.

Patients with less than two “yes” answers on the CRAFFT should receive a brief counseling intervention. (UW Health Low quality evidence, weak/conditional recommendation) A score of two or more “yes” answers suggest a serious problem and need for further assessment. Patients with two or more “yes” answers on the CRAFFT should receive a brief intervention and a referral to treatment with a specialist in alcohol and drug related issues. (UW Health Low quality evidence, weak/conditional recommendation)

Adults and Alcohol Use
The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (USPSTF B Recommendation) UW Health recommends using the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) to screen for alcohol misuse in non-pregnant adults. The AUDIT-C includes the first three questions of the full AUDIT screening tool.

Adult patients who screen positive for unhealthy alcohol use (AUDIT-C score of 3 to 7 for men over 65 years and all adult women; 4 to 7 for men 18 to 65 years) should receive a brief counseling intervention. (UW Health Moderate quality evidence, weak/conditional recommendation) It is important to note that even low or moderate drinking is risky for some patients in certain clinical situations (e.g. pregnancy, taking warfarin), and these patients should be advised to not drink at all. (UW Health Moderate quality evidence, weak/conditional recommendation)

Adult patients who are likely to have an alcohol use disorder (AUDIT-C score of 8 or greater) should receive further assessment and/or a referral to treatment with a specialist in alcohol and drug related issues. (UW Health Moderate quality evidence, weak/conditional recommendation)
Clinicians may consider using the entire AUDIT screening tool to evaluate adult patients for potential negative health or social consequences associated with drinking.\textsuperscript{10,32} \textit{(UW Health Moderate quality evidence, weak/conditional recommendation)} This information may be helpful when conducting the brief intervention or when discussing referral to treatment with the patient.

**Brief Intervention**

Motivating patients to reduce or stop drinking is the essence of a brief intervention. The intervention includes providing feedback on alcohol use and harms, identification of high risk situations for drinking and coping strategies, as well as motivating patients to develop a personal plan to reduce drinking. A brief intervention can be as short as five minutes in the primary care clinical setting.\textsuperscript{33}

Clinicians may consider using the entire AUDIT screening tool to evaluate adult patients for potential negative health or social consequences associated with drinking.\textsuperscript{10,32} \textit{(UW Health Moderate quality evidence, weak/conditional recommendation)} The patient’s responses may provide insight into the patient’s values and concerns, which can be incorporated into the brief intervention.

Below are specific statements and messages clinicians may want to utilize with patients who use alcohol above recommended limits.

1. **Direct feedback:**

   “As your clinician I am concerned about how much you drink and how it is affecting your health.”
   “You are drinking alcohol at a level that puts you at serious risk for a number of alcohol related problems, especially accidents, injuries or a worsening of your health problems.”

2. **Discuss how their alcohol use is affecting their health:**

   “As your clinician I am concerned about how your alcohol use is affecting our ability to treat your ___________ (mention additional conditions, e.g. hypertension, diabetes, depression).”
   “All of your previous suicide attempts were associated with heavy drinking.”
   “Your ___________ (other stated) medication will work better if you cut down or stop drinking.”

**NOTE:** If a patient reports excessive daily drinking, provide brief anticipatory guidance for possible withdrawal symptoms and consider providing the patient with educational materials. \textit{(UW Health Low quality evidence, strong recommendation)}

3. **Negotiate and set goals:**

   “As your clinician, I would recommend for you to [abstain from or reduce] your drinking.” (if the clinician recommends abstaining, such as in alcohol addiction, it is beneficial to add: “However, if you are unable to abstain, even if you reduce your drinking it will be beneficial for your health”)
   “What do you think about cutting down to three drinks 2 to 3 times per week?”
   “Can you reduce your drinking for the next month?”

4. **Behavioral modification strategies:**
“There are some situations when people drink and sometimes lose control of their drinking. These situations include going out to dinner with friends, having difficulty sleeping, or during times of stress. Let’s talk about ways you can avoid these situations.”

