# BEHAVIORAL HEALTH SCREENING TOOLS

## FOR THE CO-LOCATION OF BEHAVIORAL HEALTH SERVICES IN A PRIMARY CARESETTING

Date: August 29, 2017

NYC HEALTH+ HOSPITALS | ONECITY HEALTH

# Introduction
## Today's Presenter

**Jacqueline Delmont, MD, MBA**
*Delmont Healthcare*

Grassi & Co.

General partner questions and comments will be addressed today via the chat function.

# Agenda

1. Introduction
2. Measurement informed care
3. Screening tools
   - Depression
   - Anxiety
   - Alcohol and Substance use
   - SBIRT
   - Co-jointed screening: CAGE-AID

# What is co-location?

## Co-location of behavioral health in primary care settings

- Co-location of mental health and/or substance use services
- Target population: Patients with more complex and stable behavioral health problems (e.g. schizophrenia, bipolar disorder, severe depression, psychoses) that can be appropriately managed in a primary care setting
- Behavioral health services can be provided by a co-located psychiatrist or psychiatric nurse practitioner, preferably supported by psychologist or social worker

# What is co-location?

## Co-location of primary care in behavioral health settings

- Target population: behavioral health patients with difficulty navigating routine primary care services
- Primary care services can be provided by any independently licensed provider (MD, DO, NP)
- Primary care services will include functions including:
  - Standard preventive care services
  - Screening and medical management issues specific to behavioral health population
  - Population health management for common chronic conditions
  - Collaboration with care management services

# Measurement Informed Care

1. Standardizes response to treatment or any intervention
2. Identifies and  targets the symptoms not improving
3. Monitors treatment progress
4. Guides stepped care
5. Improves care quality and clinical outcomes
6. Assists with patient self-management
7. Aligns with health care and payment reform initiatives

# Measurement-based treatment to target for populations

Systematic screening of a target population to proactively identify patients in need of care and improvement rates

Use of a registry to track a defined population of patients with identified behavioral health needs

**BEHAVIORAL HEALTH:**
PHQ-9, GAD-7

**SUBSTANCE ABUSE:**
AUDIT / DAST-10

**“vital signs” of the emotional system**

Adapted from: Behavioral Health Integration Framework Evaluation (BHI-FE) Project

Implementation Guide Supplement. Organized, evidence-based care: BH Integration http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Behavioral-Health-Integration.pdf

# Engaging Patients for Measurement Informed Care

# Approaching Patients with Screening Tools

## Common Patient Questions

## QUESTION

### Why do I need to fill this out?

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## ANSWER

### Normalize the process as part of routine check

in by saying “We give this survey to all our patients”

Adapted from: Behavioral Health Integration Framework Evaluation (BHI-FE) Project

# Approaching Patients with Screening Tools

## Common Patient Questions

## QUESTION

**I don’t have these problems. Why do you want me to fill this out?**

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## ANSWER

**Make a connection between feelings and physical health** by saying “Sometimes feeling sad or depressed can impact your physical health. As part of your overall healthcare it’s important to measure how you’re feeling regularly.”

Adapted from: Behavioral Health Integration Framework Evaluation (BHI-FE) Project

Behavioral Health Patient Screening Questionnaires

# Screening Instrument for Depression: Patient Health Questionnaire (PHQ-9)

# Patient Health Questionnaire: (PHQ-9)

## Screening Instrument for Depression

### OVERVIEW

- The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression
- Incorporates DSM-V depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool
- Rates the frequency of the symptoms which factors into the screening severity index
- Question 9 screens for the presence and duration of suicide ideation

Kroenke et al. The PHQ-9. Validity of a brief depression severity measure. JGIM, 2001. 16,606-616

# Patient Health Questionnaire: (PHQ-9)

## Screening Instrument for Depression

### CLINICAL UTILITY

- The PHQ-9 is brief and useful in clinical practice
- Is completed by the patient in minutes and it is rapidly scored by the clinician ( health provider)
- Can be administered repeatedly to assess improvement or worsening of depression in response to treatment

Kroenke et al. The PHQ-9. Validity of a brief depression severity measure. JGIM, 2001. 16,606-616

# The Patient Health Questionnaire (PHQ-9)

| | NOT AT ALL | SEVERAL DAYS | MORE THAN HALF THE DAY | NEARLY EVERY DAY |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | X |
| 2. Feeling down, depressed or hopeless | 0 | X | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | X | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | X |
| 5. Poor appetite or overeating | 0 | X | 2 | 3 |
| 6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down | 0 | 1 | X | 3 |
| 7. Trouble concentrating on thigs, such as reading the newspaper or watching television | 0 | 1 | 2 | X |
| 8. Moving or speaking so slowly that other people could have noticed. On the opposite-being so fidgety or restless that you have been moving around a lot more than usual | X | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | X | 2 | 3 |
| Add columns | | 3 + | 4 + | 9 |

