

CDC *Vital Signs* Town Hall Teleconference

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

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer session of the call. If you would like to ask a question at that time, please press star then 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I'd like to turn over the meeting to Dr. Dan Baden. You may begin.

Dr. Dan Baden: Thank you Angela. Good afternoon everyone. I'm Dr. Dan Baden, I'm the associate director for External Partner Outreach and Connectivity in CDC's Office for State, Tribal, Local and Territorial Support. Welcome. I'm glad you could join us today.

Today we're going to be discussing the latest *Vital Signs* report on alcohol screening and brief counseling. Before we get started, I wanted to go over some housekeeping details if I could.

You can go online and download today's PowerPoint presentation so you can follow along with the presenters. The web address is www.cdc.gov/stltpublichealth, again that's S-T-L-T public health.

There's a link directly to the *Vital Signs* town hall webpage under highlighted products and resources on the lower right side of the page. On this town hall webpage you can also view biographies for each of the presenters. This is where we'll have the audio recording in transcript from today's teleconference. And it should be available next week.

But back to our topic. Alcohol screening and counseling is an important public health topic because drinking too much is the fourth leading preventable cause of death. At least 38 million adults in the US drink too much causing about 88,000 deaths in the US each year, and costing the economy about \$224 billion.

Alcohol screening and brief counseling can reduce drinking on an occasion by 25% in people who drink too much. But most adults have not talked to a health professional about how much they drink.

A couple of ways that help departments and community organizations can help are to encourage healthcare plans and provider organizations to start screening and counseling, and to consider alternative ways to deliver these services in state and community programs using computers, smart phones and other electronic devices.

On today's call we're going to hear from three colleagues. First we'll hear from Dr. Lela McKnight-Eily, a licensed clinical psychologist and epidemiologist formerly with the Excessive Alcohol Use Prevention Team at the National Center for Chronic Disease Prevention and Health Promotion, and currently with the Fetal Alcohol Center and Prevention Team in the National Center for Birth Defects and Developmental Disabilities here at CDC. She'll provide a summary of this month *Vital Signs* report.

Dr. McKnight-Eily will hand over the call to Dr. Sheryl Sun, the chair of the Chiefs of Adult and Family Medicine and chief of Adult and Family Medicine at Santa Clara Medical Center for Kaiser Permanente of northern California. Dr. Sun will share key findings on lessons learned from Kaiser Permanente's experience implementing alcohol screening and brief intervention in northern California.

Dr. Sun will hand the call over to Dr. Hillary Kunins, assistant commissioner for the Bureau of Alcohol and Drug Use Prevention, Care and Treatment at the New York City Department of Health and Mental Hygiene. Dr. Kunins will discuss the screenings and brief intervention program at the New York City Department of Health and Mental Hygiene.

There will be time for questions and answers after the presentation today. But you can get in queue at any time to ask a question. Just press star 1 and record your name when prompted. And now I'll turn the call over to Dr. McKnight-Eily.

Dr. Lela McKnight-Eily: Good afternoon. Today I will be discussing highlights from the *Vital Signs* and NWR report communication between health professionals and their patients about alcohol use.

Slide 5, drinking too much also called excessive or risky drinking, is a major public health problem associated with a number of chronic diseases, birth defects, and injuries including heart disease, breast cancer, fetal alcohol spectrum disorders, sudden infant death syndrome, motor vehicle crashes, and violence.

As Dr. Baden said, it is responsible for 88,000 deaths per year, making it the fourth leading preventable cause of his death in the United States. Further, economic costs of drinking too much were estimated to be nearly \$224 billion in 2006, or \$1.90 drink.

Slide 6, drinking too much, the problem in adults. One in three US adults drink too much. But only a small number, 4% of US adults are considered alcoholics or alcohol dependent. In fact, for every alcoholic there are six people who drink too much who are not alcohol dependent. Characteristics of

alcoholism include not being able to stop or reduce drinking and continue to drink despite problems.

The CDC estimates that in 2011 one and six adults reported at least one episode of binge drinking in the past month. Binge drinking is defined as four or more drinks per occasion for women and five or more for men. And generally leads to a blood alcohol concentration level of .08, or the level of legal intoxication. An occasion is generally defined as two hours.

The National Institute on Alcohol Abuse and Alcoholism estimates that 10% of adults exceed weekly limits. That's eight or more drinks for women and 15 or more for men and daily limit.