“Can you identify a family member or a friend who can help you?”

“What are the things you like about drinking?”

“What are some of the things you don’t like about your alcohol use?”

“Let’s practice what you will say to your friends or family members when they offer you a drink.”

5. **Self-help directed bibliotherapy : (when available)**

“I would like you to review this booklet on ways to reduce your alcohol use and bring it with you to our next visit.”

“It would be very helpful if you would complete some of the exercises in this guide.”

6. **Follow-up and reinforcement**

“I would like you to return to see me in one month to see how you are doing.”

“Someone from my office will call you in two weeks to check in with you.”

“Please make an appointment to see me in 2 weeks.”

“Sometimes people, despite best intentions, are not able to achieve the goals they set for themselves. I hope you’ll be successful, but if you have problems with it, please come and talk to me, and we’ll start from there.”

As with most kinds of behavioral therapy, Brief Intervention works best when delivered in a non-judgmental, caring, empathetic manner.

**Further Assessment and Referral to Treatment**

Adolescent patients with two or more “yes” answers on the CRAFFT should receive a brief intervention and a referral to treatment with a specialist in alcohol and drug related issues.³,⁷ *(UW Health Low quality evidence, weak/conditional recommendation)*

Adult patients who are likely to have an alcohol use disorder (AUDIT-C score of 8 or greater) should receive further assessment and/or a referral to treatment with a specialist in alcohol and drug related issues.⁵,¹⁶ *(UW Health Moderate quality evidence, weak/conditional recommendation)*

Clinicians may consider using the entire AUDIT screening tool to evaluate adult patients for potential negative health or social consequences associated with drinking.¹⁰,³² *(UW Health Moderate quality evidence, weak/conditional recommendation)* This information may be helpful to further assess the patient or when discussing referral to treatment.

The following questions are included as examples for clinicians to further assess a potential alcohol problem via a semi-structured interview following use of the previously described assessment tools.
Clinician-Patient Interview:
1. Have you ever missed an important family event due to your drinking? (i.e., one of your children’s birthdays, a sporting event, or a school activity?)
2. Has anyone ever asked you to cut down or stop your drinking?
3. Have you ever tried to cut down on your drinking for a while?
4. What made you cut down?
5. Have you ever driven a car while under the influence of alcohol?
6. Has drinking affected your work or school?
7. What are some things you like about drinking? What don’t you like?
8. How many risky drinking days have you had in the last month? (Risky defined as more than 4 (women, men > 65 yrs.) or 5 (men< 65 yrs.) drinks/day).1

Based upon the answers provided during the interview and on the formal assessment, a provider may consider establishing a diagnosis for alcohol use disorder (see Appendix E). It may also be beneficial to consider adding a diagnosis to the problem list, to alert colleagues to the potential for additional health complications, and for higher risk of misuse of potentially addictive prescription medications. (UW Health Low quality of evidence, strong recommendation)

NOTE: Following diagnosis, patients are subject to follow requirements established by the Healthcare Effectiveness Data and Information Set (HEDIS) for initiating and engaging patients in treatment. For more information, see Appendix G.

Follow Up and Management
Patients in all clinical settings who do not drink or who have a negative screen for alcohol misuse should be given positive reinforcement (verbal). Patients may be encouraged to continue to abstain or drink below recommended limits (see Table 1). (UW Health Very low quality evidence, weak/conditional recommendation)

Patients who have received a brief intervention should have follow up with primary care in about 4 weeks. (UW Health Very low quality evidence, weak/conditional recommendation)

The primary care clinic should follow up with patients who have received a referral for treatment in about 2 to 8 weeks. If the patient has NOT started with the referred treatment, for whatever reason, pharmacotherapy and/or behavioral management in primary care should be considered. (UW Health Very low quality evidence, weak/conditional recommendation)

