NCC_EdBoudreaux11_03272017

Alcohol Screening in Primary Care: What's in a Name?
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Hello, this is Ed Boudreaux. I'm a Behavioral Health Consultant for the G-1 Task and I'm going to present today an alcohol screening in primary care. I had some valuable contributions from Jon Glover from MetaStar and John Higgins-Biddle, who's the co-author of the AUDIT.

Today, we're going to answer two questions: What do the Centers for Disease Control recommend using in primary care settings to screen for risky alcohol use; and, How and why does this strategy differ from other recommendations?

Following this video, our expectation is that you will be better prepared to decide which risky alcohol use screener to use in primary care settings.

This is a confusing area because there are many different alcohol use screeners out there and they all have different strengths and weaknesses, so it can be quite a conundrum and a challenge to figure out which one to use. Some instruments that have been used for a long time that's been promoted like the CAGE have recently fallen out of favor and others might be out there that have "false positives" that are inordinately high rate and some are not compatible with instruments that are used for further assessments, so if you have a positive screen, it's not readily apparent what you should do to follow up on that positive screen.

So the Centers for Disease Control has recognized that this is a problem and that is it has impacted implementation of risky alcohol use screening, so they developed planning and implementation guide that is kind of like one-stop shopping for primary care practices to help them decide which screeners to use and what to do when those screeners are positive. So I'm going to base my presentation today primarily on this CDC guide and all of the images that I'm going to talk about and present today are taken directly from that guide.

As I mentioned before, some screeners have limitations and are not lined up well with healthy drinking recommendations in the United States and that prevents easy transition into counseling. Some have high false positive rates and some are not practical because of the length and the complexity, so the CDC recommends two-stage screening. Stage 1 is to assess the drinking pattern of the person and Stage 2 is to assess problem severity and harm.

So, let's start with Stage 1. There are a couple of different options here for Stage 1 to assess the drinking pattern. There's the Single Item Alcohol Screening that can be used in primary care, and you can see the item right here. How many times in the past year have you had five or more, for men, four or more, for women, drinks in a day? So this is a single item, and the clinician would use the drinking rate that's associated with that person's sex. So, five for men, four for women. This has strong advantages because it's a single item and it can be easily memorized so it can be incorporated into routine care fairly easy. The full description of that instrument is in Appendix F of the CDC guide that I've referenced earlier.

There's another option besides the single item screener and it's called the AUDIT 1-3. So, you can see here that it's the first three items of the AUDIT screener: How often do you have a drink containing

alcohol; how many drinks containing alcohol do you have on a typical day when you're drinking; and, how often do you have X or more drinks on one occasion where 'X' is five for men and four for women. So, this 1-3 AUDIT has additional advantages because it fits in seamlessly with the longer AUDIT.

So, let's talk a little bit about the AUDIT. The original AUDIT was created by the World Health Organization, using international standards for standard drink instead of the United States standards. The problem with that is the U.S. standard drink is forty percent larger than the international standard, so that makes the AUDIT not necessarily a very good fit with U.S. – for use in the U.S. And so several efforts have attempted to adapt the AUDIT to account for this by modifying the first three items, or the associated scoring with those first three items, and the most notable efforts are the AUDIT-C which you probably have heard about because it's received lots of press, and the AUDIT 1-3 which is the one I just mentioned earlier that's being promoted by the Centers for Disease Control.

I have them out here side by side so you can see the differences. Notice that the AUDIT 1-3 response options change when you compare it to the AUDIT-C. Where there's maximum of four points here for the AUDIT-C, you can see that you can get up to six points on this first item for the AUDIT 1-3 and that is similar for the other items. There are more response options so there's better granularity in determining the drinking pattern. And also notice here that in the final item, that it has been modified so that it reflects the drinking rates for men and women and men over age sixty-five. So this helps it to line up more closely with the recommendations from the National Institute of Alcohol Abuse and Alcoholism whereas here in this AUDIT-C, those adjustments have not been made.

So with a practical example, you can see that if a person, a man, drinks one drink per day, every day of the week, he or she would not screen positive on the AUDIT 1-3 but would screen positive on the AUDIT-C. This is what I referred to earlier as having a high false positive rate because this person who now screens positive on the AUDIT-C would require additional assessment, additional screening to make sure that the person wasn't having problems with their drinking whereas that would not happen if the AUDIT 1-3 had been administered.

So in some, the AUDIT-C item response options are not clearly aligned with the U.S. drinking guidelines and that makes interpretation more difficult. The AUDIT-C has been shown to produce many false positives, in other words it incorrectly classifies many people as risky drinking when they really aren't and it leads to unnecessary use of patient and clinician time. The AUDIT 1-3 addresses those problems and blends seamlessly with the USAUDIT which I'll talk about next.

So that's step two of the CDC recommendations. If the person screens positive on their drinking patterns, in other words, they're above the low-risk drinking guidelines, then the rest of the AUDIT, which is seven items, would be administered to that individual. So you can see what that looks like here. The top three items are the AUDIT 1-3, if they're positive on that using the criterion we referenced in the other slide then they would take the rest of the AUDIT which is items four through ten. This really drills down into the problems that might be associated with their alcohol use.

So we can flow this out in a decision tree that shows consideration of the population to be screened which is primary care patients. You can use either the single question or the AUDIT 1-3 in step 1. If the person screens negative then that can simply be followed up by a conversation or a brochure on drinking limits for prevention purposes to help that person stay below the risky drinking level. If they're positive, then you follow-up with the USAUDIT or the AUDITUS and that helps you to determine whether

the person is likely to be dependent, in which case, they need a brief intervention, not likely to be dependent in which case they get a brief intervention only or if they're likely to be dependent, they not only get a brief intervention but they get referral to specialized behavioral health treatment.

So in summary, screening for risky alcohol use should occur in two stages. Stage 1 determines if the person drinks above the low-risk drinking guidelines, and Stage 2 further assesses severity and harm. The CDC recommends use of the single question or the AUDIT 1-3 for Stage 1, and the USAUDIT for Stage 2. This combination is likely to result in the best balance between efficiency of the administration of the screeners and the accuracy of the screening.

Thank you. My contact information is here if you'd like to discuss it further.