



Cutting Back[®]: Managed Care Screening and Brief Intervention for Risky Drinking

An RWJF national program

SUMMARY

From 1994 to 2002, researchers at the [Alcohol Research Center](#) at the University of Connecticut Health Center in Farmington conducted a study of the practicality and effectiveness of a low-cost intervention to address risky drinking by patients attending managed care clinics.

The Robert Wood Johnson Foundation (RWJF) funded the development and implementation of this national program called *Cutting Back[®]: Managed Care Screening and Brief Intervention for Risky Drinking*. The program was authorized by the Board of Trustees for up to \$3,834,373.

Researchers recruited five managed care organizations, which made available 15 clinics—five using regular clinic staff (usually physicians) to deliver the interventions, five using dedicated specialists (usually nurses) and five serving as comparison sites, which screened patients but provided no intervention.

Key Findings

Findings reported by the researchers included:

- The interventions produced a modest but statistically significant reduction in at-risk drinking.
- Interventions organized and delivered by nonphysician specialists proved as effective as those provided in the course of a routine medical visit, at about 40 percent lower cost.
- There was no significant difference between intervention and comparison groups in their use of medical services during the one-year study period.
- In delivering interventions to patients who screen positive, clinics that use a dedicated specialist may be slightly more effective than those relying on regular staff.
- Training is effective in changing providers' knowledge, attitudes and practice of screening and brief interventions for at-risk drinking.

- Patients were overwhelmingly comfortable answering questions about their drinking and felt it was important for their health care provider to know that information.

Limitations

Limitations of the findings included:

- The project was limited to five managed care organizations that served a predominantly employed population with health benefits.
- Comparisons could reflect differences between the clinics, rather than differences between patients who did and did not receive the intervention.

THE PROBLEM

Contrary to popular opinion, a significant proportion of the harm relating to alcohol abuse is incurred or caused not by alcoholics but by persons who drink too much on some occasions.

Findings of the 1992 National Longitudinal Alcohol Epidemiologic Survey suggest that while 4 to 5 percent of adult Americans are alcohol-dependent, approximately 20 percent drink in a way that creates a risk of harm to themselves or others. That is, they consume either:

- More than two drinks per day for men or more one drink per day for women or
- More than five drinks on any one occasion. (These guidelines are set by the federal Department of Agriculture and the National Institute on Alcohol Abuse and Alcoholism.)

A 1990 report of the Institute of Medicine (IOM) noted, "If the alcohol problems experienced by the population are to be reduced significantly, the distribution of these problems in the population suggests that a principal focus of intervention should be on persons with mild or moderate alcohol problems."

Brief Intervention

During the 1980s and early 1990s, researchers from several countries developed, tested, and documented simple procedures—now known as screening and brief intervention—that can recognize and address alcohol (and other substance abuse) problems effectively and economically.

Screening and brief intervention begins with a short questionnaire about drinking and other habits. Respondents whose answers indicate a potential or current problem receive one or more short counseling sessions, ranging from five minutes of advice to several hour-long sessions.

A 1993 review of 32 studies of screening and brief intervention involving more than 6,000 problem drinkers, published in the journal *Addiction*, concluded: "The results from this substantial body of clinical trials are remarkably consistent across cultures: brief intervention yields outcomes significantly better than no treatment, and often comparable to those of more extensive treatment."

However, screening and brief intervention had not been widely tested outside of research settings, and efforts to increase its use by primary health care providers had not been successful.

Many providers lacked training in the intervention, had limited understanding of how to implement it within a medical clinic, and expressed concern that patients would resent questions and advice about drinking.

Therefore, little was known about the feasibility of implementing screening and brief intervention in real-world situations such as managed care organizations, higher education, workplaces or social service agencies.

CONTEXT

One of RWJF's primary goals has been to reduce the harm caused by substance abuse. In addition, its interest in improving access to care included concerns about rising health care costs.

During the 1990s, managed care organizations became important providers of health care, and RWJF was interested in finding ways to address substance abuse cost-effectively within managed care settings.