Pharmacotherapy
Medications may be used to assist adult patients in their recovery from alcohol dependence, whether or not they are receiving specialty-based treatment.34-38 Use is indicated for patients motivated to reduce alcohol intake. (UW Health High quality evidence, strong recommendation) The following table (Table 2) provides information on the contraindications, adverse effects, and recommended doses for FDA-approved medications.39-41 There is insufficient evidence to recommend a particular medication as a first line agent; therefore, treatment should be individualized based on patient-specific factors.2,42 (UW Health Very low quality evidence, weak/conditional recommendation) Given its relative lack of efficacy and its toxicity, disulfiram should be considered only after an inadequate response to other agents.42 (UW Health Moderate quality evidence, weak/conditional recommendation) Witnessed dosing by an appropriate close personal contact or specialist treatment provider is generally preferable to ensure adherence.43
<table>
<thead>
<tr>
<th>Medication</th>
<th>Contraindications/Precautions</th>
<th>Adverse Effects</th>
<th>Dosage</th>
<th>Initiation</th>
<th>Discontinuation</th>
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<tbody>
<tr>
<td>Naltrexone (ReVia® - tablet)</td>
<td>- Concurrent use of opioids (use in the last 7-10 days)</td>
<td>Nausea, headache, dizziness, abdominal discomfort, increased liver function tests and CK, injection site reactions</td>
<td>Tab – 50 mg PO daily &lt;br&gt; If at increased risk for side effects (e.g. active drinker, elderly), consider starting at 25 mg and taper up. Injection – 380 mg IM every 28 days</td>
<td>3+ days abstinence from alcohol recommended but not required &lt;br&gt; Initial LFTs and urine drug screen</td>
<td>Duration: 3-12 months. Clinical response may allow for continued use. No withdrawal effects; no need to taper</td>
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<tr>
<td></td>
<td>- Opioid withdrawal</td>
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<tr>
<td></td>
<td>- Pregnancy Category C</td>
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<td></td>
<td>- Active liver disease</td>
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<td>Acamprosate (Campral®)</td>
<td>- Severe renal impairment (creatinine clearance &lt; 30 mL/min)</td>
<td>Diarrhea, insomnia, anxiety, fatigue</td>
<td>333 mg TID for 3-5 days (initiation) &lt;br&gt; 666 mg PO three times daily (maintenance)</td>
<td>Most efficacious with 7 days abstinence &lt;br&gt; Initial renal function tests</td>
<td>Duration: &gt; 12 months &lt;br&gt; No withdrawal; no need to taper</td>
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<td></td>
<td>- Suicide ideation</td>
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<td></td>
<td>- Pregnancy Category C</td>
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<tr>
<td></td>
<td>- Use with caution in elderly patients</td>
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<tr>
<td>Topiramate (Topamax®)</td>
<td>- Conditions or medications that predispose to metabolic acidosis &lt;br&gt; - Psychiatric or behavior disturbances - Pregnancy Category D</td>
<td>Dizziness, cognitive impairment, anorexia, weight loss, somnolence, abnormal serum bicarbonate</td>
<td>Initiate at 50 mg daily and increase dose over several weeks to 150 mg twice daily</td>
<td>Initiate at 50 mg daily, increase by 50 mg weekly to 100 mg twice daily. If cravings persist, doses can be titrated up to 150 mg twice daily.</td>
<td>Taper by decreasing daily dose by 50 mg each week, unless safety considerations warrant more rapid withdrawal.</td>
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<tr>
<td>(Not FDA-approved for alcohol use disorder)</td>
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<tr>
<td>Gabapentin (Neurontin®)</td>
<td>- Use with caution in severe renal impairment, elderly as dosage adjustments may be needed &lt;br&gt; - Pregnancy Category C</td>
<td>Somnolence, dizziness, peripheral edema,</td>
<td>Therapeutic benefit seen at 1600-2400 mg/day in divided doses</td>
<td>Initiate at 300 mg, 3 x daily. Titrate to 1200 mg total daily dose by day 5, in divided doses as tolerated.</td>
<td>Could taper by 25% weekly. Clinical response may allow for continued use.</td>
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<tr>
<td>(Not FDA-approved for alcohol use disorder)</td>
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<tr>
<td>Disulfiram (Antabuse®)</td>
<td>- Myocardial disease &lt;br&gt; - Alcohol-containing cough preparations &lt;br&gt; - Psychosis &lt;br&gt; - Pregnancy Category B2 (Australian) &lt;br&gt; - Use with caution in elderly patients &lt;br&gt; - Concurrent metronidazole &lt;br&gt; - Active liver disease</td>
<td>Dermatitis, flushing with alcohol ingestion, increase in liver function tests, metallic taste, peripheral neuropathy</td>
<td>500 mg PO daily for 1 – 2 weeks, then 250 mg daily</td>
<td>12+ hours abstinence and/or BAC = 0 &lt;br&gt; Baseline LFTs, urine HCG &lt;br&gt; ECG if clinically indicated</td>
<td>Duration: Up to 20 months &lt;br&gt; No withdrawal; no need to taper &lt;br&gt; Reaction with alcohol up to 2 weeks after discontinuation</td>
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**UW Health Implementation**

