

CDC *Vital Signs* Town Hall Teleconference
Q&A

Alcohol Screening and Brief Counseling: An Important Part of Adult Preventative Care
January 14, 2014
2:00 pm EST

Dr. Dan Baden: All right, I want to thank you all for those excellent presentations. At this point I'd like to remind everyone that you can get in queue to ask a question by pressing star 1, say your name when prompted. And then you'll be announced into the conference by the operator when it's your turn to ask your question.

I want to encourage you to take advantage of this opportunity to share your own strategies, lessons you've learned, challenges, or other success stories. At this point, Angela do we have any questions in the queue?

Coordinator: Yes. Our first question comes from Mary Applegate with the University of Albany.

Mary Applegate: Hi. I was interested in hearing what the epidemiology is broken down by age groups. And if there are any particular strategies that are more useful than others in different age groups.

Dr. Lela McKnight-Eily: This is Lela McKnight-Eily—Are you asking based upon the MMWR report in terms of healthcare provider discussions what the prevalence was of that age group? I'm sorry.

Mary Applegate: Are providers more or less likely to ask about alcohol use with different age groups?

Dr. Lela McKnight-Eily: Okay, so I can speak to that for the overall MMWR from the 44 states and DC. We did find that person's 18 to 24 were more likely to report having this discussion with a doctor or other health professional.

And we know that person's 18 to 24 also are more likely to report excessive alcohol use, despite the fact that it is a problem across the board by age groups. Even among older adults who might have a higher frequency of binge drinking occurrences.

So it's an issue across the board. The US Preventive Services Task Force recommendation is for adults at this time.

Mary Applegate: Thanks.

Dr. Dan Baden: Okay operator, next question.

Coordinator: The next question comes from Susan Miller with Methodist Hospital Research Institute.

Susan Miller: I want to thank everyone for this wonderful presentation. Did the patients as they participated in the surveys give any negative feedback from this? And are there confidentiality issues in terms of medical record documentation?

Dr. Sheryl Sun: I can speak to some of that. At Northern California Kaiser we've been doing this for about six months. And I've not heard a single complaint from patients, about being asked these questions.

It's usually often surprise at what the low-risk drinking limits are considered because probably one of the most common scenarios is someone who is having two or three glasses of wine every night with dinner. And they consider that to be fine and not a problem.

And then when you talk about it it's above what's considered the safe limits. And you can often link that to their hypertension, their obesity, their insomnia, et cetera. And it's really an educational opportunity for the patient and an opportunity for improving their health and solving some of those problems. So it's been I think very well received.

Dr. Hillary Kunins: In New York City, I'll just add to that, our program has been well received in our STD clinic program with good patient acceptance. And I'll also add that there is literature in the SBI intervention world surveying patient satisfaction. And there are high levels of patient acceptability and satisfaction with being asked about their alcohol use.

Susan Miller: That's very helpful. Thank you.

Coordinator: Our next question comes from Charlene Howard with SAPTA.

Charlene Howard: Hello. Thank you. I have a logistics question for Dr. Kunins. Dr. Kunins when a patient has been identified say by a medical assistant for being positive for safe limits of drinking, at what point does that clinic assistant counsel that person? Is it the same visit in the same, while there in the room, before they see the doctor? Or how does that work?

Dr. Hillary Kunins: So let me - this is Hillary Kunins. And I'll also ask Dr. Sun to weigh in. I think her perspective might be useful as well.

Let me just stress that there are - the way that we are doing it is not necessarily the way it must be done. And our experience in working with different practices is that different practices make different choices about how and where to do those handoffs.

In our STD clinic, the initial screen is on paper. And then the patient meets with an interventionist who takes them through all the rest of the steps.

In contrast, and some of the practices we've worked with the medical assistant might do a screen in person, provide some initial counseling, and then bring the patient - and the patient off to either the physician or nurse practitioner or physician assistant who will be seeing the patient in sort of a warm handoff to continue the conversation.

Dr. Sheryl Sun: Yes. In our system the medical assistant does the screening. And then were not - we don't expect their medical assistants who have a lot of other work to do to get involved in doing any kind of counseling with the patient.

But then when the physician opens the chart, it's right there. That being our best practice alert that this patient is drinking above unhealthy limits. And it's then up to the physician to do the counseling.

