



## Complete Summary

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### GUIDELINE TITLE

Screening and ongoing assessment for substance use.

### BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Screening and ongoing assessment for substance use. New York (NY): New York State Department of Health; 2005 Mar. 11 p. [8 references]

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT  
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IDENTIFYING INFORMATION AND AVAILABILITY  
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## SCOPE

### DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Alcohol and/or drug use/abuse

### GUIDELINE CATEGORY

Evaluation  
Prevention  
Screening

### CLINICAL SPECIALTY

Allergy and Immunology  
Family Practice  
Infectious Diseases

Internal Medicine  
Pediatrics

### **INTENDED USERS**

Advanced Practice Nurses  
Health Care Providers  
Hospitals  
Managed Care Organizations  
Physician Assistants  
Physicians  
Public Health Departments  
Substance Use Disorders Treatment Providers

### **GUIDELINE OBJECTIVE(S)**

To provide guidelines for screening and ongoing assessment for substance use in human immunodeficiency virus (HIV)-infected patients

### **TARGET POPULATION**

Human immunodeficiency virus (HIV)-infected patients

### **INTERVENTIONS AND PRACTICES CONSIDERED**

1. Incorporating brief screening instruments (a two-question screen, CAGE-AID) into the history-taking process.
2. Identifying clinical indicators of possible substance and/or alcohol use including
  - History of referrals or participation in substance/alcohol treatment programs, job loss, relationship problems, history of psychiatric symptoms, heavy smoking
  - Physical signs, such as hypertension, resting tachycardia, tremor, puffy facies, weight loss
  - Laboratory indicators, such as elevated mean cell volume (MCV), elevated serum B<sub>12</sub>, blood alcohol level
3. Use of TWEAK (Tolerance, Worry, Eye-opener, Amnesia, Kut down) and AUDIT questionnaires
4. Ongoing assessment of patients with known substance/alcohol abuse at regular intervals
5. Referring identified substance/alcohol abusers to appropriate substance use treatment programs
6. Providing positive feedback

### **MAJOR OUTCOMES CONSIDERED**

Efficacy of interventions (history taking, screening instruments) at identifying substance/alcohol use/abuse

## METHODOLOGY

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Not stated

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus (Committee)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

Not applicable

### **METHODS USED TO ANALYZE THE EVIDENCE**

Review  
Review of Published Meta-Analyses

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Not stated

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

Clinicians should screen all human immunodeficiency virus (HIV)-infected patients for substance use at baseline and at least annually. Screening questions should be phrased to include both alcohol and drug use.

### Key Point

Screening for substance use is particularly important in HIV-infected patients because 1) both alcohol and substance use are risk factors for HIV infection acquisition and transmission, and 2) addressing problems associated with substance use can help patients improve adherence with HIV medications and adopt risk-reduction behaviors, such as practicing safer sex.

See Appendix A in the original guideline document for examples of screening instruments that can be easily integrated into primary care practice.

### **General Approach to Screening for Substance Use**

The clinician should incorporate selected brief screening instruments into the history-taking process. The chosen screening instruments should be tailored for

optimal use at initial, annual, and interim visits and adjusted for the patient's substance use history.

To obtain more reliable results, the clinician should perform screening tests when patients are not under the influence of substances.

The clinician should carefully screen patients who are heavy smokers for other addictions because heavy smoking is often a surrogate marker of other substance and alcohol dependence.

When a patient's response to a query indicates substance use, clinicians should inquire about injection drug use, both currently and anytime in the past.

The clinician should use nonjudgmental language when inquiring about substance use.

### **Basic Principles of Screening**

- Ask about current and past substance use in a nonjudgmental way.
- Ask about the most commonly used recreational drugs including alcohol, marijuana, stimulants (cocaine including crack cocaine, methamphetamines), opiates, and benzodiazepines. A separate question about the use and abuse of prescription opiates and benzodiazepines is also important.
- Ask if the patient, or those around him/her, has any perception of having a substance use problem, now or in the past.
- Ask about substance use again if other historical, physical, or laboratory indicators suggest it (see the Table below).