The emergence of managed care created an opportunity to work from within health care systems to help promote best practices such as screening and brief intervention.

Managed care organizations offered more centralized systems of care and new tools to support improved care (e.g., computer reminders). In theory, they also had an economic incentive to keep people healthy.

In 1996, after this program started, RWJF funded a cost-benefit study of a brief intervention for problem drinkers in a primary care setting. The study found that:

- Brief intervention generated \$56,263 in cost savings in emergency room and hospital use, crime and motor vehicle accidents for every \$10,000 invested, a benefit-to-cost ratio of 5.6 to 1. See [Program Results](#) on ID# 027204.

In addition to screening and brief intervention for alcohol use, RWJF launched a national program promoting the same approach for tobacco smokers. *Addressing Tobacco in Managed Care*, established in 1997 in collaboration with the American Association of

Health Plans, funded a mix of planning grants and larger studies. The work evaluated innovative efforts to implement screening and brief intervention for tobacco use as part of the basic health care provided by managed care organizations.

PROGRAM DESIGN

Beginning in 1994, RWJF awarded a series of three grants to the [Alcohol Research Center](#) at the University of Connecticut Health Center to study the potential for wider adoption of screening and brief intervention to reduce risky alcohol use.

John C. Higgins-Biddle, Ph.D., was the program director and Thomas F. Babor, Ph.D., was the principal investigator.

Each of these grants was designed, developed and initially managed by RWJF Program Officer Marilyn Aguirre-Molina, Ph.D.; they were transferred to RWJF Program Officer C. Tracy Orleans, Ph.D., for management when Aguirre-Molina left the foundation in 1999.

THE PROGRAM

The Initial Grant

Under the first grant (ID# 023464), funded to help plan the program, the investigators examined the potential to implement screening and brief intervention in a range of settings, including higher education, workplaces, social service agencies and health care providers. They:

- Interviewed researchers.
- Conducted focus groups and interviews with practitioners in the fields of health, education, human resources and social services.
- Visited several programs that employed screening and brief intervention techniques.

The investigators also analyzed economic factors such as current costs of risky drinking and the costs and savings that might accrue from screening and brief intervention.

In a 1996 report, *Reducing Risky Drinking: A Report on Early Identification and Management of Alcohol Problems Through Screening and Brief Intervention*, the investigators offered four recommendations:

- Establish and evaluate a demonstration program of 6 to 10 "best practice" models.
- Reframe traditional understanding of alcohol problems so that service providers and at-risk drinkers alike understand that risky drinking is a problem, and that it can be addressed.

- Use the demonstration phase to create:
 - Screening instruments.
 - Counseling manuals.
 - Job descriptions for those doing the screening and counseling.
 - Materials to train people for these jobs.
- Establish an organization to provide leadership in building alliances necessary to advance widespread application of screening and brief intervention.

The Planning Grant

While the first grant had considered a range of settings for screening and brief intervention, RWJF decided with the second grant (ID# 026073) to focus on managed care organizations.

This planning grant allowed the investigators to design a research project that would implement and evaluate screening and brief intervention in managed care settings. The investigators conducted site visits to 12 managed care organizations to solicit their input on the design of the evaluation project and gauge their interest in participating in the evaluation.

Investigators proposed a demonstration project involving three clinics at each of eight managed care organizations. Clinic staff would receive training in screening and brief intervention.

The research team would gather and analyze data on:

- The number of patients screened.
- The number who received the interventions.
- Changes in patient drinking patterns.
- The effectiveness of training materials.
- The costs and benefits of the initiative.

Because of its scope and importance, RWJF elevated this project to the category of national program in 2001.

The Implementation Phase

RWJF approved a third grant to fund the proposed research project (ID# 029620). The project goals were to:

- Evaluate how best to implement and sustain screening and brief intervention in primary care settings within managed care organizations.
- Estimate the effectiveness of the intervention in those settings.
- Measure the costs and benefits of the intervention.

