Alcohol Screening and Brief Intervention is needed in Montana

At a Glance

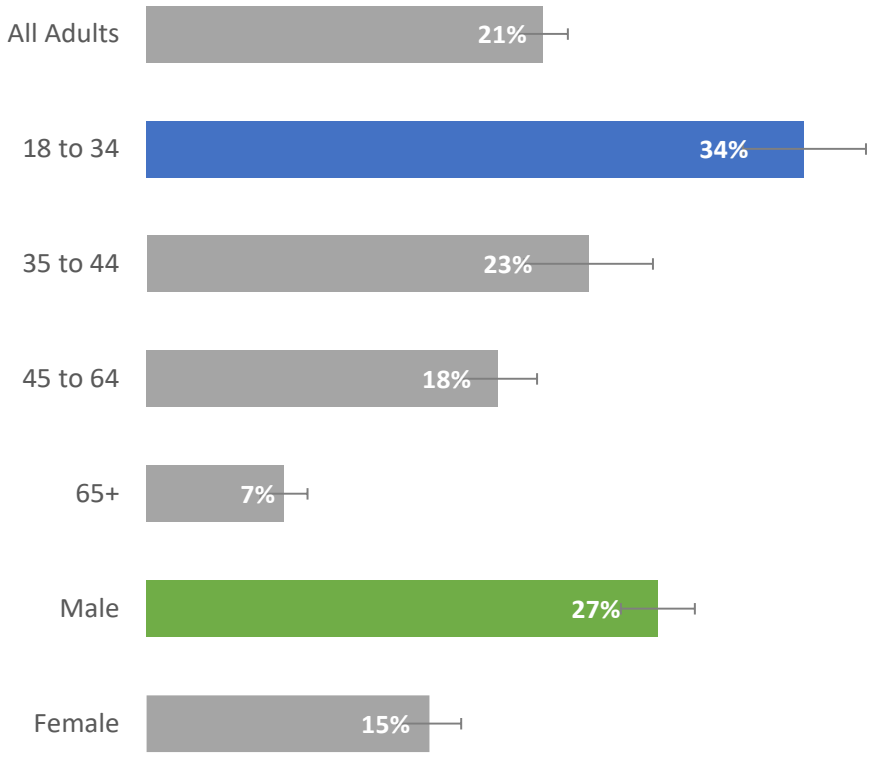
- Alcohol use is more common in Montana than in the US overall.
- One in five (21%) of Montana adults reported binge drinking in the past year.
- Binge drinking was highest among males and young adults aged 18–34 years.
- Nearly one in ten (9%) of Montana adults reported heavy drinking in the past year.
- 86% of Montana adults who had seen their doctor within the past 2 years reported being asked about alcohol use by a healthcare provider.
- Only one in five (19%) binge drinkers and one in four (26%) heavy drinkers who had seen their doctor within the past 2 years reported being advised to reduce their drinking.

Introduction

Excessive alcohol use is a leading cause of preventable death in the U.S and Montana. Heavy drinking, which is defined as 8 or more drinks per week for a woman or 15 or more drinks per week for a man, is associated with alcohol poisoning and chronic health problems such as liver disease.[1] Binge drinking, which is defined as adult men having five or more drinks or women having four or more drinks in a two-hour duration, can lead to alcohol poisoning, unintentional injuries and can contribute to many types of cancers.[2] Heavy and binge drinking are also linked to the cardiovascular health outcomes of high blood pressure, heart disease, and stroke. [1]

Montana has a high prevalence of heavy drinking and binge drinking compared with the U.S. In 2019 9% of Montana adults self-reported heavy drinking, compared with 6.4% nationwide, according to Behavioral Risk Factor Surveillance System (BRFSS). One in five (21%) of

Figure 1: Binge drinking was more common among young adults and males in Montana during 2019.