And 7.6% of pregnant women reported any alcohol use, 1.4% reported range drinking in the past month according to 2011 CDC BRFSS estimates.

Slide 7, so what is alcohol screening and brief counseling? Alcohol screening and brief counseling focuses on the non-dependent majority of adults who drink too much.

It involves the use of a standardized screening instrument like the alcohol use disorders identification test, or AUDIT, or an approved single questions screener to determine the patients who drink too much.

For those who do, brief counseling interventions for patients which are 6 to 15 minute sessions with the health professional where a plan for reducing drinking given health, legal and social concerns is established. And then the patient is followed up with to determine if they are drinking less.

Again, the small percentage of alcoholics, an estimated 4% of the US population only, can be referred for specialized treatment.

Alcohol screening and brief counseling was ranked as one of the five most effective and cost-efficient underutilized clinical preventive services by the National Commission on Prevention Priorities.

It was recommended by the US Preventive Services Task Force in 2004 and again in 2013 for all adults in primary care, including pregnant women based upon the evidence of effectiveness. And is now covered with out to co-pay by the Affordable Care Act for new insurance plans.

Slide 8 please. For this *Vital Signs* report, we analyzed Behavioral Risk Factors Surveillance System data (BRFSS) collected from over 166,000 adults in 44 states and DC from August 1 through December 31, 2011.

The BRFSS is an annual state-based telephone administered survey of non-institutionalized US adults. And the single question was added to the emerging core of the survey with the following lead-in.

The next question is about counseling services related to prevention that you might have received from a doctor, nurse, or other health professional. The single question, has a doctor or other health professional ever talked with you about alcohol use been followed?

For responses of yes, persons were then asked when a talk occurred, including ever or in the past year. We analyzed data from this question by selected demographic characteristics and drinking patterns in the past month.

Slide 9, key findings from the *Vital Signs* report are that only a small number of US adults, one in six or 15% reported ever discussing alcohol use with a health professional.

Current drinkers only reported this discussion slightly more than non-drinkers. And a fourth of binge drinkers reported discussing alcohol use with a health professional in comparison to one in seven non-binge drinkers.

Slide 10 please. This figure indicates that among binge drinkers, nearly a fourth or 23% of those reporting one to two episodes in the past 30 days had ever discussed alcohol use with a health professional.

This percentage only increased to 34% among those reporting 10 or more episodes during the past 30 days. This suggests ample missed opportunities to intervene with those who drink too much, even at the highest levels.

Prevalence estimates varied by state, but were generally around to the overall estimate of one in six adults. Still suggesting low levels of alcohol screening and counseling at the state level, particularly given that a conversation is the usual method of delivery for this clinical preventive service.

So in summary, few US adults surveyed by the 2011 BRFSS emerging core questionnaire reported ever discussing alcohol use with their doctor or other health professional despite the proven effectiveness of alcohol screening and brief counseling.

Healthcare systems level changes are needed to increase implementation. And these changes could include the inclusion of alcohol screening and brief counseling in health insurance plans as a standard of care.

Therefore, all patients would be screened for drinking too much as part of usual services. And those who screened positive would receive brief counseling and follow-up.

Also teaching a variety of health providers including nurses, social workers, and psychologists how to do alcohol screening and counseling at various levels of training.

Increasing the knowledge of health providers of the importance of alcohol screening and counseling in treating their patient's overall health. Addressing perceived barriers to implementation, which might include time or the efficacy of the provider to do the intervention.

The adaptation of approved clinical guidelines and implementation guidelines for medical practices or health system. In the consideration of inclusion of alcohol screening and brief counseling in the electronic health records privacies, potentially including meaningful use.

The Community Preventive Services Task Force recently recommended electronic methods of alcohol screening and brief intervention as effective in reducing excessive consumption. And then the continued monitoring of implementation through state-level surveillance and evaluation.

Thank you for your time and attention. I would like to now turn over the presentation to Dr. Sheryl Sun from Kaiser Permanente.

Dr. Sheryl Sun: Thank you Lela. Thank you very much anyway. I'm thrilled to be here. I'm on Slide 14, by the way. I'm thrilled to be here to share with you today what we've done at Northern California Kaiser Permanente around alcohol screening and the unhealthy use of alcohol.

In northern California, I'm now on slide 15, we serve 3.4 million members. That's about one of every hundred Americans. And we have about 40% of the commercially insured population in our area.