**TOTAL** 16

Kroenke et al. The PHQ-9. Validity of a brief depression severity measure. JGIM, 2001. 16,606-616

# Measurement Informed Care (PHQ-9): Treatment Recommendations

| PHQ-9 SCORE | Provisional Diagnosis | Treatment Recommendation<br>*Patient Preferences should be considered* |
|---|---|---|
| **5-9** | Minimal Symptoms | Support, educate to call if worse,<br>Return in 1 month & repeat PHQ-9 |
| **10-14** | Moderate Depression<br>Major Depression, *mild* | Antidepressant and/or psychotherapy<br>Antidepressant and/or psychotherapy |
| **15-19** | Major Depression,<br>*moderately severe* | Antidepressant and/or psychotherapy |
| **> 20** | Major Depression, *severe* | Antidepressant and psychotherapy<br>*(specially if not improved on monotherapy)* |

1. Kroenke et al. The PHQ-9. Validity of a brief depression severity measure. JGIM, 2001. 16,606-616.2. http://www.agencymeddirectors.wa.gov/files/AssessmentTools/14-PHQ-9%20overview.pdf

Behavioral Health Patient Screening Questionnaires

# Generalized Anxiety Disorder: Assessment (GAD-7)

# Generalized Anxiety Disorder Assessment (GAD-7)

The GAD-7 originates from Spitzer RL, et al; A brief measure for assessing generalized anxiety disorder. 2006

This easy-to-use self-administered patient questionnaire is used as a **screening tool** and **severity measure**

1. The GAD-7 score is calculated by assigning scores of **0, 1, 2**, and **3**
2. The response categories of **'not at all**', **'several days**', **'more than half the days**', and **'nearly every day'**
3. Adding together the scores for the seven questions

1. Swinson RP. The GAD-7 scale was accurate for diagnosing generalized anxiety disorder. Evid Based Med. 2006 Dec 11(6):184. **2**. Spitzer et al. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22 166(10):1092-7. **3**. Kroenke et al. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007 Mar 6 146(5):317-25. **4**. GAD-7 © Pfizer Inc. all rights reserved; used with permission.

# Generalized Anxiety Disorder Assessment (GAD-7)

GAD-7

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | X | 3 |
| 2. Not being able to stop or control worrying | 0 | X | 2 | 3 |
| 3. Worrying too much about different things | 0 | X | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | X | 3 |
| 5. Being so restless that it is hard to sit still | X | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | X | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | X | 3 |

Total Score 8 = Add Columns 2 + 6 + 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | X | ☐ | ☐ |

**SCORES:**

| | |
|---|---|
| **5-9** | Mild Anxiety |
| **10-15** | Moderate Anxiety |
| **>15** | Severe Anxiety |

When used as a screening tool, further evaluation is recommended when the score is **10** or greater

Do not forget to rule out medical causes of anxiety before diagnosing an anxiety disorder (for example, EKG for arrhythmias, TSH for thyroid disease).

# Generalized Anxiety Disorder Assessment (GAD-7)

## Using the threshold score of 10

**For Generalized Anxiety Disorder**

**89%** sensitivity

**82%** specificity

It is moderately good at screening three other common anxiety:

**For Panic Disorder**
**74%** sensitivity
**81%** specificity

**For Post-traumatic Stress Disorder**
**66%** sensitivity
**81%** specificity

**For Social Anxiety Disorder**
**72%** sensitivity
**80%** specificity

**1.** Swinson RP. The GAD-7 scale was accurate for diagnosing generalized anxiety disorder. Evid Based Med. 2006 Dec 11(6):184. **2**. Spitzer *et al.* A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22 166(10):1092-7. **3**. Kroenke *et al.* Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007 Mar 6 146(5):317-25. **4**. *GAD-7 © Pfizer Inc. all rights reserved; used with permission.*

# Measurement Informed Care (PHQ-9 / GAD-7): Adjusting Treatment Plans

*A stepped care algorithm for treatment plans can be developed and adjusted for your clinic's needs

| PHQ-9 / GAD-7 | Treatment Response | Treatment Plan |
|---|---|---|
| Drop of 5 points from baseline & < 10<br>*(or 50% reduction from baseline)* | **ADEQUATE** | No treatment change needed<br>Follow-up in 4 weeks |
| Drop of 2-4 points from baseline | **POSSIBLY INADEQUATE** | May warrant an increase in antidepressant dose |
| Drop of 1 point, no change, or increase | **INADEQUATE** | Increase medication dose;<br>Augmentation;<br>Informal or formal psychiatric evaluation;<br>Add or adjust psychotherapy |

Adapted from: Behavioral Health Integration Framework Evaluation (BHI-FE) Project

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## Screening, Brief Intervention and Referral to Treatment (SBIRT)

### Components

- **Universal Annual Screening (S)** identifies unhealthy use.