And we often - it's just, it's so common that you are able to leave that into may be the immediate concern that the patients actually there for or to tie it to some of the patient's chronic medical conditions when you do the counseling.

Because the vast majority of the time the patient is not answering positive to the dependence questions they're - those are - they're negative on those. But they're just drinking above the unhealthy, for what are considered healthy safe limits.

And just some brief counseling, brief intervention about what those are and advice to cut back takes a minute or two of the physician's time to quickly...

Charlene Howard: Okay thank you.

Coordinator: Next question comes from Gerry King with New York State OASAS.

Gerry King: Yes, this is for Dr. Kunins. You mentioned in your presentation the lessons learned, reimbursement minimal, or nonexistent. Could you just sort of expand on that? Is that because of the rates for the payments are low? Or is there problems with the reimbursement with the codes or modifiers? Or if you could just expand on that a little bit?

Dr. Hillary Kunins: Hi Gerry.

Gerry King: Hi. How are you?

Dr. Hillary Kunins: So as many of us are finding, a couple of things happened we believe. And we are very much sorting this out.

One is as you know, many folks are working in safety net systems or within managed care payers, often services are bundled. So though there are Medicaid specific rates, often care happens or is reimbursed in a bundled or capitated fashion. So we've identified that as one potential issue.

Another issue is that sometimes practices are getting some reimbursements, but because they are modest, sometimes the billing and coding falls away instead of I guess that being reinforced. So that is another issue.

And much of our work, as is obviously is happening just before full ACA implementation. So some of this may change as ACA implementation unfolds more fully.

Dr. Lela McKnight-Eily: This is Lela McKnight-Eily from CDC. I also wanted to add that I think key to what both other presenters indicated is that there has to be a systems level type of change for it to really currently be integrated.

Agencies like SAMHSA, they're working with CMS to educate health providers about Medicare billing and insurance coverage. And there are codes out there but I think that it's moving to a necessary but definitely not efficient aspect of implementation.

For SBI to be effective we integrated it into a healthcare system, there are some economic studies that indicate I think in trauma settings may be for every dollar spent that there's four dollars saved.

So even if there's not, I guess billing and coding are occurring they're still can be cost savings in a variety of different ways.

Gerry King: Thank you.

Coordinator: Our next question comes from Amanda Toohey with the Texas Office for Prevention of Developmental Disabilities.

Amanda Toohey: Hi. Many of the screening tools evaluate risky drinking. And because there is no known safe amount for pregnant women, no known safe amount of alcohol, which tool do you all recommend for use with screening pregnant women and/or providing them with brief interventions?

Dr. Lela McKnight-Eily: I think this is - I'll let the other speakers answer as well. But you can still use like the AUDIT or the AUDIT-C because you're trying, in the screening you're really trying to understand the person's pattern of consumption.

In your correct. If a pregnant woman is indicating drinking at all, then you're going to want to do a brief counseling intervention. But you want to also

better understand her pattern of consumption to determine the level of help that she's going to need to decrease her consumption of alcohol.

Dr. Sheryl Sun: Yes, in the Kaiser system we would advocate absolutely no alcohol consumption for pregnant women and if the patient is pregnant and screens positive for that in our OB/GYN clinics, they're placed in sort of the high risk pregnancy queue and get a lot of counseling and intervention and support around that.

Dr. Dan Baden: Okay. Are there any more questions in the queue Angela?

Coordinator: Yes. Our next question comes from Bertha Madras with Harvard Medical Group.

Bertha Madras: Yes, this is Bertha Madras. I just have a few questions, which I'll try to be very brief with. The first one is in terms of the two centers that we've heard from, the Kaiser Permanente and New York City, how many of these locations that are being tracked had a follow-up information with regard to reduction in drinking as well as improvement in overall health and specific health? So, that's question number 1.

Dr. Sheryl Sun: In the Kaiser Permanente we just started this six months ago. So we don't have any follow up data on it yet. That is something we will be able to get probably over the next year or two to see if counseling and intervention has made a difference.

Since we'll be screening these people annually, you'll be able to compare their answers to the questions from one year to the next. But since I just started six months ago, we don't have that kind of data yet.

Bertha Madres: The reason I ask is because if there are locales, especially as was mentioned in New York City where there's bundling of services and capitation; it may be that one can argue very forcefully for implementing of these services, especially where there's capitation and a potential consequent reduction in healthcare costs because of a provision of these services.