**Potential Benefits:**
- Help patients recognize problems or potential problems related to their drinking.
- Provide encouragement for positive change and belief in the ability to change
- Reduce harms related to alcohol use, including traumatic injuries, medical problems, and social/relationship/employment problems

**Potential Harms:**
- Incorrect identification of patients who do not have risky behaviors.
- Failure to properly identify all patients who may be abusing alcohol.

**Pertinent UW Health Policies & Procedures**
1. UWHC Policy 10.0: Screening of Emergency Department Patients

**Patient Resources**
1. Health Facts For You #7628 – Cutting Back on Your Drinking
2. Health Facts For You #5717 – Older Adults and Alcohol Abuse
3. Health Facts For You #4611 – Alcohol and Drug Abuse: A Guide to Community Services
4. Healthwise – Alcohol Use: Teen: General Info
5. Healthwise – Alcohol Abuse: Your Teen: General Info
6. Healthwise – Alcohol Abuse and Addiction: Teen: General Info
7. Healthwise – Alcohol and Drug Problems
8. Healthwise – Alcohol, Drug, or Poison Ingestion
9. Health Information – Alcohol Abuse, Teen
10. Health Information – Alcohol Abuse: Dealing with teen substance use
11. Health Information – Alcohol and Drug Problems
12. Health Information – Alcohol Abuse and Dependance
13. Health Information – Alcohol Abuse, Do You Have a Drinking Problem Interactive Tool
14. Health Information – Alcohol Abuse: Other Health Problems That May Occur
15. Health Information – Alcohol and Heart Disease
16. Health Information – Alcohol Problems: How to Stop Drinking
17. Kids Health – Kids and Alcohol (Parents)
18. Kids Health – Alcohol (Teens)
19. Kids Health – Binge Drinking (Teens)
20. Kids Health – I Think I May Have a Drinking/Drug Problem. What Should I Do? (Teen)

**Guideline Metrics**
1. See Appendix F and Appendix G for required metrics
2. Number of patients being screened in the ambulatory setting using the AUDIT-C
3. Number of brief interventions performed in the ambulatory setting
4. Number of referrals made in the ambulatory setting to a specialist in alcohol and drug issues

**Implementation Plan/Clinical Tools**
1. Guideline will be posted on uConnect in a dedicated location for Clinical Practice Guidelines.
2. Release of the guideline will be advertised in the Physician/APP Briefing newsletter.
3. Content and hyperlinks within clinical tools, documents, or Health Link related to the guideline recommendations (such as the following) will be reviewed for consistency and modified as appropriate.