  **ASK AND ASSESS**
  75-85% of patients will screen negative.
- **Brief Intervention (BI)** provides feedback about unhealthy substance use. It also focuses on education, increasing patient insight and awareness about risks related to unhealthy substance use, and enhances motivation toward healthy behavioral change.
- **Referral to Treatment (RT)** helps facilitate access to addiction assessment and treatment. A referral is usually indicated for only about 5% of people screened.

http://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

**Screening, Brief Intervention and Referral to Treatment (SBIRT)**

**Components**

- **Universal Annual Screening (S)**

  **Ask and Assess**
  **Screening strategies:**

  - **Standard Approach AUDIT/DAST:** longer, better when using an EHR requires scoring but has been more rigorously tested
  - **Quick Approach CAGE-AID:** can be completed within a few minutes.

http://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf

Substance Abuse Patient Pre-Screening & Screening Questionnaires

# The Alcohol Use Disorders Identification Test (AUDIT):
# Pre-Screening: AUDIT-C
# Screening: AUDIT FULL

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care.2001

# Pre-Screening: The AUDIT-C Questionnaire

**The AUDIT-C** is a 3-item alcohol screen that can help identify people who are hazardous drinkers or have active alcohol disorders

1. **How often do you have a drink containing alcohol?**
   a. Never
   b. Monthly or less
   c. 2-4 times a month
   d. 2-3 a week
   e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   a. 1 o 2
   b. 3 o 4
   c. 5 o 6
   d. 7 o 9
   e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   a. Never
   b. Less than monthly
   c. Monthly
   d. Weekly
   e. Daily or almost daily

# Scoring: The AUDIT-C Questionnaire

**The AUDIT-C is scored on a scale of 0-12**

a. 0 points
b. 1 point
c. 2 points
d. 3 points
e. 4 points

**POSITIVE SCORE:**

**Men: 4 or more**

**Women: 3 or more**

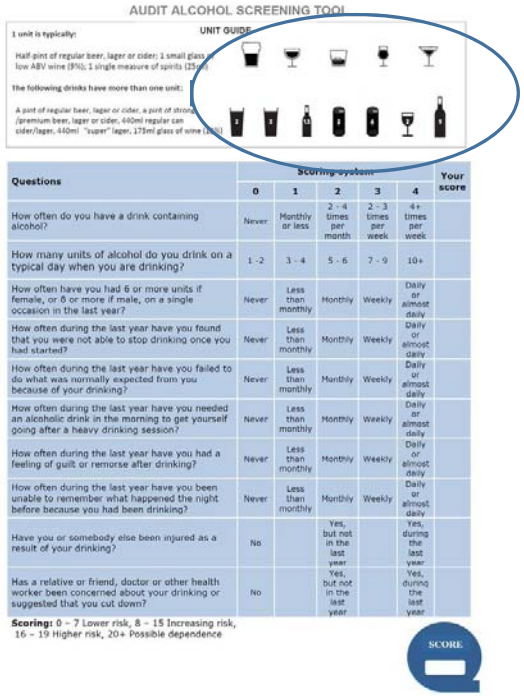
## CONSIDERATIONS

When the points are all from question # 1 alone

1. It can be assumed that the patient is drinking below recommended limits
2. Review alcohol intake over the past few months to confirm

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care. 2001

# The Alcohol Use Disorders Identification Full Test (AUDIT)



AUDIT ALCOHOL SCREENING TOOL

UNIT GUIDE

| Questions | Scoring system: 0 | 1 | 2 | 3 | 4 | Your score |
|---|---|---|---|---|---|---|
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| Have you or somebody else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

SCORE

Self-report version of the AUDIT

**A self-report version of the AUDIT**

**A clinician-administered version of the AUDIT**

Is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems

Patients should be encouraged to answer the AUDIT questions in terms of standard drinks

A score of 8 or more is considered to indicate hazardous or harmful alcohol use

The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well suited for use in Primary Care settings

