The Practice Gap: National Estimates of Screening and Counseling for Alcohol, Tobacco, and Obesity

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ABSTRACT

Tobacco use, lack of physical activity and poor diet, and alcohol consumption are leading causes of death in the United States. We estimated screening and counseling rates by using a nationally representative sample of adults aged 35 years and older with a preventive care supplement to the 2014 Medical Expenditure Panel Survey. Receipt of the recommended level of services ranged from nearly two-thirds (64.2% for obesity, 61.9% for tobacco use) to less than one-half (41.0% for alcohol misuse). There is significant room for improving care delivery, but primary care practices probably also need additional resources to raise screening and counseling rates.

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INTRODUCTION

Tobacco use, lack of physical activity and poor diet, and alcohol consumption are leading causes of death in the United States, and the US Preventive Services Task Force has developed recommendations targeted at reducing their prevalence.[1,2] Screening and counseling for tobacco use, obesity, and alcohol misuse require 2 steps: patients must be screened for a behavior or condition, and clinicians must provide appropriate counseling for those screening positive. Prior research has demonstrated gaps in receipt of these screening and counseling services,[3,4] but we do not know at a population level what percentage of adults are receiving the recommended services and whether the screening or counseling component is driving any practice gaps–the latter of which is critical for quality improvement efforts.

METHODS

We used the Preventive Care Self-Administered Questionnaire (PSAQ) from the 2014 Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality.[5] MEPS is a nationally representative annual survey of approximately 30,000 individuals in more than 10,000 households, serving as a comprehensive source of measures of health status, health insurance coverage, health care use, and spending in the United States.[6] The PSAQ was fielded in early 2015 and included 2,186 adults aged 35 years and older. Survey development included expert review by survey methodologists and the use of focus groups and cognitive, usability, and field testing.[5] The survey instrument and documentation are available through the MEPS website.[7]

We estimated rates of screening and counseling for tobacco use (any use within past year), obesity (BMI ≥30), and alcohol misuse (4 or more drinks on a day in the past year for women and 5 or more for men). Receipt of the recommended preventive service includes reporting being screened and, if screening positive, then also receiving counseling. Our estimates are weighted to be nationally representative, with standard errors adjusted to account for the complex survey design of the MEPS and the PSAQ subsample.

Conflicts of interest: authors report none.

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RESULTS

The overall rate of receipt of appropriate tobacco screening and counseling was 61.9% (Table 1). Of the approximately two-thirds (66.2%) of adults who were screened for tobacco use, 21.6% used tobacco. Of these, almost three-quarters (71.1%) received counseling or medication to help stop smoking. The overall rate of appropriate screening and counseling for obesity (64.2%) was similar to the rate for tobacco. It was achieved in a very different way, however. More adults reported being screened for obesity (78.6%), and of those screened, nearly 40% had a BMI of 30 or higher (39.2%); however, only slightly more than one-half (53.5%) of obese adults screened reported receiving counseling about weight management. The rate of receipt of appropriate screening and counseling for alcohol misuse was lower (41.0%) than for either tobacco or obesity. Only about one-half of adults were screened for alcohol misuse (48.5%), with one-fifth (20.0%) screening positive. Of these, less than one-quarter (24.4%) reported receiving counseling to reduce their alcohol use.

Table 1. Screening and Counseling Rates for Tobacco Use, Obesity, and Alcohol Misuse Among US Adults Aged 35 Years and Older, 2014

	Weighted %[a] (95% CI)			
Measure	Receiving Recommended Services, %	Screened, %	Screening Positive, % (Of Those Who Were Screened)	Counseled, % (Of Those Who Screened Positive)
Tobacco use	61.9 (59.4-64.3)	66.2 (63.9-68.6)	21.6 (18.9-24.3)	71.1 (65.3-76.9)
Obesity	64.2 (61.7-66.8)	78.6 (76.4-80.9)	39.2 (36.3-42.2)	53.5 (48.7-58.3)
Alcohol misuse	41.0 (38.8-43.3)	48.5 (46.1-50.8)	20.0 (16.9-23.3)	24.4 (17.7-31.1)

MEPS = Medical Expenditure Panel Survey; PSAQ = Preventive Care Self-Administered Questionnaire.

[a] These weighted estimates using the PSAQ subsample (n = 2,186) represent a population size of 170,400,202 adults aged 35 years and older. The unweighted counts and denominators are not provided because they should not be interpreted without accounting for the sampling design of MEPS and the PSAQ.

DISCUSSION

These results remind us that there is significant room for improving the delivery of clinical preventive services for these drivers of morbidity and mortality, a finding that is consistent with prior studies.[3,4] In 2018, the PSAQ will be fielded again in a larger subsample, allowing us to monitor progress in the receipt of clinical preventive services at a population level over time. Different solutions are probably necessary to increase the delivery of each of these services, given the varied profile of gaps in screening and counseling for these 3 conditions.

For example, quality improvement may require preparing teams to ensure delivery of effective weight loss counseling, whereas improving tobacco cessation may require additional attention to universal screening. Counseling can be provided within primary care or referred from primary care. Resources are available to guide integration of behavioral health in primary care and other ambulatory settings.[8] Attention is needed to increase screening and counseling for alcohol misuse. Some promising strategies for increasing screening include the use of electronic medical reminders and panel management support.[9] Primary care practices probably also need additional training and resources to improve overall screening and counseling rates for their patients.[10] Solutions may vary and should be tailored to the local environment to balance the competing demands of primary care.[11-13]

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Key words: primary health care; preventive medicine; preventive health services; tobacco use; obesity; alcohol drinking; counseling; health behavior

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