**Best Practice Alerts (BPA)**
UWIP B AUDIT-C AODA CONSULT NEEDED ADULT [3000850]
UWED B FLOWSHEET AUDIT-C ADDING FOLLOW UP ED QUESTION TO DISCHARGE INFO [181181] – adds an educational follow-up question that’s not shown to the end user
UWIP B ADD CARE PLAN FOR AUDIT-C SCORE GREATER THAN 3 [3000852]
UWIP B ADD PATIENT ED FOR AUDIT-C SCORE GREATER THAN 3 [3000180]

EAP/ERX Records
Consult Addictive Disorders (Inpatient) [CON0003]

Smart Text
ARI GUIDLINES - BRIEF INTERVENTION 3012521
AODA ASSESSMENT [3000333]

Disclaimer
Clinical practice guidelines assist clinicians by providing a framework for the evaluation and treatment of patients. This guideline outlines the preferred approach for most patients. It is not intended to replace a clinician’s judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.
Appendix A. Evidence Grading Scheme(s)

Figure 1. GRADE Methodology adapted by UW Health

GRADE Ranking of Evidence

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>High</td>
<td>We are confident that the effect in the study reflects the actual effect.</td>
</tr>
<tr>
<td>Moderate</td>
<td>We are quite confident that the effect in the study is close to the true effect, but it is also possible it is substantially different.</td>
</tr>
<tr>
<td>Low</td>
<td>The true effect may differ significantly from the estimate.</td>
</tr>
<tr>
<td>Very Low</td>
<td>The true effect is likely to be substantially different from the estimated effect.</td>
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</tbody>
</table>

GRADE Ratings for Recommendations For or Against Practice

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>The net benefit of the treatment is clear, patient values and circumstances are unlikely to affect the decision.</td>
</tr>
<tr>
<td>Weak/conditional</td>
<td>Recommendation may be conditional upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented.</td>
</tr>
</tbody>
</table>

USPSTF Grades for Recommendations

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
</tr>
<tr>
<td>I Statement</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
</tr>
</tbody>
</table>
Appendix B.

ADOLESCENT Alcohol Screening and Intervention Algorithm

Screen for alcohol misuse

Primary Care: Screen new patients and at least annually.
Hospital Inpatients: Every Admission
ED: Every Admission

CRAFFT 2.0, Part A: 3 Question Pre-Screen
During the past 12 months, on how many days did you:
1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Say “0” if none.
2. Use any marijuana (pot, weed, hashish, or in foods) or "synthetic marijuana" (like "K2" or "Spice")? Say “0” if none.
3. Use anything else to get high? (like other illegal drugs, prescription or over-the-counter medications, and things you sniff or “huff”)? Say “0” if none.

Ask all six CRAFFT questions

Patient Response “0” for all questions?

Complete CAR question of CRAFFT Assessment

2 or more YES answers?

Provide brief intervention and Refer to specialist in alcohol/drug related issues*

*Addiction Medicine consult suggested for inpatients. AUD diagnosis and/or referral for additional outpatient treatment may be made by consulting service.

Provide brief intervention

Follow up with Primary Care in about 2-8 weeks

Consider pharmacotherapy and/or behavioral management in Primary Care

Did patient begin treatment with referred services?

Follow up per PCP discretion

Yes
No

Provide patient education regarding safe driving habits.

Yes
No

Give positive reinforcement, encourage to continue to not use

Screening complete

Yes
No

Patient Response “Yes”?

Last Reviewed Nov 2016

Alcohol – Pediatric/Adult –
Ambulatory/Inpatient
Appendix C.

**ADULT Alcohol Screening and Intervention Algorithm**

**Screen for alcohol misuse using the AUDIT-C**

- **Primary Care:** Screen New Patients and at Least Annually
- **Hospital Inpatients:** Every Admission
- **ED:** Every Admission

**AUDIT-C Score**

- **Low Risk**
  - 0-2
    - Men over 65 years and all women

- **High Risk**
  - 3-7
    - Men over 65 years and all women
  - 4-7
    - Men age 65 years or younger

- **Likely Alcohol Use Disorder**
  - 8-12
    - Men and women

**Give positive reinforcement.**
Advise to continue to drink below recommended limits*:
- Men age 65 years or younger: ≤4 standard drinks per day; ≤14 per week
- Men over 65 year and all women: ≤3 drinks per day; ≤7 drinks per week

*Abstinence should be recommended to some patients in certain clinical situations (e.g., pregnancy, warfarin)

**Screening complete**

**Provide brief intervention (BI)**

**Follow up with Primary Care in about 4 weeks**

**Refer to specialist in alcohol/drug related issues**

*Addiction Medicine consult suggested for inpatients. AUD diagnosis and/or referral for additional outpatient treatment may be made by consulting service.