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care. 2001

# The Risk Levels of Intervention: AUDIT

| RISK LEVEL | INTERVENTION | AUDIT SCORE |
|---|---|---|
| **Zone I- Healthy** | Alcohol Education | **0-7** |
| **Zone II - Risky** | Simple Advise | **8-15** |
| **Zone III - Harmful** | Simple Advise plus Brief Counseling and Continued Monitoring | **16-19** |
| **Zone IV- Dependent** | Referral to Specialist for Diagnostic Evaluation and Treatment | **20-40** |

Review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10)

Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care. 2001

Substance Abuse Patient Pre-Screening & Screening Questionnaires

# The Drug Abuse Screening Test (DAST): Pre-screening: DAST-10 Screening: DAST-20

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care.2001

# The Drug Abuse Screening Test (DAST-10)

## CONSIDERATIONS

- Is a **10-item brief screening tool** that can be administered by a clinician or self-administered
- Each question requires a **yes or no** response, and the tool can be completed in less than 8 minutes
- This tool assesses drug use, not including alcohol or tobacco use, in the **past 12 months**

http://www.drugabuse.gov/nidamed-medical-health-professionals

# DAST – 10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

| These questions refer to the past 12 months | NO | YES |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | 0 | 1 |
| 2. Do you abuse more than one drug at a time? | 0 | 1 |
| **3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."** | 1 | 0 |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use? | 0 | 1 |
| 5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No." | 0 | 1 |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | 0 | 1 |
| 7. Have you neglected your family because of your use of drugs? | 0 | 1 |
| 8. Have you engaged in illegal activities in order to obtain drugs? | 0 | 1 |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | 0 | 1 |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | 0 | 1 |

http://www.drugabuse.gov/nidamed-medical-health-professionals

# The Risk Levels of Intervention: DAST-10

| RISK LEVEL | INTERVENTION | DAST SCORE |
|---|---|---|
| **Zone I- Healthy** | None | **0** |
| **Zone II - Risky** | ▪ Offer advise on benefits and importance of remaining drug abstinent.<br>▪ Monitor and reassess next visit<br>▪ Consider providing educational materials | **1-2** |
| **Zone III - Harmful** | ▪ Brief intervention<br>▪ Brief treatment | **3-5** |
| **Zone IV- Dependent** | Referral to Specialized treatment | **6 +** |

**Brief intervention:** Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as screening. The recommended behavior change is to abstain from illicit drug use.

**Referral to specialized treatment:** A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care. 2001

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## Screening, Brief Intervention and Referral to Treatment (SBIRT)

### Components

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# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## Step I. ASK about alcohol and drug use

### Alcohol Use

- **Do you sometimes drink beer, wine or other alcoholic beverages?**

  **If negative, reinforce their healthy decisions**

  **If positive, Your patient has at least RISKY drug use.**

***Proceed to AUDIT C.***

- How often do you have a drink containing alcohol?
- How many standard drinks containing alcohol do you have on a typical day?
- How often do you have six or more drinks on one occasion?

**POSITIVE SCORE:**

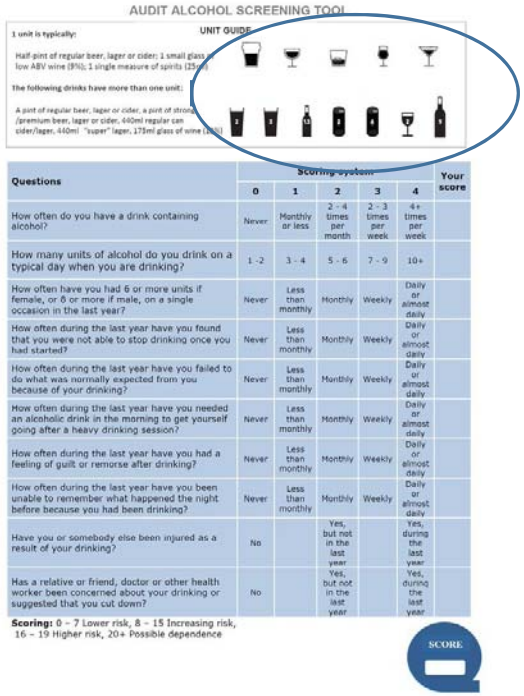
**Men: 4 or more**

**Women: 3 or more**

***If positive, go to STEP 2A –*** **ASSESS with Full AUDIT**

http://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf

# The Alcohol Use Disorders Identification Full Test (AUDIT)



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| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
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| Have you or somebody else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

SCORE

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# Substance Abuse Patient Pre-Screening & Screening Questionnaires

