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Do financial incentives for delivering health promotion counselling work? Analysis of smoking cessation activities stimulated by the quality and outcomes framework.

Coleman T. *BMC Public Health* 10: 167, 2010. (36 refs.)

Background: A substantial fraction of UK general practitioners' salaries is now intended to reflect the quality of care provided. This performance-related pay system has probably improved aspects of primary health care but, using the observational data available, disentangling the impacts of different types of targets set within this unique payment system is challenging. Discussion: Financial incentives undoubtedly influence GPs' activities, however, those aimed at encouraging GPs' delivery of health promotion counselling may not always have the effects intended. There is strong, observational evidence that targets and incentives intended to increase smoking cessation counselling by GPs have merely increased their propensity to record this activity in patients' medical records. The limitations of using financial incentives to stimulate the delivery of counselling in primary care are discussed and a re-appraisal of their use within UK GPs' performance-related pay system is argued for. Summary: The utility of targets employed by the system for UK General Practitioners' performance related pay may be inappropriate for encouraging the delivery of health promotion counselling interventions. An evaluation of these targets is essential before they are further developed or added. Copyright 2010, BioMedical Central.

The effect of linking community health centers to a state-level smoker's quitline on rates of cessation assistance.

Shelley D; Cantrell J. *BMC Health Services Research* 10(25), 2010. (29 refs.)

Background: Smoking cessation quitlines are an effective yet largely untapped resource for clinician referrals. The aim of this study was to assess the effect of a fax referral system that links community health centers (CHCs) with the New York State Quitline on rates of provider cessation assistance. Methods: This study was conducted in four CHCs using a quasi experimental study design. Two comparison sites offered usual care (expanded vital sign chart stamp that prompted providers to ask about tobacco use, advice smokers to quit, assess readiness, and offer assistance (4As)) and two intervention sites received the chart stamp plus an office-based fax referral link to the New York State Quitline. The fax referral system links patients to a free proactive telephone counseling service. Provider adherence to the 4 As was assessed with 263 pre and 165 post cross sectional patient exit interviews at all four sites. Results: Adherence to the 4As increased significantly over time in the intervention sites with no change from baseline in the comparison sites. Intervention sites were 2.4 ($p < .008$) times more likely to provide referrals to the state Quitline over time than the comparison sites and 1.8 ($p < .001$) times more likely to offer medication counseling and/or a prescription. Conclusions: Referral links between CHCs and state level telephone quitlines may facilitate the provision of cessation assistance by offering clinicians a practical method for referring smokers to this effective service. Further studies are needed to confirm the efficacy of fax referral systems and to identify implementation strategies that work to facilitate the utilization of these systems across a wide range of clinical settings. Copyright 2010, BioMedical Central.

Readiness to change in adolescents screening positive for substance use in urban primary care clinics.

Stevens J; McGeehan J; Kelleher KJ. *Journal of Child & Adolescent Substance Abuse* 19(2): 99-107, 2010. (21 refs.)

Primary care physicians often perceive patients as unlikely to decrease their substance use and suggest this reluctance to change diminishes their willingness to screen and intervene. The literature on readiness to change has primarily focused on adults, and the available studies on adolescents have largely included hospitalized and/or incarcerated youths with severe substance-related difficulties. The present study focuses on an urban primary care system's teenage population, which consists of youths typically engaging in less serious forms of substance use. One

hundred sixty-eight of these youths ages 11 to 20 screened positive for substance use on a self-report questionnaire. These youths then completed the Readiness to Change Questionnaire. Nearly 60% of these positive screens were in the Action stage, with another 16% in the Contemplation stage. Depressive symptoms and suicidal ideation were positively associated with later stages of change. Implications for screening, prevention, and early intervention programs for adolescent substance use are discussed. Copyright 2010, Haworth Press.

Screening and brief intervention for underage drinkers.

Clark DB; Gordon AJ; Ettaro LR; Owens JM; Moss HB. *Mayo Clinic Proceedings* 85(4): 380-391, 2010. (59 refs.)