The program team contacted more than 200 managed care organizations about participating. The team sought those with at least three clinics of sufficient size (at least 7,000 patients visiting each clinic annually) that were not already screening for alcohol problems.

Recruitment proved difficult, in part because of financial and other challenges facing the industry at the time. With RWJF's approval, the researchers reduced the number of managed care organizations from eight to five, and increased the level of reimbursement for participation.

Five managed care organizations—four employing their own medical staff and one a consortium of independent practice associations—submitted formal proposals and became participants in the project.

A sixth managed care organization served as the site of a pilot test of the intervention and research efforts. Researchers agreed to maintain the confidentiality of these organizations by not naming them.

Under the research project, the three clinics in each managed care organization were assigned to one of three groups:

- Clinics in which regular medical staff (typically physicians, but occasionally physician assistants and nurse practitioners) provided the intervention.
- Clinics in which a dedicated specialist (usually a nurse) provided the intervention.
- Comparison clinics, in which patients answered an initial screening questionnaire but received no intervention.

(One participating managed care organization had only two clinics large enough meet the project's requirements, so researchers used a fourth clinic at one of the other organizations.)

The investigators, working with several consultants, developed a screening and brief intervention program for alcohol use, including:

- Marketing and recruitment materials.
- Implementation procedures.
- Training curricula.
- Videos for participating clinics.
- Patient education materials.
- Technical assistance procedures.

The intervention program was branded under the trademark *Cutting Back*. (For details on development of the training and patient education materials, see the [Appendix](#).)

The researchers provided training to staff at the 10 clinics that would practice screening and brief intervention, as well as to third-year medical students at the University of Connecticut School of Medicine.

Measuring Change

The national program office examined:

- The impact of training on providers' knowledge.
- Expectations for success, self-efficacy.
- The practice of screening and brief intervention at the clinics.

At clinics implementing *Cutting Back*, patients over age 18 who consented to participate in the study first completed a 14-question Health Appraisal Survey asking about diet and exercise, smoking, alcohol use and attitudes toward answering these questions. (This was the only screening conducted at the comparison clinics.)

Those whose responses to the questions about their drinking patterns indicated some risk of alcohol-related harm completed a second questionnaire, the Alcohol Use Disorders Identification Test (AUDIT), a widely used 10-item survey that asks about:

- Frequency of drinking.
- Number of drinks per day when drinking.
- Patterns of heavy drinking.
- Frequency of problems such as guilt, injury or memory problems related to drinking. (More information on AUDIT is available online.)

Based on the responses to the AUDIT screening, clinic staff assigned patients to one of three "zones" and provided appropriate counseling:

- Patients who scored in Zone I received advice lasting from three to seven minutes and were given a reference guide *Cutting Back: A Sensible Approach to Drinking and Health. A Quick Reference Guide*.
- Patients who scored in Zone II received advice and a self-help manual, *Cutting Back: A Sensible Approach to Drinking and Health. Five Steps to Sensible Drinking. A Self-Help Manual*.

The manual allowed them to record their drinking experiences, their goals for changing their drinking patterns, and the steps they planned to take to achieve their goals.

- Patients who scored in Zone III were recommended for referral for diagnostic assessment and possible treatment, with follow-up at the discretion of the primary care provider.

During the three- to five-minute intervention, the medical provider or specialist:

- Interpreted the results of the AUDIT questionnaire.
- Expressed concern about the level of the patient's alcohol consumption.
- Provided feedback to the patient on how drinking affected him or her.
- Made recommendations.
- Negotiated a course of action and next steps for the patient.

About 11 percent of the 53,000 patients screened scored positive for at-risk drinking.

A subcontractor, the Research Triangle Institute, conducted follow-up telephone interviews with a random sample of 1,329 of these patients three months after they completed the Health Appraisal Survey. A second round of interviews at 12 months reached 737 of the patients that had been interviewed at three months. These interviews sought to gather information about the drinking patterns of patients.