<b>Common Indicators of Possible Substance and/or Alcohol Use/Abuse</b>	
<b>History</b>	<ul style="list-style-type: none"> <li>• History of referrals or participation in substance/alcohol treatment programs</li> <li>• Trauma, especially after drinking/substance use</li> <li>• Legal problems</li> <li>• Job loss, turnover, downward mobility</li> <li>• Relationship problems</li> <li>• Medical history: seizures, pancreatitis, liver disease, cytopenias, tachyarrhythmias, endocarditis, abscesses</li> <li>• History of psychiatric symptoms, especially affective disorders</li> <li>• History of or current heavy smoking</li> </ul>
<b>Physical signs (substances associated with findings)</b>	<ul style="list-style-type: none"> <li>• Hypertension (alcohol, cocaine, methamphetamine)</li> <li>• Resting tachycardia (alcohol, cocaine, marijuana, methamphetamine)</li> <li>• Tremor (alcohol withdrawal or stimulant intoxication)</li> <li>• Alcohol on breath</li> <li>• Dilated pupils (stimulant use or sedative withdrawal)</li> <li>• Small pupils (opiate use)</li> <li>• Needle marks/tracks (any injection use)</li> </ul>

<b>Common Indicators of Possible Substance and/or Alcohol Use/Abuse</b>	
	<ul style="list-style-type: none"> <li>• Bruises (alcohol)</li> <li>• Puffy facies (alcohol)</li> <li>• Hepatomegaly (alcohol)</li> <li>• Weight loss (cocaine, methamphetamine)</li> </ul>
<b>Laboratory</b>	<ul style="list-style-type: none"> <li>• Elevated mean cell volume (MCV), if not taking zidovudine</li> <li>• Elevated gamma-glutamyl transferase (GGT) (associated with alcoholic liver disease, and a more sensitive marker than aspartate transaminase [AST])</li> <li>• AST &gt; alanine transaminase (ALT)</li> <li>• Elevated serum B<sub>12</sub></li> <li>• Healed fractures, especially of ribs</li> <li>• Urine drug screens*</li> <li>• Blood alcohol levels*</li> </ul>

\* Except under certain circumstances (e.g., suspected drug-induced coma), performing toxicology testing without the patient's consent is not appropriate.

### **Ongoing Assessment of Patients with Known Substance/Alcohol Abuse Problems**

If the initial drug screening result is positive, or if the patient has a history of substance use, the clinician should re-evaluate the patient's drug use at least quarterly.

Clinicians should ask patients with a history of substance use about their last use of alcohol and substances to help diagnose relapses earlier and refer the patient back into care.

Clinicians should offer referral to appropriate substance use treatment programs or other substance use services to patients with active substance use/abuse problems.

Blood alcohol levels (BAL) and urine drug screens should not be ordered as routine screening tests. When these tests are performed, patient consent should be obtained.

Clinicians should provide positive feedback to patients who are successfully engaged in a recovery program.

#### Key Point

A refusal for a urine drug screen or blood alcohol level should raise suspicion that the patient has relapsed.

### **CLINICAL ALGORITHM(S)**

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

- Appropriate screening and ongoing assessment for substance use in human immunodeficiency virus (HIV)-infected patients
- Identification of patients who need referral to substance and alcohol treatment units
- Screening for substance use is particularly important in HIV-infected patients because 1) both alcohol and substance use are risk factors for HIV infection acquisition and transmission, and 2) addressing problems associated with substance use can help patients improve adherence with HIV medications and adopt risk-reduction behaviors, such as practicing safer sex.

### POTENTIAL HARMS

Not stated

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening, or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (*HIV clinical practice guidelines*, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience.
- Define target audience (providers, consumers, support service providers).

- Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
  - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
  - What steps need to be taken to make these activities happen?
  - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
  - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
  - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
  - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
  - Did the processes and strategies work? Were the guidelines implemented?
  - What could be improved in future endeavors?

## **IMPLEMENTATION TOOLS**

Personal Digital Assistant (PDA) Downloads

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Living with Illness

### **IOM DOMAIN**

Effectiveness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

New York State Department of Health. Screening and ongoing assessment for substance use. New York (NY): New York State Department of Health; 2005 Mar. 11 p. [8 references]

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

2005 Mar

**GUIDELINE DEVELOPER(S)**

New York State Department of Health - State/Local Government Agency [U.S.]

**SOURCE(S) OF FUNDING**

New York State Department of Health

**GUIDELINE COMMITTEE**

Substance Use Committee

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## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

## **GUIDELINE STATUS**

This is the current release of the guideline.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p.

Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

This guideline is available as a Personal Digital Assistant (PDA) download from the [New York State Department of Health AIDS Institute Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

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