We have about 2,000 adult primary care physicians who are both internists and family medicine physicians. And we're a prepaid, integrated healthcare system with medical, psychiatric, and chemical dependency services available.

On slide 16, it's in everyone's interest to screen for unhealthy alcohol use. It exacerbates or makes more difficult to control many common conditions that we see in primary care, from hypertension to acid reflux to insomnia to depression, panic disorders, sleep apnea, diabetes.

It also increases the risk for injuries, motor vehicle accidents, increases the risk for breast, colon, and head and neck cancers, and for sexually transmitted infections. It also makes patients more unlikely to take their medications correctly.

For primary care physicians in our medical home type model, it's really in my interest if I can improve my patient's health, I might be a little less busy. And so it's really in all of our interests to identify unhealthy alcohol use and counsel about it and educate our patients.

On slide 17, this is how this effort started. So a few years ago about 54 of our primary care modules in Northern California Kaiser Permanente were involved in what was called the ADVISE study, the alcohol drinking as a vital sign study that was funded by the NIAAA.

In what we found in that study was that the medical assistance were really good at screening and asking the questions in a systematic fashion. And the physicians were much better at delivering the advice and counseling about unhealthy drinking behavior.

And the physicians were not that good at systematically asking the screening questions. And in the modules involved in that study, every patient was asked the questions so that alcohol screening was normalized just as we had been asking about smoking for about a decade.

On slide 18, we took the learnings basically from that study and rolled out what we called “Alcohol as a Vital Sign” last June. More than a decade ago we had rolled out BMI, or body mass index as a vital sign. In several years ago we rolled out smoking as a vital sign. So this was sort of just the latest in a series of things we considered to be vital signs for the patient’s health.

And so all patients 18 years old and above are screened annually. The medical assistant screens for unhealthy daily and weekly alcohol use. And if either of those are positive, the physician asks two dependence questions.

And if either of those dependence questions are positive, the physician can then refer the patient to the chemical dependency programs. And if the dependence questions are negative, then we do the brief intervention and advice to cut back to the lower risk limits. And really try to attempt to link that to the patient’s medical issues.

On slide 19, these are the questions that appear on what we call our Medical Assistant Smart Form Rooming Tool, which is embedded in the electronic medical record. And again the questions appear once a year for patients 18 and above.

Or if they’ve screened actually positive for unhealthy use on either the daily or the weekly limits, then the questions actually will appear again in six months if that patient comes in for an office visit.

The first question, how many times in the past three months have you had five or more drinks containing alcohol, is age and gender specific. So the five would be what would come up if the patient was a man under 65. If it was a man over 65 or a woman, it would come up as four drinks.

And then you can see the other questions. On average, how many days a week do you have an alcohol drink? And on a typical drinking day how many drinks do you have? And the electronic record does the calculation.

One of the other things we did was that this poster was given to all the primary care physicians to display in their exam rooms to normalize screening and do some education about the size of drinks and what the low risk limits are.

And I will tell you personally this is the thing on my exam room bulletin board that I get the most comments and questions about from patients since I put this up a few years ago when we were involved in the ADVISE study.

And then on slide 21, if the patient screened positive, the physician upon opening the electronic chart will see this yellow BPA or best practice alert that tells us immediately the patient has screened positive for drinking above either the daily or weekly limits or both.

The best practice alert actually reminds the physician in case they've forgotten about the two dependence questions to ask, they are there at the bottom.

In the past year have you sometimes been under the influence of alcohol in situations where you could have caused an accident or gotten hurt? And then the second one is have there often been times when you've had a lot more to drink than you intended to have?

It also reminds the physician what they might want to code in this situation. And if the patient has screened positive, our after visit summary, which comes I think with most electronic medical records, is pre-populated with some advice to cut down and what those amounts are.

Moving on to the next slide, to slide 22. The key is to getting this adopted were that each medical center or facility had a physician and a manager who were selected as the alcohol education champions. And they were trained regionally. And then they were responsible for training the physicians in their department. In the managers trained the staff.

I think another key facilitation was the pretty simple workflow that really heavily leverages the electronic medical record. And I think the other thing was it was sold to physicians that it would over time probably reduce their work and save them time because only about 7% of patients would screened positive. The other 93% would have been screened. So the physician would not need to do that screening, which they should be doing.

