

Low Screening and Follow-up for Unhealthy Alcohol Use Among Health Plan Beneficiaries

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About 30% of the US population misuses alcohol, and 21% of adults report engaging in risky or hazardous drinking.¹ Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amount, resulting in increased risk of adverse health consequences such as heart disease, cancer, and stroke. Alcohol misuse is a leading cause of preventable death in the United States, accounting for 1 of every 10 deaths.² More than 2200 deaths every year are caused by alcohol overdose.² A 2010 report estimated the economic costs due to excessive alcohol use at \$249 billion.³

Alcohol screening and follow-up have been shown to reduce alcohol misuse,⁴ but they remain underutilized health services in primary care.⁵ The grade B recommendation of the US Preventive Services Task Force (USPSTF) states that clinicians should screen adults 18 years or older for unhealthy alcohol use and provide brief behavioral counseling interventions to persons engaged in risky or hazardous drinking to reduce unhealthy alcohol use.⁶ The Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach is the most common prevention and early intervention model for unhealthy alcohol use.⁷ Health plans play an important role in addressing the issue of unhealthy alcohol use because not only do they pay for services, but they can also conduct screening for unhealthy alcohol use, provide brief counseling by clinical case managers, and encourage their network providers to deliver SBIRT services. Keeping in mind the crucial role of identification and appropriate intervention, this study evaluated health plan performance on unhealthy alcohol use screening and follow-up and examined the extent to which 3 standardized alcohol screening tools (Alcohol Use Disorders Identification Test [AUDIT], AUDIT-Concise [AUDIT-C], and National Institute on Alcohol Abuse and Alcoholism [NIAAA] single-question screener) were used. We adapted the Physician Consortium for Performance Improvement (PCPI) Foundation's provider-level measure, Unhealthy Alcohol Use Screening & Brief Counseling, for health plan reporting because it is endorsed by the National Quality Forum and used by national quality payment programs.⁸ The adapted Unhealthy Alcohol Use Screening and Follow-Up measure is the first plan-level measure for use in the general adult population.

ABSTRACT

OBJECTIVES: Alcohol misuse is a leading cause of preventable death in the United States. This pilot study examined rates of screening and follow-up for unhealthy alcohol use among health plan beneficiaries.

STUDY DESIGN: We analyzed medical records and claims data from 4 health plans—2 nonintegrated Medicaid plans and 2 integrated plans serving Medicaid, Medicare, and commercial product lines. The nonintegrated plans used medical records, case management, and claims data to identify alcohol screening and follow-up services using a random sample of 108 (plan 1) and 120 (plan 2) adults. The integrated plans (plans 3 and 4) used provider electronic health record data for all adults.

METHODS: We adapted the Physician Consortium for Performance Improvement Foundation's measure, Unhealthy Alcohol Use Screening & Brief Counseling, and applied it to plan populations for the 2014 and 2015 calendar years. We calculated rates of screening and follow-up for unhealthy alcohol use for each plan.

RESULTS: Results from the Medicaid plans showed that between 40% and 46% of members had documentation of alcohol screening, but standardized alcohol screening tools were rarely used and screening results were inconsistently documented. Results from the integrated plans with multiple product lines showed wide variation: 5% to 69% of members were screened; of those, 3% to 31% screened positive. Among members who screened positive, 1% to 46% received follow-up care.

CONCLUSIONS: Rates of screening and follow-up for unhealthy alcohol use are low in plan populations. There is room for improvement in documentation and quality of care for alcohol misuse.

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METHODS

Measure

The plan-level Unhealthy Alcohol Use Screening and Follow-Up measure captures members 18 years or older who were screened for unhealthy alcohol use during the year or the year prior using 1 of 3 standardized alcohol screening tools (AUDIT, AUDIT-C, NIAAA single-question screener) and received counseling or other follow-up within 2 months of a positive screen. We made the following measure adaptations: (1) allowing brief counseling and other unhealthy alcohol use treatment (eg, detoxification, crisis intervention) as follow-up care (the PCPI Foundation measure captured only brief counseling), (2) specifying that follow-up care should occur within 2 months of a positive alcohol screen (the PCPI Foundation measure allowed brief counseling anytime within 2 years of a positive screen), and (3) excluding plan members with a diagnosis of alcohol use disorder or dementia (the PCPI Foundation measure excluded only members with limited life expectancy). These adaptations were helpful for the plan-level measure because (1) the claim codes for follow-up care, provided across care settings and time, were available to health plans; (2) timely follow-up was clinically appropriate; and (3) the measure focused on preventive screening of members who did not have an existing alcohol diagnosis. Members with dementia were excluded because of unclear reliability of alcohol screening results for them. To be consistent with other health plan measures used in national programs, we did not exclude members with limited life expectancy.

Study Site

To examine variation in measure performance, we conducted outreach through health plan trade organizations and used a list of health plans maintained by the National Committee for Quality Assurance (NCQA) to recruit diverse plans that serve different types of populations. Four health plans representing diversity in geographic location, product line, and enrollment size agreed to participate in the study—2 Medicaid plans (in 2 states in the South and Northwest regions) and 2 plans with integrated delivery systems representing Medicaid, Medicare, and commercial product lines (in 2 states in the West). All plans were responsible for medical, pharmacy, and chemical dependency benefits and have been in business for at least 20 years. Two plans are NCQA accredited.

