Implementing alcohol screening and brief intervention in a private, primary care healthcare system: Lessons learned from the Texas High-Impact Project

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BACKGROUND

- Risky alcohol use is a common and concerning public health issue in the United States (U.S.) and worldwide.
- The effectiveness of alcohol screening and brief intervention in primary care is well established.
- Primary care teams are ideally positioned to assist patients in making decisions to cut back on their drinking, thereby reducing the adverse health and social effects associated with risky drinking.
- In support of these efforts, the Healthcare Effectiveness Data and Information Set (HEDIS) 2018, a tool used by the vast majority of health plans in the U.S. to measure health care performance, introduced the Unhealthy Alcohol Use Screening and Follow-up measure.
- Despite this, adoption and sustainability of alcohol SBI remains a challenge for primary care practices, particularly in traditional, private practice settings.

METHODS AND MATERIALS

- A practice-based, interprofessional training and technical assistance program was implemented across multiple sites in a private, predominantly commercial insurance primary healthcare system in the greater Houston, Texas, USA area.
- Steps taken to pilot this alcohol SBI model in clinics consisted of:
  - 1) building a clinic profile
  - 2) providing in-clinic didactic and role-specific training, coupled with an implementation discussion to trouble shoot potential barriers and identify facilitators
    - Interprofessional training targeted both physicians and medical assistants (MAs)
    - Items discussed included conducting alcohol SBI, incorporating the alcohol SBI process into the clinic workflow, and identifying and overcoming common barriers, such as time constraints and comfort level in discussing alcohol use with patients
  - 3) identifying potential champions
  - 4) conducting key-informant interviews to further identify needs, challenges and lessons learned
  - 5) providing consistent follow-up to ensure a smooth implementation
    - Materials and resources were developed to facilitate the implementation process (Fig 3)
- Pre, post, and follow-up questionnaires were administered to collect participant feedback on the training content and satisfaction.

RESULTS

- During the two-year implementation project, a total of 22 providers and 27 clinic staff at 7 Houston-area clinics received practice-based training on alcohol SBI.
- Family practitioners' knowledge, confidence, and skills related to alcohol SBI increased and participants were satisfied with training content.
  - Increased confidence was indicated after the training related to educating women of reproductive age about alcohol effects, conducting brief intervention for alcohol use, and using resources to refer patients to specialized treatment (Table 1).
  - 91% of participants were either satisfied or very satisfied with the training and 95% of participants agreed that they would recommend this training to others (Fig. 1 & 2).
- Key informant interviews led to the development of a patient handout designed to address clinic barriers which contains the USAUDIT, educational information, and a drinking agreement (Fig 3).

Figure 1. Evaluation of trainee satisfaction (n=22)

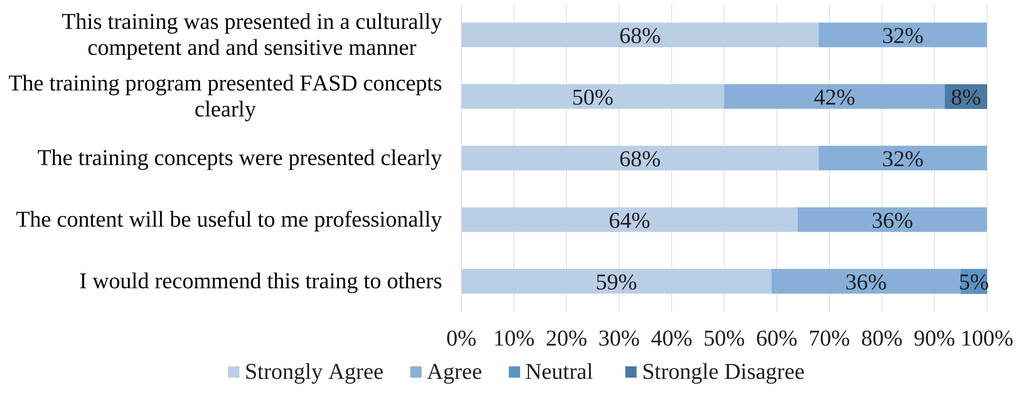


Table 1. Change in family practitioners' knowledge, perceptions, and confidence following training on alcohol screening and brief intervention (n=20)

