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Medication-Assisted Withdrawal and Alcohol Use Disorder Treatment in the Ambulatory Setting

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Exploring Primary Care Treatment of Alcohol Withdrawal Syndrome (AWS) and Alcohol Use Disorder (AUD) in Central Vermont

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MENTOR: JAVAD MASHKURI, MD

Case study: XY, 26 year old male

- XY is a 26 yo male who presents midday to the CVMC ED with acute 10/10 epigastric pain and associated nausea and vomiting. Patient describes many past ED visits for similar symptoms, has 8-12 alcoholic drinks per day, last drink was last night at 10:30 pm. Labs and CT confirm acute pancreatitis with signs of liver damage. Although concerned that he may lose his job, patient agrees to be admitted to the hospital.
- While in the hospital, patient is treated for acute alcohol withdrawal and alcoholic pancreatitis. Patient expresses a strong desire to quit alcohol but doubts his ability to remain sober given many failed prior quit attempts and an unsupportive living environment.
- Patient recounts that his father was an alcoholic, his parents had been abusive towards him and each other, and that he has been drinking heavily since high school.

Problem Identification and description of need: Central VT Background

- 2013 – Federal SAMHSA grant funded Screening, Brief Intervention, Referral to Treatment (SBIRT) clinicians in the CVMC ED to conduct universal screening for AUD
- 2015 - Washington County Substance Abuse Regional Partnership (WCSARP) founded in to bring all addiction treatment stakeholders together to collaborate and create a common treatment pathway
- 2018 - CVMC ED establishes Peer Recovery Services and Rapid Access to MAT (RAM) to stabilize patients with OUD presenting in the ED and facilitate transfer to local addiction treatment providers
- Recognizing that AUD represents the largest burden of substance use-related disease in Central VT, WCSARP begins work to adapt the RAM model and the Vermont Hub and Spoke model (1) to address AUD
- Asked Jacob Weiss to assist in researching current local primary care provider perceptions and practices treating AWS and AUD

Public health cost and unique cost considerations in host community

- Vermonters use alcohol more than any other drug, at a higher rate than the US average (64% vs 53%) (2)
  - Ages 18-25: 70.5% ETOH vs 37.7% marijuana vs 0.85% opiates (3)
- **Deaths attributed to alcohol in Vermont have risen steadily (2016: 342, 5.8%),** while the number of Vermonters with AUD in treatment have fallen (2, 4)
  - **2016: 96 opioid-related deaths in Vermont (5)**
- In 2016, 9% of Vermonters with AUD sought treatment, leaving more than 33,000 Vermonters who meet criteria for AUD untreated (6)
- The annual cost of excessive acute and chronic alcohol use in the United States is estimated to be $249 billion dollars, roughly $2 for each drink consumed, mostly due to lost productivity (7)
- There is a paucity of survey data about PCP treatment for AWS and AUD specific to central VT

Community Perspective: Barbara Gramuglia, CVMC ED SBIRT clinician/CHT team

- "AUD seems magnitudes more pervasive and damaging than opioids. Opioid overdoses are dramatic, because they often kill young people, but alcohol addiction is a slow burn. And the damage that it does to families in particular is terrible."
- "I'm thinking of this one guy, who started drinking after a traumatic event at work 7 years ago, and his life fell apart, he lost his job and became homeless. Oddly enough, it was during Covid when he pulled himself together. We worked closely with his PCP Marissa Patrick, realized when he was missing appointments, and made sure he got his doses of Vivitrol (IM Naltrexone). That was a really powerful example of primary care and the ED working together."

Community Perspective: Hilary Denton, Recovery Coach Supervisor, Turning Point Center of Central VT

- "It's the whole understanding that, on the one the one hand, you really want to quit, you hate it, you want to stop. But on the other hand… you don't. It's understanding that a person wants both things at the same time. I think that's confusing for most people, but I think that's the one thing that connects me with patients. And then once you have that understanding, you can start sharing, 'This is how I got out of it.'"
- "Just treating addiction with medication is not going to cut it. It's good as a tool, but it's just a piece. There's so much more to learning how to really live than just stopping using or drinking. It's a life changing event, getting sober, because addiction affects every area of our lives, so every area is affected when we stop."