In a 2007 report, the US Surgeeon General called for health care professionals to renew efforts to reduce underage drinking. Focusing on the adolescent patient, this review provides health care professionals with recommendations for alcohol-related screening, brief intervention, and referral to treatment. MEDLINE and published reviews were used to identify relevant literature. Several brief screening methods have been shown to effectively identify underage drinkers likely to have alcohol use disorders. After diagnostic assessment when germane, the initial intervention typically focuses on education, motivation for change, and consideration of treatment options. Internet-accessible resources providing effective brief interventions are available, along with supplemental suggestions for parents. Recent changes in federal and commercial insurance reimbursement policies provide some fiscal support for these services, although rate increases and expanded applicability may be required to prompt the participation of many practitioners. Nevertheless, advances in clinical methods and progress on reimbursement policies have made screening and brief intervention for underage drinking more feasible In general health care practice. Copyright 2010, Mayo Clinic Proceedings.

A cluster randomized trial in general practice with referral to a group-based or an internet-based smoking cessation programme.

Pisinger C; Jorgensen MM; Moller NE; Dossing M; Jorgensen T. *Journal of Public Health* 32(1): 62-70, 2010. (31 refs.)

Background: Reviews state that there is a room for improvements of smoking cessation (SC) intervention in general practice Methods: In 2005, all 61 general practitioners (GPs) in four municipalities in Copenhagen, Denmark, were invited to participate Twenty-four GPs accepted and were cluster randomized to one of three groups Group A, referral to group-based SC counselling (national model), n = 10, Group B, referral to internet-based SC programme (newly developed), n = 8, or Group C, no referral ('do as usual'), n = 6 A total of 1518/1914 smokers were included, and 760 returned a questionnaire at 1-year follow-up. Results: The participating GPs reported significantly more SC counselling than GPs who refused participation (P = 0 04) Self-reported point abstinence was 6 7% (40/600), 5 9% (28/476) and 5 7% (25/442) in Groups A, B and C, respectively Only 40 smokers attended group-based SC counselling, and 75 logged in at the internet-based SC programme In cluster analyses, we found no significant additional effect of referral to group-based (OR 1 05, 95% Cl 0 6-1 8) or internet-based SC programmes (OR 091, 95% Cl 0 6-1 4) Conclusions: We found no additional effect on cessation rates of GPs' referring to group-based SC counselling or Internet-based SC programme This finding might, to some degree, be explained by the short time used by the GPs on SC counselling and the selection of the participating doctors. Copyright 2010, Oxford University Press.

The validity and reliability of an interactive computer tobacco and alcohol use survey in general practice.

Bonevski B; Campbell E; Sanson-Fisher RW.
Addictive Behaviors 35(5): 492-498, 2010. (42 refs.)

Background: Uncertainty regarding the accuracy of the computer as a data collection or patient screening tool persists. Previous research evaluating the validity of computer health surveys have tended to compare those responses to that of paper survey or clinical interview (as the gold standard). This approach is limited as it assumes that the paper version of the self-report survey is valid and an appropriate gold standard. Objectives: First, to compare the accuracy of computer and paper methods of assessing self-reported smoking and alcohol use in general practice with biochemical measures as gold standard. Second, to compare the test re-test reliability of computer administration, paper administration and mixed methods of assessing self-reported smoking status and alcohol use in general practice. Methods: A randomised cross-over design was used. Consenting patients were randomly assigned to one of four groups; Group I. C-C : completing a computer survey at the time of that consultation (Time 1) and a computer survey 4-7 days later (Time 2); Group 2. C-P: completing a computer survey at Time