Institute staff also gathered data from the managed care organizations on the cost of implementing *Cutting Back* and the effect of screening and brief intervention on overall health care utilization. Researchers estimated the cost of:

- Administering the two questionnaires.
- Delivering the brief intervention (including the number of minutes it takes and the wages of staff involved).
- The space used for the project.

- The materials required to screen patients and deliver the intervention.

To learn the effect of screening and brief intervention on overall health care use, they examined:

- Administrative claims data collected from each managed care organization regarding outpatient, inpatient and emergency room visits.
- Annual visits related to alcohol, drug or mental health conditions.

Communications

A report produced under the first grant (ID# 023464), *Reducing Risky Drinking: A Report on Early Identification and Management of Alcohol Problems Through Screening and Brief Intervention*, was later distributed to 300 researchers involved in alcohol studies, managed care organizations, the subjects of interviews or focus groups during the project and other interested people.

Cutting Back program directors submitted five articles to peer-reviewed journals reporting:

- Findings of the study.
- Training for clinical workers.
- Implementation of screening and brief intervention.
- Patient outcomes.
- Health care use.
- Costs of implementation.

See the [Bibliography](#) for more details.

As part of its proposal for the implementation grant (ID# 029620) the investigators requested funds to develop and implement a public education and communications strategy regarding at-risk drinking in general, and screening and brief intervention in particular.

RWJF decided not to authorize funds for a communications strategy at that time, preferring to wait until the program had established its feasibility and had outcomes to report.

In 2001, RWJF contracted with Sutton Social Marketing to develop a strategic communications plan for *Cutting Back*. RWJF chose not to implement the resulting plan however, deciding that screening for alcohol problems should be integrated with screening for other behaviors such as exercise and nutrition.

OVERALL PROGRAM RESULTS

The investigators reported the following findings in a series of articles that have been submitted to peer-reviewed journals (see the [Bibliography](#)), and in a report to RWJF:

- **The interventions produced a modest but statistically significant reduction in at-risk drinking.** Recipients of interventions reduced their drinking from an average of more than 10 drinks per week to about 6.7 drinks per week after three months, and to 6 or fewer drinks per week after 12 months.

Patients in the comparison clinics reduced their drinks per week from 10.2 to 8.2 after three months and 6.9 after 12 months.

The difference between intervention and comparison patients was statistically significant for both time periods. ("Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations")

- **Interventions organized and delivered by nonphysician specialists proved as effective as those provided in the course of a routine medical visit, at about 40 percent lower cost.** There was no significant difference in reduction and drinking between the groups at the specialist clinics and the regular provider clinics.

Interventions cost an average of \$4.16 per patient when delivered by physicians, and \$2.82 when delivered by nurse-specialists. ("Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations")

- **There was no significant difference between intervention and comparison groups in their use of medical services during the study period.** Risky drinkers who received an intervention and those who did not had approximately the same number of annual days of total and inpatient care, and approximately the same number of outpatient, emergency room and alcohol, drug or mental health-related visits. ("The Health Care Utilization Effect of Screening and Brief Intervention for Risky Drinking in Four Managed Care Organizations")

- **Clinics that use a dedicated specialist may be slightly more effective than those relying on regular staff to deliver interventions.** The specialist clinics screened about the same number of patients as the regular provider clinics. However, some 76 percent of patients who screened positive at the specialist clinics received an intervention, compared to 57 percent at the regular provider clinics. Factors that contributed to successful implementation included:

- Participatory planning.
- Strong leadership.
- Lack of competing priorities.
- Low staff turnover.

- Use of technical assistance.

("Implementing Alcohol Screening and Brief Intervention in Primary Care Settings: Results of the *Cutting Back* Project")

- **Training is effective in changing providers' knowledge and attitudes—and their practice of screening and brief interventions for at-risk drinking.** Both physicians and medical students experienced an increased sense of confidence in performing screening procedures. Students reported greater self-confidence in conducting brief interventions.