Intervention and Methodology

- Designed a survey using SurveyMonkey to learn about current outpatient provider practices and perceptions regarding the treatment of AWS and AUD
  - Most frequently prescribed medications and recommended psychosocial interventions
  - Which evidence-based medication regimens and psychosocial interventions providers are interested in learning more about
  - Barriers to successful treatment of AWS and AUD
- Elicited feedback from
  - Clinical and non-clinical WCSARP members
  - Local addiction specialist
  - Ran "pilot survey" with local PCPs
- Deployed the survey throughout CVMC-affiliated primary care providers
- Used SurveyMonkey platform to collect and analyze findings

Response Data

- 29 responses to date
- 69% report treating alcohol withdrawal syndrome in the OP setting
- 83% report treating alcohol use disorder in the OP setting
- Demographics of providers: (from a limited sample of respondents)
  - Primary care practitioners
    - Family medicine and Internal Medicine physicians
    - Adult-Gerontology and Psychiatric-Mental Health nurse practitioners
  - 1 Pediatrician
  - 1 Psychiatrist
  - Number of patients currently treating for AUD: 3 to 20, average 9.5

Findings: Themes

- Benzodiazepines are the most prescribed medications (69%) for AWS, but providers indicate a high level of concern for their associated risks
- Oral naltrexone prescribed for AUD by 72% respondents, injectable by only 15%
- Providers indicated robust interest in learning about other medications and psychosocial interventions for AWS and AUD
- Top barriers to providing effective care for patients with AUD:
  1. Lack of mental health/substance use resources for follow-up and coordination
  2. Patient not ready to disclose/quit/limit their drinking
  3. Lack of knowledge and comfort managing AWS (e.g., prescribing benzodiazepines to someone who may still be drinking)
  4. Lack of adequate placement options for patients in active withdrawal or requiring higher level of care for AUD

Evaluation of effectiveness and limitations

- Effectiveness
  - Good response rate
  - Has generated many ideas of possible next steps to improve care
  - Findings were well-received when presented to WCSARP on 2/16/2021
  - Enthusiastic response from primary care providers to participate in a Primary Care Working Group headed by Marissa Patrick, NP
- Limitations
  - Initially overlooked collecting demographic data about respondents, resulting in limited data about respondents' practice setting, medical training, and number of patients treated for AUD

Recommendations for future interventions/projects

- ROAD (Rapid Outpatient Alcohol Discontinuation) pilot project for rapid access to AUD treatment involving CVMC ED and Treatment Associates
  - Jacob assisting with data collection as 4th year Scholarly Project
- Creation of Primary Care Working Group to further explore development and support of AWS/AUD treatment in OP setting
  - Development of protocol to guide decision-making as to appropriateness of inpatient vs outpatient treatment
    - PAWSS – Prediction of Alcohol Withdrawal Severity scale
  - Nurse training on administration of injectable long-acting Naltrexone
  - Integrate Peer Recovery Services into primary care settings

Clinical: XY, 26 yo male, continued

- While in the hospital, after acute withdrawal and pancreatitis stabilized, patient was started on oral naltrexone
- CHT contacted Valley Vista, a local residential addiction treatment facility, learned of a bed becoming available (VERY unusual)
- Patient arranged a ride to VV from his estranged mother (living in NH)
- CHT/LIC student reached out to XY's primary care provider, who agreed to prescribe a short course of oral naltrexone to bridge the patient after discharge from the hospital
- Patient completed treatment at VV, transferred to sober living house, is still sober. Did not tolerate oral naltrexone due to GI side effects, is not currently using medication. Attends multiple group support meetings a week, is planning to move into new permanent housing.
- Attributes part of his success to the compassionate care he received while at CVMC.

Parting thoughts

We need 3 things to effectively treat alcohol abuse

1. Access
   - How do we make every door *the right door* to enter treatment?
2. Relationships
   - Between patient and provider, and between all providers
3. Advocacy
   - How to eliminate stigma? EDUCATION
     - This is a chronic disease, like any other

-Javad Mashkuri

Thank you!

- Javad Mashurki MD, Marissa Patrick NP, members of WCSARP
- Christine Payne MD and Sarah Childs
- CVMC Primary Care providers and entire CVMC community

DSM-5 Criteria: Alcohol Use Disorder (AUD)

A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol.
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- 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.
- 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, pp. 499 to 500).
- b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

- **Mild:** Presence of two to three symptoms.
- **Moderate:** Presence of four to five symptoms.
- **Severe:** Presence of six or more symptoms. (8)

DSM-5 Criteria: Alcohol Withdrawal Syndrome (AWS)

DSM-5 diagnostic criteria for alcohol withdrawal are as follows:

- ●A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
- ●B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in criterion A:
  - •1. Autonomic hyperactivity
  - •2. Increased hand tremor
  - •3. Insomnia
  - •4. Nausea or vomiting
  - •5. Transient visual, tactile, or auditory hallucinations or illusions
  - •6. Psychomotor agitation
  - •7. Anxiety
  - •8. Generalized tonic-clonic seizures
- ●C. The signs or symptoms in criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ●D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance. (9)

Interview Consent Form

Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview.

Consented: X

Name: Barbara Gramuglia

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Consented: X

Name: Hilary Denton

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