	Pre-training mean ± SD	Post-training mean ± SD	*P* value
Knowledge			
Score on six FASD content related questions	5.8 ± 0.4	5.9 ± 0.3	0.45
Perceptions regarding importance to… (1=low importance to 5=high importance)			
…routinely screen all patients/clients for alcohol use	4.6 ± 0.5	4.8 ± 0.4	0.13
…screen all pregnant women for alcohol use	4.9 ± 0.4	5.0 ± 0.2	0.63
…screen all women of reproductive age for alcohol use	4.5 ± 0.6	4.9 ± 0.4	**0.03**
…educate women of reproductive age, about the effects of alcohol on a developing fetus	4.8 ± 0.4	4.9 ± 0.4	0.99
…inquire about and document potential prenatal exposure for all pediatric patients	4.4 ± 0.7	4.8 ± 0.4	**<0.01**
Perceptions regarding stigma (1=low importance to 5=high importance)			
Screening confers a stigma to person being screened	2.3 ± 1.2	2.9 ± 1.4	0.21
Diagnosis of one of the FASDs may confer a stigma to a child and/or his or her family	3.4 ± 1.2	3.6 ± 1.3	0.53
Confidence (1=low confidence to 5=high confidence)			
Asking women, including pregnant women, about their alcohol use	4.3 ± 0.8	4.5 ± 0.7	0.18
Having a conversation with patients who indicate risky alcohol use	4.0 ± 0.9	4.3 ± 0.8	0.09
Educating women of childbearing age about the effects of alcohol on a developing fetus	3.7 ± 1.2	4.4 ± 0.8	**<0.01**
Conducting brief interventions for reducing alcohol use	3.3 ± 1.0	4.2 ± 0.8	**<0.01**
Utilizing resources to refer patients who need formal treatment for alcohol abuse	3.1 ± 1.4	4.2 ± 0.8	**<0.01**
Inquiring about potential prenatal alcohol exposure for my patients	3.4 ± 1.4	4.3 ± 0.8	**0.02**
Identifying persons who may have one of the FASDs	2.4 ± 0.9	3.2 ± 1.2	**<0.01**
Diagnosing persons who may have one of the FASDs	2.3 ± 0.9	3.1 ± 1.2	**<0.01**
Referring patients for diagnosis and/or treatment services for an FASD or alcohol use disorder	2.6 ± 1.5	3.8 ± 1.2	**<0.01**
Managing/coordinating the treatment and care of persons who have one of the FASDs	2.3 ± 1.3	3.3 ± 1.4	**<0.01**

P value from a Wilcoxon signed rank test (nonparametric equivalent to the paired t-test)

Note: Three participants were dropped from this analysis due to failure to complete a pre-survey (n=2) or post-survey (n=1), which removes ability to assess pre-post change in metrics.

Figure 2. Evaluation of overall trainee satisfaction (n=22)

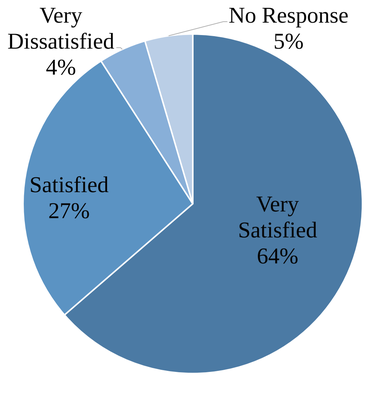
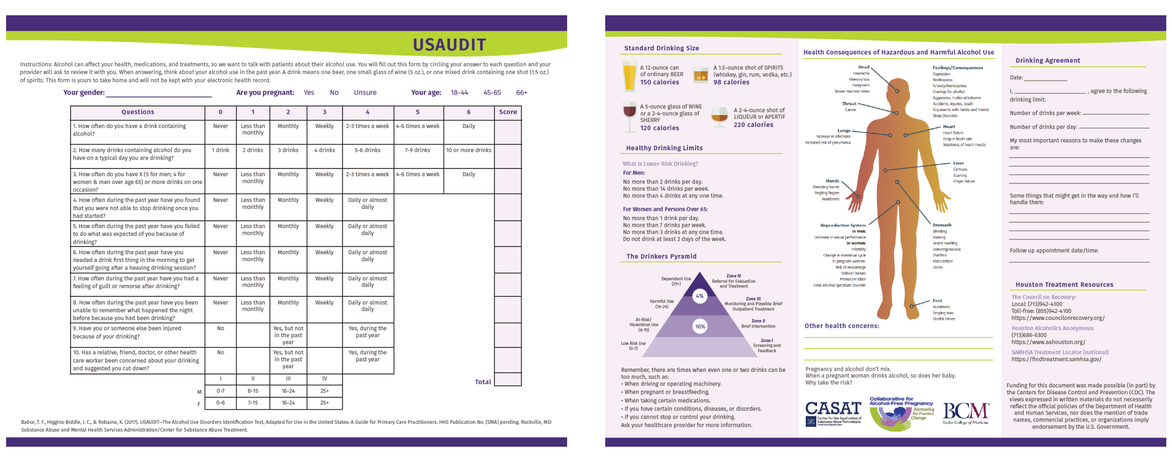


Figure 3. One-page, front/back USAUDIT and educational handout developed created for clinics



CONCLUSION

- Adoption and sustainability of alcohol SBI in private, primary care settings may pose unique challenges for healthcare providers.
- An interprofessional approach with organizational and technical support, including electronic health record (EHR) integration, can assist practices in overcoming common barriers.
- The Electronic Health Record (EHR) system was the most commonly reported barrier to full alcohol SBI implementation and was perceived as the most necessary element in routinizing and documenting alcohol SBI services
  - e.g., classification into risky/abusive behavior based on US-AUDIT, prompts for the brief intervention, readiness ruler to change, next steps, etc.
- Developing a interprofessional model for alcohol SBI in primary care clinics can contribute to better patient care and outcomes by increasing provider and MA knowledge and skills and integrating effective clinic workflow strategies.