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Montana adults self-reported binge drinking in the past year, compared with 16.7% nationwide.[3,4] Binge drinking was even higher among young adults aged 18 to 34 (34%) and among men (27%) (Figure 1). Montana also has one of the highest rates of alcohol-related deaths in the country with 23.7 deaths per 100,000 population, compared with 11 per 100,000 nationwide.[5]

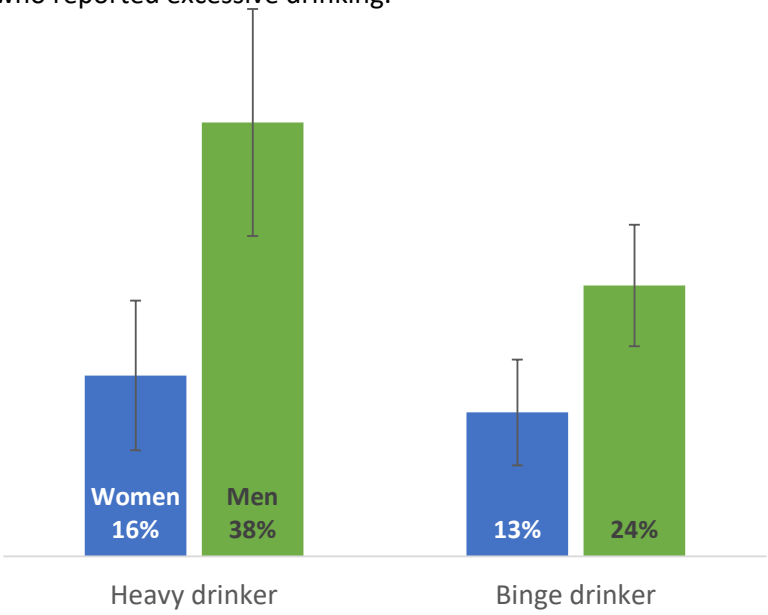
Alcohol screening and brief intervention (ASBI) is one evidence-based strategy for reducing excessive drinking.[6] Healthcare providers who implement this strategy do so first by screening their patients for excessive alcohol use; this can be done by asking patients in person or on a form about their alcohol use. Second, healthcare providers counsel patients who report excessive drinking. A conversation between healthcare provider and patient about the dangers of excessive drinking, and advice on how to develop a plan to address the problem, can be an effective intervention to help reduce excessive drinking. One Study found that ASBI reduced episodes of binge-level consumption, reduces weekly alcohol consumption, and increases compliance with recommended drinking limits among adults.[7]

In 2019, Montana Department of Public Health and Human Services (DPHHS) added five alcohol ASBI-related questions to the Montana BRFSS survey, to evaluate the use of the strategy by clinicians in the state, to assess changes since the questions were last asked in 2014, and to inform how the state can further implement the strategy moving forward. This report describes the findings from those survey questions.

Results

In 2019, 86% of Montana adults were asked about alcohol use, either in person or by form, at their last routine health checkup; 75% were asked how much they drink; and 39% were asked about binge drinking. One in five (20%) Montana adults were advised on the level of drinking that may be harmful or risky to their health, and 7% reported being advised to reduce their drinking. Among self-identified binge drinkers, only 13% of women and 24% of men were advised to reduce their drinking. Among heavy drinkers, 16% of women and 38% of men were advised to reduce their drinking (Figure 2).

Figure 2: **Men** who reported excessive drinking also reported being advised to reduce their drinking more often than **women** who reported excessive drinking.

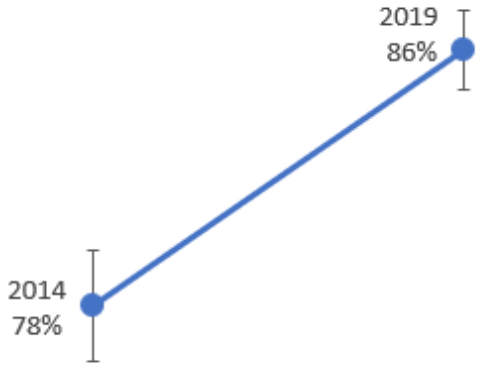


ASBI implementation increased significantly from 2014 to 2019 in Montana. The percent of Montana adults, overall, who reported that their healthcare providers asked about their alcohol use increased significantly from 78% in 2014 to 86% in 2019 (Figure 3).

