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Health Care For Alcohol Abuse and Dependence is Poor

“The First National Report Card on Quality of Health Care in America “was released by the Rand Corporation. A team of experts assessed the extent to which recommended care was provided to over 1300 adults in 12 metropolitan areas, including Newark, New Jersey. Six thousand seven hundred files were evaluated for 439 clinical indicators of quality for 30 acute and chronic conditions, including diabetes, hypertension, asthma, and alcohol abuse and dependence. The quality of care for alcohol abuse and dependence was significantly lower than all other conditions.

The report by Elizabeth McGlynn was based on the Community Quality Index study, which evaluated the extent to which quality indicators were met. For alcohol abuse and dependence these quality indicators included:

• All new patients or those receiving a routine history and physical should be screened for quantity and frequency of their alcohol consumption

• Positive responses should be followed with a more detailed interview with the patient or family members to confirm alcohol abuse or dependence. Increased detection of problem drinkers may lead to counseling, detoxification, and ultimately cessation of alcohol intake.

• All patients hospitalized for trauma, hepatitis, pancreatitis, or gastrointestinal bleeding should be screened at least once during their hospital stay. There is a high prevalence of problem drinking in those who present with trauma. There is good evidence that interventions to treat both dependent and nondependent drinkers may lead to a reduction in alcohol consumption and may at least reduce hospital day utilization.

• Regular or binge drinkers who do not meet criteria for dependence can benefit from medical intervention, counseling, and stopping drinking. Intake screening may in itself have an intervention effect. Early identification of those at risk for problem drinking may alter their pattern of drinking with brief counseling intervention.

• The record should indicate more detailed screening for dependence, tolerance of psychoactive effects, loss of control, and consequences of use with a validated screening questionnaire. Increased detection of alcohol dependence may lead to detoxification, treatment, and cessation.

• For alcohol-dependent patients medical record should indicate referrals for detox, treatment and rehabilitation, or relapse prevention.
• Providers should review all regular or binge drinkers’ alcohol consumption at subsequent visits.

For all medical conditions, participants in the study received an average of 55% of recommended care. Care for chronic disease varied across conditions. Care for alcohol abuse and dependence was significantly lower than that for other chronic conditions. Diabetes met 45% of the quality indicators and recommended care, hypertension met 69%, pulmonary met 48%, depression met 47% and alcohol dependence met only 11% of their quality indicators and recommended care.

All communities received a higher score in preventing chronic disease through screening tests (e.g., measuring blood pressure) and immunizations than other types of preventive care, like alcohol counseling. STD.HIV screening met 50% of the quality indicators and recommended care, immunizations met 59%, cancer screening met 61%, preventing chronic disease met 72%, and alcohol abuse counseling met only 37% of their quality indicators and recommended care.

The deficit in care for alcohol abuse and dependence shown in the Community Quality Index Study “creates serious threats to the health of the American public and translate into thousands of preventable complications and deaths per year” The study shows substantial gaps between what clinicians know works and the care actually provided. (McGlynn 2004)

Alcohol is consumed by over half of all American adults. About 20% of the patients seen in primary care settings meet the criteria for alcohol abuse or dependence (Allen et al., 1995). Heavy alcohol use and dependence is associated with numerous medical conditions, including alcohol withdrawal syndrome, psychosis, hepatitis, cirrhosis, liver disease, pancreatitis, thiamine deficiency, neuropathy, dementia, and cardiomyopathy, increase in blood pressure, hemorrhagic stroke, and cancers of the oropharynx, larynx, esophagus, and liver, gastrointestinal bleeding, vomiting, ascites, abdominal pain, bleeding, shortness of breath, anemia, and other complications. In addition half of the more than 100,000 annual deaths attributed to alcohol are due to injuries, including traffic fatalities, fires, drowning, homicides, assaults, and suicides.

According to a new study, Join Together reported that hospitals could save $2 billion each year by screening emergency-room patients for alcohol use and offering them brief interventions. Researcher Larry Gentilello, professor of surgery at the University of Texas Southwestern Medical Center estimated that hospitals save $3.81 for every dollar spent on brief counseling of ER patients.

Alcohol is by far the leading risk factor for injuries … Patients are most likely to consider changing a harmful behavior when that behavior has caused a crisis or a severe problem in their life. It appears that an injury makes patients with an alcohol problem much more responsive to coun-
soring. If brief interventions were offered routinely to these patients nation-wide, the annual net savings to hospitals and insurers could be up to $1.82 billion.

Join Together quoting Larry Gentilello

Despite these statistics, the quality of care for screening, referrals, treatment, and follow up for alcohol abuse and dependence remain well below the average quality of care for other medical conditions. Many hospitals don’t screen patients for alcohol use because of a 1947 law still in effect in many states, including New Jersey that allows insurers to deny payments to patients if their injuries are a result of alcohol use.