1 and a paper survey at Time 2; Group 3. P-C: completing a paper survey at Time I and a computer survey at Time 2: and Group 4. P-P: completing a paper survey at Time 1 and 2. At Time I all participants also completed biochemical measures to validate self-reported smoking status (expired air carbon monoxide breath test) and alcohol consumption (ethyl alcohol urine assay). Results: Of the 618 who were eligible, 575 (93%) consented to completing the Time 1 surveys. Of these, 71% (N = 411) completed Time 2 surveys. Compared to CO, the computer smoking self-report survey demonstrated 91% sensitivity, 94% specificity, 75% positive predictive value (PPV) and 98% negative predictive value (NPV). The equivalent paper survey demonstrated 86% sensitivity, 95% specificity, 80% PPV, and 96% NPV. Compared to urine assay, the computer alcohol use self-report survey demonstrated 92% sensitivity, 50% specificity, 10% PPV and 99% NPV. The equivalent paper survey demonstrated 75% sensitivity, 57% specificity, 6% PPV, and 98% NPV. Level of agreement of smoking self-reports at Time 1 and Time 2 revealed kappa coefficients ranging from 0.95 to 0.98 in each group and hazardous alcohol use self-reports at Time 1 and Time 2 revealed kappa coefficients ranging from 0.90 to 0.96 in each group. Conclusion: The collection of self-reported health risk information is equally accurate and reliable using computer interface in the general practice setting as traditional paper survey. Computer survey appears highly reliable and accurate for the measurement of smoking status. Further research is needed to confirm the adequacy of the quantity/frequency measure in detecting those who drink alcohol. Interactive computer administered health surveys offer a number of advantages to researchers and clinicians and further research is warranted. Copyright 2010, Elsevier Science.

Tobacco-related documentation in pediatric practice.

Martin LA; Dilley KJ; Ariza AJ; Sullivan C; Seshadri R; Binns HJ. *Academic Pediatrics* 9(5): 353-359, 2009. (32 refs.)

Objective. The goal of this study was to evaluate tobacco-related documentation in children's medical records. Method. A cross-sectional, consecutive sample of 42 I 6 parents at 13 primary care practices was surveyed on demographics, health habits, and smoking status of household members. The medical records of 2085 children from a subsample of 1149 families (all households with smokers and a sample of nonsmoking households) were reviewed for tobacco-related documentation at the first visit to the practice and visits in the 14 months preceding recruitment. Relationships of documentations with visit type, household smoking status, and use of charting prompts were examined. Results. Most children (93%) had >= 1 visit during the reviewed period (77% had a health supervision visit), 23% were aged >= 11 years, 52% were Medicaid/uninsured, and 70% lived with smokers; 30.6% of children had family tobacco use status documented at a first visit to the practice and 15.4% had prenatal tobacco use status documented. Among children with a visit in the reviewed period, 39.3% with a health supervision visit and 9.6% without had a tobacco-related notation at a visit (P < .001). Overall, 15.2% of children living with a smoker had a visit notation indicating that someone in the household smoked. In households with smokers, documentation of household tobacco use status often disagreed with parent survey. Charting prompts significantly increased rates of identification of family tobacco use history and prenatal tobacco use history. Conclusions. Correct identification of household smoking status was absent for most children living with smokers. Improved documentation systems may facilitate tobacco-related surveillance and counseling. Copyright 2009, Elsevier Science.

Urine drug screening: A valuable office procedure.

Standridge JB; Adams SM; Zotos AP. *American Family Physician* 81(5): 635-640, 2010. (17 refs.)

Urine drug screening can enhance workplace safety, monitor medication compliance, and detect drug abuse. Ordering and interpreting these tests requires an understanding of testing modalities, detection times for specific drugs, and common explanations for false-positive and false-negative results. Employment screening, federal regulations, unusual patient behavior, and risk patterns may prompt urine drug screening. Compliance testing may be necessary for patients taking controlled substances. Standard immunoassay testing is fast, inexpensive, and the preferred initial test for urine drug screening. This method reliably detects morphine, codeine, and heroin; however, it often does not detect other opioids such as hydrocodone, oxycodone, methadone, fentanyl, buprenorphine, and tramadol. Unexpected positive test results should be confirmed with gas chromatography/mass spectrometry or high-performance liquid chromatography. A positive test result reflects use of the drug within the previous one to three days, although marijuana can be detected in the system for a longer period of time. Careful attention to urine collection methods can identify some attempts by patients to produce false-negative test results. Copyright 2010, American Academy of Family Physicians.

Smoking prevalence, cigarette consumption and advice received from physicians: Change between 1996 and 2006 in Geneva, Switzerland.

Etter JF. *Addictive Behaviors* 35(4): 355-358, 2010. (27 refs.)