Non-physician clinicians perceived fewer obstacles to screening patients after receiving the training. Providers who were trained reported conducting significantly more screening and brief interventions than providers who were not trained, a difference confirmed by patients' reports of their provider's activity. ("Training Medical Providers to Conduct Alcohol Screening and Brief Interventions")

- **Patients were overwhelmingly comfortable answering questions about their drinking and felt it was important for their health care provider to know that information.** There was little difference in such attitudes between drinking, smoking, exercise and dieting. The heaviest drinkers were only slightly less comfortable answering questions about alcohol use than were those who drank less. (Report to RWJF)

Limitations

- The project was limited to five managed care organizations that served a predominantly employed population with health benefits. Findings based on this group may not be generalizable to other groups of people.
- Because clinics (as opposed to individual patients) were assigned to receive either the intervention or usual care, it is possible that comparisons could reflect differences among the clinics.
- There is a tendency for members of comparison or control groups to report significantly lower levels of alcohol consumption at follow-up than they report when they are recruited. They may do this because:
 - They develop sensitivity to the measurement procedures.
 - They receive advice as part of routine medical care.
 - Their medical conditions interfere with their alcohol consumption.
 - The screening itself has had a motivational effect on them.

This may also reflect "regression to the mean": If risky drinking is only an occasional phenomenon, people may engage in the behavior in one period, but not in the next.

- Factors such as the need to obtain patient consent to participate in the study and the need to collect data may yield different results than would be achieved under non-study conditions when those factors are not present.
- Patients were followed up for only one year. It is possible that some effects of reduced drinking, such as reductions in use of health care, cannot be detected within that short period.
- The small number of clinics participating in the study limited the analyses that researchers could perform and the inferences that they could draw from the data.

LESSONS LEARNED

Program lessons were taken from written documents and from conversations with Program Director John Higgins-Biddle, the RWJF Program Officer C. Tracy Orleans, Margaret Gunter from a managed care organization and Ann Von Worley from a managed care organization.

Principal Investigator, Thomas Babor, was not interviewed about lessons because he was mainly involved in the research end. Marilyn Aguirre-Molina, the original program officer, was not interviewed because she left RWJF before the program was fully implemented.

1. **When conducting research involving clinical trials in managed care organizations, researchers should secure commitment from both senior managers and front line staff in all relevant departments within participating organizations.** Senior managers may be interested in a project and voice support for it, but they are not generally involved in overseeing it on a daily basis. In larger managed care organizations, communications between clinical and office management staff may be limited. This project would have benefited from more extensive and early involvement from clinic receptionists and office managers. (Program Director Higgins-Biddle)
2. **Less time and effort may have been required, and less resistance encountered, in identifying ideal sites for this work and working on implementation if RWJF had recruited sites already interested in screening and brief intervention and committed to sustaining their screening and brief intervention efforts if successful, offering RWJF funding only for the evaluation.** This was the model used in the similar *Addressing Tobacco in Managed Care* National Program. (Program Officer Orleans)

3. **Clinics participating in field trials perform better if they have an enthusiastic and competent coordinator to oversee day-to-day operations, facilitate communication among staff and troubleshoot problems.** Coordinators can play important roles in supporting clinic staff in:
 - Delivering services.
 - Ensuring that adequate numbers of screenings are conducted to meet research requirements.
 - Collecting and transmitting data from centralized clinic records to project staff.
 - Working closely with staff in monitoring operations. (Program Director Higgins-Biddle, Managed Care Organization Gunter, Managed Care Organization Worley)
4. **Researchers interested in testing clinical interventions in real-world health care environments should be cautious about asking agencies to depart too far from traditional practice.** Using receptionists in the clinics to initiate the screening process had the advantage of allowing patients to complete the screening in the waiting room without adding time to the physician visit. However, this required involving administrative personnel and changes in job responsibilities, neither of which was easy to accomplish. (Program Director Higgins-Biddle)
5. **Clinicians providing brief interventions should praise patients whose screens indicate good behavior, as well as offering interventions for patients whose screen indicate problematic behavior.** In subsequent projects with the World Health Organization, researchers changed the Zone categories by adding a fourth Zone and redefining Zone I so that people whose scores placed them in Zone I were those whose drinking was within federal guidelines, and could receive praise and support for their behavior. (Program Director Higgins-Biddle)
6. **When trying to change the way primary care providers practice, concentrate on the systems and procedures that govern how they work.** Training individual providers to act differently may be less effective than changing the system within which they work. This system includes the role of competing demands, accreditation and performance measurements systems, and office and administrative set-ups.