Data Collection

We used 2014 and 2015 data submitted by the health plans. The study focused on adults 18 years or older as of January 1, 2013. The 2 Medicaid plans provided data from a manual review of electronic and paper health records and auto-abstraction of claims and case management data for a randomized sample of 108 (plan 1) and 120 (plan 2) adults. Health plan staff manually reviewed medical

TAKEAWAY POINTS

Screening and follow-up for unhealthy alcohol use are low among plan members. Healthcare organizations need to improve care through:

- ▶ Reporting the Unhealthy Alcohol Use Screening and Follow-Up measure that was included in the Healthcare Effectiveness Data and Information Set 2018
- ▶ Wider use of this measure in programs such as the Medicare Star Rating System, the Medicaid Adult Core Set, and the Quality Rating System for qualified health plans in the Marketplace
- ▶ Training providers on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach and on reimbursement requirements of SBIRT claims
- ▶ Using standardized screening tools and Logical Observation Identifiers Names and Codes to document screening tools and results

record data, and a second abstractor reviewed a subsample of 25 medical records to test interrater reliability ($\kappa = 0.96$) that was almost perfect for alcohol screening. The 2 plans with integrated delivery systems covering Medicaid, Medicare, and commercial product lines extracted data from structured fields in electronic health records (EHRs) and provided aggregated data for all adult beneficiaries, which ranged from 400,000 to 2 million members. During our recruitment, plan 3 stated that it was conducting an organization-wide initiative to improve care for unhealthy alcohol use. Plan 1 used medical records mainly from behavioral healthcare providers, whereas other plans used medical records from primary care providers. The medical record data (paper and electronic) provided information on alcohol screening (whether screening was conducted and what screening tool was used), screening results, and data on follow-up, alcohol use disorder, and/or dementia. Additional members were identified as receiving follow-up care by using claims (eg, Current Procedural Terminology, Healthcare Common Procedure Coding System, G and H codes) and case management data. The denominator, adults who did not have an alcohol use disorder or dementia diagnosis, was the population used to examine unhealthy alcohol use screening and follow-up.

Analysis

We used SAS 9.4 (SAS Institute Inc; Cary, North Carolina) to calculate 3 performance rates for each product line. The screening rate for unhealthy alcohol use was the percentage of members in the denominator who were screened for unhealthy alcohol use. The positive rate was the percentage of members who screened positive relative to those who were screened. The follow-up rate was the percentage of members who received follow-up care relative to those who screened positive.

RESULTS

As noted above, we excluded plan members with a diagnosis of alcohol use disorder (1%-35%) or dementia (0%-5%), as shown in the [Table](#). After these exclusions, the denominator consisted of 64% to 99% of the adult population. We used this population to examine the rates of screening and follow-up for unhealthy alcohol

TRENDS FROM THE FIELD

TABLE. Unhealthy Alcohol Use Screening and Follow-up: Study Population and Performance Rates by Plan

Product	Plan ^a	Adult Population (n)	Members With Alcohol Use Disorder n (%) ^b	Members With a Dementia Diagnosis n (%) ^b	Denominator After Exclusions ^c n (%) ^b	Screened n (%) ^d	Screened Positive n (%) ^e	Follow-up 0-60 Days After Positive Screening n (%) ^f
Medicaid	Plan 1	108	38 (35.2)	1 (0.9)	69 (63.9)	32 (46.4)	8 (25.0)	3 (37.5)
	Plan 2	120	6 (5.0)	0 (0.0)	114 (95.0)	45 (39.5)	1 (2.2)	1 (100.0)
	Plan 3	48,342	1442 (3.0)	113 (0.2)	46,787 (96.8)	25,531 (54.6)	983 (3.9)	371 (37.7)
	Plan 4	5856	227 (3.9)	7 (0.1)	5622 (96.0)	450 (8.0)	101 (22.4)	0 (0.0)
Medicare	Plan 3	564,128	9965 (1.8)	26,937 (4.8)	527,226 (93.5)	361,338 (68.5)	11,383 (3.2)	5134 (45.1)
	Plan 4	98,458	2332 (2.4)	4685 (4.8)	91,441 (92.8)	7966 (8.7)	1968 (24.7)	23 (1.2)
Commercial	Plan 3	1,642,201	23,101 (1.4)	666 (0.0)	1,618,434 (98.6)	787,853 (48.7)	56,961 (7.2)	26,011 (45.7)
	Plan 4	216,699	5638 (2.6)	163 (0.1)	210,898 (97.3)	11,063 (5.2)	3462 (31.3)	56 (1.6)

^aPlans 1 and 2 were nonintegrated Medicaid plans. Plans 3 and 4 were integrated plans with Medicaid, Medicare, and commercial insurance.

^bPercent relative to the adult population.