And it would also help in those 7% of patients who did screened positive with management or explanation of their medical issues if the physician knew going into that exam room that the patient was drinking above safe limits. And this could possibly be tied to why their blood pressure was too high or why they were having trouble with insomnia.

Our medical assistants are currently screening, after about six months they are screening about 80% of patients that we see for the doctor office visits. And we are getting monthly performance feedback reports to help increase motivation and maintain the momentum of the program.

And then moving on to slide 23, there's been a very positive reaction from our physicians overall on this with comments such as without this screening they

would have missed the connection to many of the health problems the patients had had.

One of the most eye-opening things for a lot of us is there were some facilities in our Kaiser region, particularly in the Napa and Sonoma area, what we call wine country here in northern California where not 7% of patients were screening positive. But at one facility it was 25% of the patients were screening positive for unhealthy alcohol use. And that was quite eye-opening for the physicians and the patients.

Overall, as a region with six months of data, it looks like about 10% of our patients who come in for doctor office visits are screening positive for unhealthy use. And that number may be a little skewed since people with health problems tend to come in to the physician for their doctor's office visit.

Thank you. I will hand it over now to Doctor Hillary Kunins.

Dr. Hillary Kunins: Good afternoon. I'll start on slide 25. Thank you very much for inviting us to join in today's CDC *Vital Signs* Town Hall Teleconference this afternoon. I'll be speaking about our work here at New York City Department of Health and Mental Hygiene to reduce excessive drinking through our screening and brief intervention program.

On the next slide, slide 26, I'd like to just start briefly by offering some of our epidemiologic information that we have about the impact of alcohol in New York City.

Like national numbers, excessive drinking has a substantial public health impact in New York City. The numbers you see on the slide from the year 2011 are based on the CDC Alcohol Related Disease Impact, or ARDI

estimate in which direct pathophysiologic and other health effects of alcohol can be calculated.

The conditions listed on the Y axis of this graph specify these health conditions. In the bars next to each one shows the number of deaths attributable to alcohol within each condition.

In 2011 there were more than 1,700 deaths attributable to alcohol in New York City, including 649 directly attributable, nearly 800 attributable to injury and violence, and an additional 300 attributable to other alcohol related causes.

On slide 27, we present data from the New York City Community Health Survey, similar to the national BRFSS. As you can see on the first bar on the left, 55% of New York City adults report currently drinking.

Both excessive and binge drinking are common in New York City. In the middle bar shows that nearly one in five New Yorkers drink to excess. Excessive drinking in this case is defined, as you can see on the bottom, as more than seven drinks a week for women and more than 14 drinks per week for men. Or more than three drinks per occasion for women or greater than four for men.

Finally, the right-hand bar the depicts binge drinking among New York City adults. And again, nearly one in five New York City adults report binge drinking.

On the next slide, slide 28, we present similar data to the national numbers that you heard about just before. Similar to national figures, most New York City adults have not discussed alcohol use with a health professional.

And here we've looked at again our New York City Community Health Survey and found that only 24% of New York City adults and 28% of binge drinking New York City adults reported that a doctor, nurse, or other health professional had asked or talked to them about alcohol use in the past year.

From this, I think similar to national numbers, we conclude that screening and brief intervention is not a routine part of clinical care for adults in New York City.

If you drink the next slide, slide 29, I summarized the work that we are doing at the city health department in screening and brief intervention. I think in contrast to Kaiser, I would just point out that we do not here at the health department manage or administer a large health care system. And so we employ alternate strategies to promote this intervention.

I'll focus on the four main components of our program. Clinical guidance for primary care practices, direct delivery of services in our New York City Department of Health and Mental Hygiene's specialized clinics, three, training and certification for health professionals and forth, technical assistance and practice coaching.

In the next few slides I'll describe each of these four components. On slide 30 the first element that I'll review is SBI clinical guidance for primary care. As you can see from this screenshot, we put out a brief intervention for excessive drinking guidance in 2011 as part of a citywide publication, *City Health Information*.

This publication is distributed to all New York City providers. And is a vehicle by which the New York City Health Department disseminates guidelines and guidance around important public health and clinical issues.

In this guidance, which you may be able to see from the screenshot, we recommend in particular that providers screen using a validated screening tool. In this case we recommend the three-question audit, similar to Dr. Sun's intervention. And another screening tool called the "CRAFFT" for teenagers.