**Follow up with Primary Care in about 2-8 weeks**

**Did patient begin treatment with referred services?**

- **No**
  - Consider pharmacotherapy and/or behavioral management in Primary Care

- **Yes**
  - Follow up per PCP discretion

Last Reviewed Nov 2016

Alcohol – Pediatric/Adult – Ambulatory/Inpatient
Appendix D. Communication Tips for Asking Patients About Alcohol Use

Alcohol use is related to many serious health concerns, ranging from car accidents to cancer to cardiovascular disease. If we can identify those with risky or harmful alcohol use, we may be able to help patients reduce their drinking or get the help they need.

Some clinicians feel uncomfortable asking about alcohol use, especially if it is unrelated to the patient’s reason for visit or current health concerns. Most patients do not mind answering the alcohol screening questions. If you like, you may consider introducing the topic in one of the following ways:

“We screen all our patients for alcohol use because it is an important factor in your health.”

“May I ask you a few questions about your alcohol use?”

“I’m going to ask you a few questions about alcohol use. It won’t take long.”
Appendix E. DSM-5 Criteria for Alcohol Use Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) considers the following diagnostic criteria (manifested by at least two of the following within a 12-month period) indicative of an 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 a 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, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal).
   b. Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

**Mild:** Presence of 2-3 symptoms  
**Moderate:** Presence of 4-5 symptoms  
**Severe:** Presence of 6 or more symptoms.
Appendix F. Inpatient Quality Metrics
The following metrics are from the Joint Commission Hospital Inpatient Quality Reporting Program Specifications Manual.

SUB-1: “Alcohol Use Screening”
- **Description:** Psychiatric inpatients screened within the first 3 days of admission using a validated screening questionnaire for unhealthy alcohol use.
- **Numerator:** The number of psychiatric inpatients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first 3 days of admission.
- **Denominator:** The number of psychiatric hospitalized patients 18 years of age and older.
- **ABSTRACTOR COMMENTS:**
  - We currently use the Audit-C screening for this measure.
  - Documentation of cognitive impairment throughout the first 3 days following admission will exclude the case from the measure.
    - Temporary cognitive impairment due to acute substance use (e.g. overdose or acute intoxication) will not exclude the case.

SUB-2 “Alcohol Use Brief Intervention Provided or Offered”
- **Description:** “Patients 18 years and older who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay.”
  - SUB-2 is an overall rate, which includes all patients to whom a brief intervention was provided or offered and refused.
- **Numerator:** The number of patients who received or refused a brief intervention.
- **Denominator:** The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use disorder (alcohol abuse or alcohol dependence).
- **ABSTRACTOR COMMENTS:**
  - Patients (men and women) who score 6 or above on Audit C are required to receive a brief intervention.

SUB-2a “Alcohol Use Brief Intervention”
- **Description:** Patients who received the brief intervention during the hospital stay.
  - SUB-2a is a subset and only includes those patients who received a brief intervention.
- **Numerator:** The number of patients who actually received a brief intervention.
- **Denominator:** The number of hospitalized inpatients 18 years of age and older who screen positive for unhealthy alcohol use disorder (alcohol abuse or alcohol dependence).

SUB-3 “Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge” AND the subset measure
- **Description:** Patients 18 years and older who are identified with alcohol or drug use disorder and who “were referred to or refused at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.”
o SUB-3 must be reported as “an overall rate which includes all patients to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge.”

- **Numerator**: The number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment.
- **Denominator**: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.