^cDenominator after excluding plan members from the adult population with a diagnosis of alcohol use disorder or dementia.

^dPercent relative to the denominator after exclusions.

^ePercent relative to those who were screened.

^fPercent relative to those who screened positive.

use. Results from manual review of medical records for plans 1 and 2 showed some variation in performance. Forty-six percent of plan 1 members were screened for unhealthy alcohol use; of those, 25% screened positive. Nearly 38% of members who screened positive received follow-up care. Forty percent of plan 2 members were screened for unhealthy alcohol use; of those, 1 member (2%) screened positive and received follow-up care within 2 months after screening.

Both plans used homegrown questionnaires to screen for unhealthy alcohol use. These tools were mostly a single-question screener (eg, Do you drink alcohol?), and an affirmative response was a positive screen. If standardized alcohol screening tools recommended by the USPSTF were used, the screening rate decreased to 1% for plan 1 and 0% for plan 2.

Results from auto-extraction of EHR data from the 2 integrated plans (plans 3 and 4) showed wide variation in performance rates. Among the beneficiaries in the Medicaid, Medicare, and commercial product lines, 5% to 69% were screened for unhealthy alcohol use; of those, 3% to 31% screened positive. Of those with positive screens, 1% to 46% received follow-up care. The 2 integrated plans used standardized screening tools such as the AUDIT and the NIAAA single-question screener.

DISCUSSION

This study examined health plan performance on unhealthy alcohol use screening and follow-up and the extent to which standardized alcohol screening tools were used. We found wide variation in performance rates and the use of these standardized tools across the 4 plans. This was consistent with the literature on screening rates in primary care practices, which have been found to range from 8% to 70%.^{9,10} The variation found in our study appeared to be

related to the data sources used for measure reporting and whether plans had initiatives to address quality of care for unhealthy alcohol use. For example, plan 3 had the highest performance, which may be attributable to its organization-wide effort to address alcohol misuse and its consistent documentation of care in structured EHR fields. Its initiative involved using a medical assistant “rooming tool” in the EHR to remind medical assistants to screen for unhealthy alcohol use while placing a patient in an examination room. Patients who screened positive received a brief intervention from a primary care physician and referral to specialty substance abuse services if warranted. The high rate of alcohol use disorder and relatively high rate of positive screens for plan 1 may be attributed to the fact that most of the medical records came from behavioral healthcare providers.

The low use of standardized alcohol screening tools across plans may be attributed to a lack of knowledge of them among health plans and providers in their networks and a lack of structured fields in EHRs for these standardized tools. Low rates of follow-up care may reflect poor care, as suggested by the literature on follow-up rates (5%-18%) in primary care practices,^{10,11} or poor documentation due to confusion about which claim codes were appropriate and reimbursable.¹²

Health plans and providers in their networks may consider the following strategies to improve screening and follow-up care for unhealthy alcohol use. First, Logical Observation Identifiers Names and Codes (LOINC) exist for the screening tools specified in the adapted plan-level measure. Use of LOINC in EHRs and reporting the plan-level measure using electronic data, such as from EHRs, registries, and case management systems, will facilitate use of standardized screening tools, documentation of screening results, and follow-up care, as intended by the plan-level measure. Relying only on claim codes would likely underestimate measure

performance because such codes are not widely used or reimbursed by all plans and do not always specify screening tools or results. Medical record review is costly and usually limited to a sample of patients. Some EHRs have structured fields for measure elements, but most do not. Developing structured fields in EHRs for screening tools, screening results, and follow-up care will enable efficient measure reporting. Second, health information technology, such as patient portals, can be used by health plans and providers in their networks to efficiently screen for unhealthy alcohol use. Third, telehealth services may be used to conduct brief counseling, thus helping to alleviate the burden on medical staff to screen and provide brief counseling in an office visit.

The plan-level measure, Unhealthy Alcohol Use Screening and Follow-Up, was included in the Healthcare Effectiveness Data and Information Set,¹³ copyrighted by NCQA, for reporting by Medicaid, Medicare, and commercial plans. Wider use of this plan-level measure in national reporting programs such as the Medicare Star Rating System, the Medicaid Adult Core Set, and the Quality Rating System for qualified health plans in the Marketplace can encourage improved identification of and follow-up care for those with unhealthy alcohol use.

Limitations

This study was limited to 4 health plans. The 2 Medicaid plans did not have the capability to automatically extract data from the provider EHR systems and therefore could assess only a small sample of their member populations.

CONCLUSIONS

Despite national recommendations to screen for unhealthy alcohol use and offer follow-up care, rates of doing so are low in Medicaid, Medicare, and commercial plan populations. USPSTF-recommended standardized alcohol screening tools are rarely used and results are seldom documented in structured electronic data. Structured EHR fields for standardized screening tools and follow-up care will allow easier monitoring of care quality. Although interventions such as the SBIRT model have been shown to identify and treat unhealthy alcohol use effectively in adults, many providers are not trained to offer this type of counseling. Provider education, greater access to treatment, and quality measure reporting can encourage better care for those with unhealthy alcohol use. ■

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