Objective: To assess change between 1996 and 2006 in smoking prevalence, cigarette Consumption, quit attempts. motivation to quit and advice received from physicians in Geneva, Switzerland. Methods: Postal surveys in cross-sectional, representative samples of the general population of Geneva in 1996 and 2006. Results: There were 742 participants in 1996 (response rate 75%) and 1487 in 2006 (response rate 76%). Smoking prevalence remained stable between 1996 (28.0%, 95% confidence interval: 24.7 to 31.3%) and 2006 (26.5%, 24.3 to 28.7%. p = 0.46). Among smokers, cigarette consumption fell from 15 to 13cig./day between 1996 and 2006 (p = 0.003). However, tobacco dependence, as measured by the Heaviness of Smoking Index, remained stable (mean = 1.9 vs. 1.7, p = 0.18). The proportion of smokers who made a 24-hour quit attempt in the previous year remained stable (29.2% in 1996, 32.1% in 2006, p = 0.52), but more smokers reported that they intended to quit in the next 6 months in 2006 (39.6%) than in 1996 (29.1%, p = 0.045). The association between smoking prevalence and income was stronger in 2006 (chi(2) = 53.7, p<0.001) than in 1996 (chi(2) = 10.9, p = 0.012). In 2006 (no change since 1996), few smokers reported that, during their last medical visit, their physician told them to quit smoking (27.3%) or offered them help to quit (13.3%). Conclusions: Over these 10 years, smoking prevalence, nicotine dependence levels and the frequency of quit attempts remained stable, but smokers' motivation to quit increased. We observed a growing social gap in smoking prevalence and cigarette consumption. Smoking cessation advice was seldom received during medical visits. Copyright 2010, Elsevier Science.

Association of substance use discussion by pediatric providers with the parent: Provider relationship and maternal behavior change.

Garg A; Nelson CS; Burrell L; Duggan AK; Sia C. *Clinical Pediatrics* 49(3): 240-248, 2010. (41 refs.)

A cross-sectional study of data from a randomized, controlled trial was conducted to determine (1) provider and parent attributes associated with discussion of maternal substance use, (2) how substance use discussion related to the parent-provider relationship, and (3) whether discussion was associated with maternal attempts at behavior change. Of the 482 mothers, 34% reported discussing all 3 substance use items (smoking, alcohol, and drug use) with their child's provider. Mothers who discussed smoking were more likely to report discussing alcohol and other drug use (P < .001). Parent-provider relationship scores, measured by a modified version of the Primary Care Assessment Survey, were positively associated with discussion of each substance (P < .001). Discussion of smoking and drug use were significantly associated with attempted behavior change. Our findings suggest that discussion of parental substance use by pediatricians is positively associated with the parent-provider relationship and may lead to behavior change. Copyright 2010, Sage Pub.

Practice strategies to improve compliance and patient self-management.

Ruetsch C. *Journal of Managed Care Pharmacy* 16(1, Supplement B): s26-s27, 2010. (4 refs.)

BACKGROUND: Failure in treating opioid dependence is costly to the patient, the employer, managed care organizations, and the overall health care system. Opioid dependent patients tend to be less productive at work and in society and utilize a great many health care resources. Optimizing outcomes is essential. OBJECTIVE: To introduce the benefit of integrated strategies and patient support in the treatment of opioid dependence. SUMMARY. Health Analytics is currently studying the benefit of HereToHelp, a behavioral support program in which registered nurses or addiction treatment counselors with specialized training in addiction education provide information and encouragement to patients receiving pharmacologic treatment for opioid dependence A total of 470 physicians in 41 states have been enlisted to participate in this patient support study the study hypothesis is that patients who receive behavioral support and encouragement will be more compliant with their opioid replacement therapy, leading to better outcomes. Additional treatment strategies are also being developed to minimize the risk of abuse and diversion. Prodrugs and vaccines are also being investigated. CONCLUSION. A coordinated team approach is essential in treating pain patients and opioid-dependent patients offering behavior modification in addition to pharmacotherapy and utilizing strategies such as prescription monitoring programs, pain contracts, and screening are all vital components necessary for positive outcomes. Copyright 2010, Academy of Managed Care Pharmacy.