This shift in emphasis from trying to affect behaviors of individual providers to trying to address structural problems within the larger health care system have relevance for other health concerns such as tobacco counseling and managing chronic illness. (Program Officer Orleans, Program Director Higgins-Biddle)
7. **New continuous quality improvement, rapid cycle change strategies recently pioneered by the [Institute for Healthcare Improvement](#) as the "Breakthrough Series," hold great promise for future efforts to introduce and sustain the kinds of systems changes pioneered in *Cutting Back*.** The Breakthrough Series brings together health care organizations that share a commitment to making major, rapid

changes that produce breakthrough results: lower costs, better outcomes, and more satisfied patients and providers.

New continuous quality improvement is being used by the *Improving Chronic Illness Care* national program to help practices and plans implement systems changes for improved chronic illness care. (Program Officer Orleans)

8. **When getting clinics to adopt new approaches, it may take a long time to achieve acceptance, but acceptance is possible.** This project required clinic staff to change their perceptions and vocabulary about problem drinking and its solutions. They had to move from thinking only of alcoholism and alcoholism treatment involving complete abstinence, towards thinking about levels of at-risk drinking and solutions that might lead to less drinking, but not abstinence.

Requiring health professionals to make these changes is especially challenging because the general public tends to equate problem drinking with alcoholism, and because of media images of drinking that minimize drinking problems. (Program Director Higgins-Biddle)

9. **Many managed care organizations lack the kind of planning expertise required to introduce and sustain changes in practice, and research project staff should be prepared to provide this expertise.** Research project staff may need to guide organizations through a systematic planning process. The role of project staff is to identify issues, raise questions, and support the organizations in developing systems and procedures that work for them. (Program Director Higgins-Biddle)

10. **One of the barriers to more widespread use of promising screening and brief intervention approaches in primary care has been the lack of national evidence-based guidelines.** Building on research conducted in the last decade, some of it by *Cutting Back's* program directors, in 2004 the U.S. Preventive Services Task Force released a "B" grade recommendation for [screening and brief intervention approaches](#) like those tested by *Cutting Back*.

These guidelines will generate increased interest in and attention to the work of Babor and Higgins-Biddle, and the results of this *Cutting Back* demonstration. (Program Officer Orleans)

11. **Implementation of new interventions imposes high start-up costs.** Start-up costs might be reduced through increased use of computers for training, technical assistance and screenings. Start-up costs per patient would decrease if several clinics could start using the intervention at the same time, thus creating some efficiencies of scale. (Program Officer Orleans, Program Director Higgins-Biddle)
12. **Training curricula and their delivery have to be worked out with clinic staff in advance, and they have to be practical and specific.** Training is the end of a process, not the beginning, and researchers may not be the best people to write training curricula. When projects operate in several locations, project staff should

work intensively with staff from provider agencies to design the intervention, and to assure that administrative details of implementation are addressed. Local staff may be better positioned than researchers to deliver training modules that address local program operations and processes. (Program Director Higgins-Biddle)

13. **In conducting research in managed care organizations, researchers have to consider how their requests and expectations will appear to nurses, receptionists, physicians, office managers and others, some of whom may not have confidence in the intervention and may not see research as a priority.** (Program Director Higgins-Biddle)
14. **Medical staff members who have experience with screening and brief intervention can become strong salespeople and champions for its expansion to other primary care settings.** Some physicians who participated in this project were pleasantly surprised at the high payoff for a short investment and they were instrumental in helping other health care providers understand the benefits of screening and brief intervention (Managed Care Organization Gunter)

AFTERWARD

Investigators at the Alcohol Research Center continue to consult with a range of government agencies both domestically and internationally on screening and brief intervention. They have authored two manuals on alcohol screening and brief intervention for the World Health Organization (WHO) and are working with the WHO to disseminate the approach in Brazil and South Africa.