Discussion

Excessive alcohol use is more common in Montana

Figure 3: The percent of adults who were asked about their alcohol use at their last routine checkup has increased since 2014.



than in the US overall. Binge drinking is most common among young adults and males. ASBI implementation has increased since 2014 but there is still a need for universal implementation. Although a higher proportion of adults who had seen their doctor in the last year reported being asked about alcohol use in general (86%) a relatively small proportion were specifically asked about binge drinking (39%) and even less were given advice about how much alcohol use is unhealthy (20%). Additionally only a small proportion of adults who reported excessive drinking were also advised to reduce their drinking. Even fewer women who reported excessive drinking reported being advised to reduce their drinking then men.

Recommendations

All primary care providers should screen all patients aged 18 years or older for alcohol use at least annually. Implementation of ASBI by clinical and non-clinical health professionals is effective for reducing excessive alcohol use, especially when duplicative strategies are used (i.e. patient, professional, and organizational approaches).[8] The U.S. Preventive Services Task Force recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women.[7] In more rural states like Montana where patient populations are relatively small, screening all adults for excessive alcohol use standardizes the process, which may assist in removing the subjective nature of alcohol dependence diagnosis. Identifying excessive alcohol use early allows healthcare providers the opportunity to intervene before chronic conditions develop. Without proper screening and assessment for excessive alcohol use, healthcare providers will not always be able to determine which patients could benefit from a brief intervention, treatment, or a referral for alcohol dependence. Substance Abuse and Mental Health Services (SAMSHA) works with the Centers for Medicare and Medicaid Services to educate health practitioners on the importance of screening and brief intervention coverage and related Medicare billing rules. According to SAMSHA, reimbursement for screening and brief intervention is available through commercial insurance Current Procedural Technology (CPT), Medicare G codes, and Medicaid Healthcare Common Procedure Coding System (HCPCS).[9]

Methods

This report utilized data from the 2019 and 2014 Montana BRFSS survey. The BRFSS, established in 1984 by the Centers for Disease Control and Prevention (CDC), is a system of health-related telephone surveys that collect data annually from all 50 states, the District of Columbia, and three U.S. territories. Survey respondents are chosen via random-digit telephone dialing. Eligible respondents are non-institutionalized adults 18 years or older. Non-institutionalized is defined as not residing in a penal institution, mental facility, or home for the aged. Information is collected on a variety of health conditions, health practices, and risk behaviors. In 2019 and 2014, Montana DPHHS included five-questions to assess Alcohol Screening and Brief Intervention (ASBI).

The ASBI questions were asked among respondents who reported that they had visited a doctor for a routine checkup within the past two years. In 2019 out of 6415 respondents who reported the time frame of

when they had last visited their doctor, 84% of them reported seeing their doctor in the last two years. In 2014 out of 7382 respondents who reported the time frame of when they had last visited their doctor, 78% of them reported seeing their doctor in the last two years. The first ASBI question asked was: "You told me earlier that your last routine checkup was [within the past year/within the past 2 years]. At that checkup, were you asked in person or on a form if you drink alcohol?" followed by the second question: "Did the healthcare provider ask you in person or on a form how much you drink?" and then a third: "Did the healthcare provider specifically ask whether you drank [5 for men/4 for women] or more alcoholic drinks on an occasion?" and then the fourth question: "Were you offered advice about what level of drinking is harmful or risky for your health?" Finally, respondents who answered 'yes' to any of the first three questions were asked: "Healthcare providers may also advise patients to drink less for various reasons. At your last routine checkup, were you advised to reduce or quit your drinking?"

The 2019 Montana BRFSS was completed by 6,495 respondents. Respondents who answered, 'Don't Know,' 'Not Sure,' or 'Refused,' were excluded from the given analyses. Select prevalence estimates were not reported due to low precision; this included estimates with fewer than 50 respondents, with half-width confidence intervals greater than 10 percent, or with a relative standard error greater than 30 percent. Prevalence estimates were obtained using cross tabulation tables. All statistical analyses were performed using SAS 9.4 software. Analyses were conducted to account for the complex sampling design. Weighted crude and age-standardized overall and state-level prevalence estimates were calculated by select drinking patterns and demographic characteristics.

Limitations

BRFSS data is self-reported, and like all self-reported data is vulnerable to some bias. In terms of ASBI, it is possible that respondents could over or underreport experiences based on a desire to provide socially acceptable responses. Results by income, age, and race/ethnicity are only available for those who volunteered such information during their BRFSS interview. The cross-sectional survey design makes it not possible to make causal conclusions.

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Acknowledgements

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