Similar to the algorithm you just heard about, we advise providers to provide clear advice to moderate and high risk patients and regular follow up to support efforts to help patients achieve low risk drinking levels.

On slide 31 I'll review the second component of our SBI program. And that is direct delivery of SBI services in DOHMH clinics. DOHMH does have a system of sexually transmitted disease clinics and tuberculosis clinics. And in this program we provide SBI services and seven of eight STD clinics and one of our tuberculosis clinics.

The structure of the intervention in those clinics is again a brief screening with the Audit-C. The Audit-C is included on all paper intake forms and filled out by patients in waiting areas. All patients are screened at every visit.

This program also supports dedicated interventionists, frequently masters level prepared social workers or counselors. The interventionist conducts assessments following a positive screen. And then provide brief intervention or referral for a higher level of care as appropriate.

In 2013 more than 50,000 patients who attended these clinics were screened. And we found a fairly high positive rate on the Audit-C of 50%. Of these, about 42% received what we call a full assessment, highlighting one of the challenges to SBI implementation.

Even with outstanding screening rates using the paper screening form, a busy clinic flow in patient preferences can prevent that the full assessment and intervention from being carried out.

On slide 32 I'll review the third components of our SBI program. That is training and certification for health professionals.

In New York State providers must attain SBI certification to be able to build New York State Medicaid for SBI services. Training is required for providers to obtain certification.

For licensed or credentialed providers the training is four hours. These providers include physicians, as you can see on the list, nurses, social workers, psychologists, and CASACs or addition counselors.

Non-licensed providers can also bill Medicaid but the work required to have a longer training of 12 hours. These providers would include people like medical assistants and health educators.

Since 2011 when SBI specific Medicaid codes were activated in New York State, we have trained more than 1,700 licensed and non-licensed professionals from more than 200 organizations across the city.

Finally on slide 33, I'll review the fourth component of our SBI program, technical assistance and practice coaching in clinical settings. In this part of the program we provide consultation with clinical staff to design an SBI algorithm and workflow plan for their setting.

We help staff choose elements that they'll use for the SBI algorithm such as which validated screening tool. We help administrators and clinical leaders

and timing select staff and timing for how SBI will be integrated into their setting.

We also provide support to help practices modify their electronic health records (EHR), including integration of screening tools into their EHRs, and it designing of EHR templates for the different components of SBI including intervention, follow-up, and referral.

Finally, because of practice concerns about capturing best reimbursements, we help them modify coding and billing systems to support SBI reimbursement. This work has included modifying their paper or electronic systems so that it is easy to both code and bill for SBI services.

On slide 34 we present some initial results of our implementation efforts. As you can see from the top bullet, full implementation, that is where practices engage in universal screening and provision of brief intervention has taken place across five large practices, which encompass 29 specific facilities.

These sites include a variety of primary care practices, including some specialized populations like homeless healthcare and some safety net providers in federally qualified health centers.

In addition two emergency departments have fully implemented SBI. And together these sites reach more than 180,000 patient visits each year.

In addition, we are working with three other group practices across 33 sites to help them achieve full implementation. They are now implementing in a partial way either at some sites or with some visits.

We've learned a number of lessons through this work. And it namely that reimbursement, though there are Medicaid public insurance codes, reimbursement is quite modest and nonexistent for some providers.

We've also learned, and I think reflected in the earlier presentation, that electronic health records facilitate adoption of this practice.

On slide 35, I just want to remark on a few next steps that we are undertaking. In terms of SBI we are planning to continue and expand our technical assistance and practice coaching, primarily by expanded use of electronic health records for SBI.

In addition, we are planning to release an e-learning module for the SBI training, acknowledging that time away from clinical practice can be challenging.

I also want to mention that our SBI program at our health department sits within a larger alcohol and drug-related portfolio. And I just wanted to mention two other programs in the alcohol context.

We conduct alcohol-related surveillance routinely as part of our health department. But with some CDC supports via the Community Transformation Grant, we will be expanding our public health surveillance on excessive alcohol use by incorporating a dedicated alcohol epidemiologist into our staff.

In addition, we have been working to enhance enforcement of laws prohibiting alcohol sales to minors. And in the coming year we hope to assess the impact of these enhanced enforcement efforts on access to alcohol and related harm by underage New Yorkers.

I just want to also acknowledge the many people here at the Department of Health who are part of this SBI program and to our funding and grant support as well. Thank you.