The second question I had was with regard to how many physicians actually ask their patients in intake on alcohol. I wonder how many have this on an intake sheet, just a plain sheet of paper, do you drink? Or do you drink excessively?

And that is or is not counted. And whether or not those questions have any efficacy whatsoever. In other words, do they give the physician a sense of peace of mind when they ought not have it by having them on a written sheet that a patient fills out prior to an examination?

Dr. Hillary Kunins: This is Hillary in New York City. I just, to go back to your first question just for a moment and then in part on to the second. The program that we're operating in our STD clinics is in the process of a evaluating the impact on drinking.

And I should just note that this is, as you can understand, a specialized populations seeking care for possible STD. And the efficacy and effectiveness of screening and brief intervention and not population has not been as clearly demonstrated as in primary care and emergency department populations.

And so Dr. Madras, I really appreciate that need to make the case to payers. And despite sort of the infancy of some of our evaluation data, I do think that there is a strong scientific evidence base for both effectiveness and cost savings among the citations that I'm aware of is the early work by Michael

Fleming who did a large randomized trial in primary care practices, including a cost savings of this intervention.

Bertha Madras: There are many - there are at least 10 manuscripts on cost savings. I think what is really needed is to show the cost savings have usually been documented on the basis of re-hospitalization and the need for extra medical care.

But I'm just wondering whether or not, you know, Janet Mertins and Connie Reisner over at Kaiser Permanente who have done such a good job in documenting the association between substance use disorders and healthcare, whether or not this whole cost savings and improved healthcare can be expanded into - in and of itself in a real study that will help if we are moving towards capitation, which I think in some cases we probably are.

So I think we have to expand and brought in the scope of the type of follow-ups that are done in order to account for and generate a far larger database that will help convince healthcare providers of the value and validity of this not only for cost, but also for health benefits.

Dr. Hillary Kunins: Thank you for that insight and it challenges us to continue with our evaluation work.

Dr. Sheryl Sun: And in Kaiser Permanente, we will have a huge database within a couple of years that are divisional research I'm sure will be looking at to try to get that kind of information.

But I think we're fairly confident that doing this, it's the right thing to do. It's been endorsed by the US Preventative Services Task Force. And we really try to follow what they say in our organization and feel very confident that it will improve the health of our patients.

Dr. Lela McKnight-Eily: And I think you hit on a very good point, several good points also. But one is that you don't just want to ask any question. You really should be using validated screening questions like the AUDIT, the AUDIT-C, or the single question screener so that you can get the type of information that's appropriately needed to follow-up.

It's not enough just to ask. A lot of the questions on forms in the past have been questionnaires that focus on dependence. And so therefore the larger population of people who drink excessively or who drink riskily may not even be reached if they don't give the appropriate questions. So I think that that was a really good point that you hit on.

Dr. Dan Baden: Okay fabulous discussion. I think we have one last question before we close up.

Coordinator: Yes, our last question comes from Jacquelyn Serrano with Alaska Family Medicine Residency.

Jacquelyn Serrano: Hi. So I just did a quick search on my iPhone for any validated screening tools in the app store. And there were none. I looked on Epocrates. And I checked the EPSS, US Preventative Services Task Force tool for my phone. And I didn't find any of the validated alcohol screening tools on there.

Do any of you know if there is a validated app for an iPhone or an Android for doctors who use those a lot in their practice for doing the automated screening? I because I know the AUDIT- C has all the different numbers. And you got to add them up and all of that. And that takes time.

So just wondering if that is available. And if so, or if not then I would recommend that maybe someone work on getting that developed.

Dr. Sheryl Sun: Yes I mean the questions we use for Kaiser are those very specific questions are ones that are validated. I don't know if there's an app available for that or not. I defer to the other speakers if they know about that.

Dr. Dan Baden: Well it sounds like that might be a good tool to be developed. This is Dan Baden.

I want to thank everyone for the fabulous discussion, great questions. It was fabulous. Thank you for your participation. We would like to try and improve this process. So before we close, if you could let us know feedback, anything we can do to improve this. Please email us at ostltsfeedback@cdc.gov. That's O-S-T-L-T-S feedback, all one word, at CDC dot gov.

We also hope that you'll be able to join us for next month's call, which will be focusing on the use of car safety seats for children. That will be on February 11. So thank it one last time to the presenters and to everyone who participated. And that's it for today's call. Goodbye.