The federal [Center for Substance Abuse Treatment](#) funded the investigators to conduct a study comparing motivational enhancement therapy to more traditional and costly treatment for people with alcohol dependency problems. The study used three of the managed care organizations that participated in the *Cutting Back* demonstration. Findings of this study are under review.

RWJF Strategy After the Program

RWJF declined requests for continued funding of projects using screening and brief intervention only for alcohol use. It has shifted its focus to alcohol and drug treatment, rather than prevention and early intervention.

One of its programs in this area is *Paths to Recovery*[®]: *Changing the Process of Care for Substance Abuse*. This program addresses organizational and systems barriers to access, quality and efficiency in order to reduce the time from call to admission, increase the number of admissions and reduce the number of people who leave treatment in the initial stages.

However, RWJF also has built on the work of the *Cutting Back* national program by funding the following efforts to integrate brief motivational interventions into primary care screening and brief intervention to address multiple health risk factors that relied on critical insights from *Cutting Back*:

- A 2002 grant to the Bayer Institute (ID# 044632) sought to engage a variety of researchers and other stakeholders in identifying strategies for developing a screening and brief intervention questionnaire that can be applied to multiple health risk factors. Drs. Babor and Higgins-Biddle collaborated with the Bayer Institute on that project.
- A national program, *Prescription for Health: Promoting Healthy Behaviors in Primary Care Research Networks*, launched in 2002 in collaboration with the federal [Agency for Healthcare Research and Quality](#), funds research on and dissemination of innovative approaches to improving behavior change interventions used in primary care.

The initiative targets four leading health risk behaviors: risky use of alcohol, tobacco use, sedentary lifestyle and unhealthy diet. The first projects under this initiative started in July 2003.

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APPENDIX

Training and Patient Education Materials

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The Alcohol Research Center contracted with the University of Wisconsin Medical School Center for Addiction Research and Education to design and write the *Cutting Back* training curriculum. Training consisted of four modules delivered by a physician trainer and a member of the Alcohol Research Center Staff:

- The nature of alcohol misuse and its importance to medical practice.
- The *Cutting Back* screening instruments, scoring procedures and patient brochures.
- Clinic-specific implementation procedures.
- Practice in administering screening instruments and delivering the brief intervention.

Another subcontractor, Motion, developed two training videos depicting screenings and brief interventions. Researchers evaluated the training using tests that assessed participants' knowledge of at-risk drinking and their level of confidence in conducting screening and brief interventions before they received training, and then again after they completed training.

The [Legal Action Center](#), a nonprofit law and policy organization with expertise about the confidentiality of drug and alcohol treatment records, wrote the legal sections of the training and operations manuals to ensure that managed care staff, trainers and researchers understood relevant confidentiality and anti-discrimination laws, and to insure that forms and protocols used for screening and brief intervention complied with these laws.

[Cronin & Company](#), a marketing and communications firm, designed materials that would be given to patients as part of the brief intervention. In preparing patient education materials, staff from Cronin & Company conducted focus groups of managed care patients to ascertain their opinions regarding the wording of screening questions, the best settings for posing such questions, and the use of terms such as risky drinking.

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Audio-Visual Materials

Cutting Back Training Video, a 10-minute video on how to screen for problem drinking. Farmington, CT: Alcohol Research Center of the University of Connecticut Health Center. Used for training managed care clinic staff in Colorado, Michigan, New Hampshire, New Mexico and Wisconsin in 1997 and 1998.

Cutting Back: A Sensible Approach to Drinking and Health, an 11-minute video on how to discuss problem drinking with patients. Farmington, CT: Alcohol Research Center of the University of Connecticut Health Center. Used for training managed care clinic staff in Colorado, Michigan, New Hampshire, New Mexico and Wisconsin in 1997 and 1998.