**Step I. ASK about alcohol and drug use**

**Drug Use**

- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons

**If negative, reinforce their healthy decisions.**

**If positive, Your patient has at least RISKY drug use.**

**Go to STEP 2B – *ASSESS with DAST-10.***

http://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf

# DAST – 10 Questionnaire

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If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

| These questions refer to the past 12 months | NO | YES |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons? | 0 | 1 |
| 2. Do you abuse more than one drug at a time? | 0 | 1 |
| **3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."** | 1 | 0 |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use? | 0 | 1 |
| 5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No." | 0 | 1 |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | 0 | 1 |
| 7. Have you neglected your family because of your use of drugs? | 0 | 1 |
| 8. Have you engaged in illegal activities in order to obtain drugs? | 0 | 1 |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | 0 | 1 |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | 0 | 1 |

http://www.drugabuse.gov/nidamed-medical-health-professionals

Substance Abuse Patient Pre-Screening & Screening Questionnaires

# CAGE-AID
# Ask about alcohol & drug use
# Assess for alcohol and/or drug severity

AUDIT. World Health Organization. Department of Mental Health and Substance abuse. Second edition. Guide for Primary Care.2001

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## CAGE-AID

### I. Ask about alcohol and drug use

Alcohol Use

- Do you sometimes drink beer, wine or other alcoholic beverages?

If YES,

- How many times in the past year have you had 5 or more drinks (4 for women and men over age 65)
- On average how many days a week do you have an alcohol drink?
- On a typical drinking day, how many drinks do you have?

Drug Use

- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons

**One or more is considered positive**

**If positive, go to STEP 2.**
**Your patient has at least RISKY alcohol and/or drug use.**

**If negative, reinforce their healthy decisions.**

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. Arch Intern Med. 2010; 170(13): 1155-1160

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## CAGE-AID

### II. Assess for alcohol and/or drug severity

- Have you ever felt that you ought to **cut down** on your drinking or drug use? (Y/N)
- Have people **annoyed** you by criticizing your drinking or drug use? (Y/N)
- Have your ever felt bad or **guilty** about your drinking or drug use? (Y/N)
- Have you ever had a drink or used drugs first thing in the morning **(eye opener)** to steady your nerves or get rid of a hangover? (Y/N)

**Each Yes response equals 1**

**0-1 Yes** Risky use
**>1 Yes** Further diagnostic evaluation and & referral

JA Ewing "Detecting Alcoholism: The CAGE Questionnaire" JAMA 252: 1905-1907, 1984
Brown R, Rounds, L. Conjoint screening questionnaires for alcohol and other drug abuse: Criterion validity in a primary care practice. WMJ. 1995; 94(3): 135-140.

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## CAGE-AID

**I. Ask about alcohol and drug use**

Alcohol Use

- Do you sometimes drink beer, wine or other alcoholic beverages?

Drug Use

- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons

**If positive, go to STEP 2. Your patient has at least RISKY alcohol and/or drug use.**

**If negative, reinforce their healthy decisions.**

Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. Arch Intern Med. 2010; 170(13): 1155-1160

# Substance Abuse Patient Pre-Screening & Screening Questionnaires

## CAGE-AID

### II. Assess for alcohol and/or drug severity

- Have you ever felt that you ought to **cut down** on your drinking or drug use? (Y/N)
- Have people **annoyed** you by criticizing your drinking or drug use? (Y/N)
- Have your ever felt bad or **guilty** about your drinking or drug use? (Y/N)
- Have you ever had a drink or used drugs first thing in the morning **(eye opener)** to steady your nerves or get rid of a hangover? (Y/N)

**1 Yes** Risky use
**>1 Yes** Further diagnostic evaluation and & referral

*JA Ewing "Detecting Alcoholism: The CAGE Questionnaire" JAMA 252: 1905-1907, 1984*
*Brown R, Rounds, L. Conjoint screening questionnaires for alcohol and other drug abuse: Criterion validity in a primary care practice. WMJ. 1995; 94(3): 135-140.*

# Previous Webinars to Support Implementation

- Physical health screening approaches
- Behavioral health screening tools
- Measurement and quality improvement
- Billing guidance

Webinar recordings available at:
http://www.onecityhealth.org/webinar-series-co-location-primary-care-behavioral-health-services/

# Questions?

# For more information

**ONECITY HEALTH SUPPORT DESK:**

Call 646-694-7090

Email ochsupportdesk@nychhc.org with the subject line “PCBH Integration Question”

Hours of Operation:
Monday through Friday
9am to 5pm ET

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