**SUB-3a “Alcohol and Other Drug Use Disorder Treatment at Discharge”**

- **Description**: A subset of SUB-3 and identifies “Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.”
  o SUB-3a (subset) includes only those patients who received a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment
- **Numerator** The number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment.
- **Denominator**: The number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder.
Instances occur when a patient’s alcohol or drug (AOD) use is simply discussed during a visit and may not lead to diagnosis or when a patient is ambiguous about a referral to an addictions program. In those instances, it may be appropriate to use one of the following AOD related codes –

**Initialization**
- If your patient is inpatient with a new* AOD abuse or dependence diagnosis, then they are considered to have initiated treatment. 
- If your patient is given a new* AOD abuse or dependence diagnosis during an outpatient visit, they need to have an additional outpatient visit, partial hospitalization or admission with an AOD code within 14 days to be compliant with the initialization measure. 

**Engagement**
To be engaged in treatment, your patient would need to have at least two additional inpatient admissions, outpatient visits or partial hospitalizations with an AOD diagnosis. This must have occurred within 30 days after the date of initiation (the admission or first outpatient visit.)

**Follow-up or Referral**
If you have diagnosed your patient with AOD abuse or dependence, it is important to either follow-up with that patient yourself or refer them for AOD services. This follow-up helps to assure that the patient fully initiates and engages in treatment.

**HEDIS® uses the following codes to identify patients for inclusion in the Initialization and Engagement measure –**

**ICD-9**
- V79.1 - Special screening for alcoholism
- V65.42 - Counseling on substance use and abuse

**ICD-10**
- Z13.89 - Encounter for screening for other disorder
- Z71.41 - Alcohol abuse counseling and surveillance of alcoholic

**ICD-9**
- 291.0 – 291.9  – Alcohol induced mental disorders
- 303.0 – 303.9  – Alcohol intoxication or dependence
- 304.0 – 304.9  – Drug dependence
- 305.0 – 305.9  – Alcohol or drug abuse
- 535.3  – Alcoholic gastritis
- 571.1  – Acute alcoholic hepatitis

**ICD-10**
- F10.10 - F10.29  – Alcohol abuse / dependence
- F11.10 - F11.29  – Opioid abuse / dependence
- F12.10 - F12.29  – Cannabis abuse / dependence
- F13.10 - F13.29  – Sedative abuse / dependence
- F14.10 - F14.29  – Cocaine abuse / dependence
- F15.10 - F15.29  – Other stimulant abuse / dependence
- F16.10 - F16.29  – Hallucinogen abuse / dependence
- F18.10 - F18.29  – Inhalant abuse / dependence
- F19.10 - F19.29  – Other psychoactive substance abuse / dependence

* new means patient did not have an encounter with an AOD dependence diagnosis code within the past 60 days.

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ALCOHOL ASSESSMENT TOOLS

A UW Health work group composed of primary care physicians, addiction and drug abuse specialists, pharmacists, quality improvement and clinic management staff have developed a one-question screen for excessive drinking. This simple tool can be used to help determine if a patient could benefit from a referral for a comprehensive AOD evaluation.

- Female Patients:  
  How often do you drink four or more drinks on a single occasion?

- Male Patients:  
  How often do you drink five or more drinks on a single occasion?

Persons who report excessive alcohol use one or more times in the last month are considered a positive screen and should receive brief assessment and intervention services.

For more information on assessment tools, please see Unity’s Alcohol CPG. All clinical practice guidelines (CPGs) can be found by visiting unityhealth.com/clinicalguidelines.

To refer a Unity member for additional AOD services contact UW Health - Behavioral Health Care Management at (800) 683-2300 or (608) 233-3575

For information exclusive to providers, please visit unityhealth.com/providers
References


28. Results from the 2015 National Survey on Drug Use and Health: Detailed Tables. 2015.


42. John M. Eisenberg Center for Clinical Decisions and Communications Science. Pharmacotherapy for Adults With Alcohol Use Disorder (AUD) in Outpatient Settings. 2016.