Tailored Support Strategy May Increase Screening for Unhealthy Alcohol Use

— Less than a third of patients discuss alcohol use with their primary care physician

by Shannon Firth, Washington Correspondent, MedPage Today

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Key Takeaways

- Unhealthy alcohol use ranks among the top three causes of preventable deaths in the U.S., yet less than one-third of patients who visit a primary care clinician ever discuss alcohol use.
- A tailored practice facilitation strategy was linked to increased adoption of evidence-based screening and counseling for unhealthy alcohol use among adults at small and medium-sized primary care practices.
- Studies in two other states documented similarly positive findings.

A tailored practice facilitation strategy was linked to increased adoption of evidence-based screening and counseling for unhealthy alcohol use among adults at small and medium-sized primary care practices, a quality improvement study suggested.

Among 21 practices serving more than 54,000 adults in North Carolina, mean screening rates jumped from 17.4% per practice to 57.6% by the end of the second quarter of practice facilitation implementation ($P<0.001$), which included quality improvement coaching, electronic health record support, and training on screening and counseling, reported Daniel E. Jonas, MD, MPH, of the Ohio State University College of Medicine in Columbus, and co-authors.

Of the 13.9% of patients who screened positive for unhealthy alcohol use, the share who received brief counseling increased from 0 to 32.3% by the end of the second quarter ($P<0.001$), the authors noted in *JAMA Network Open*.

Unhealthy alcohol use ranks among the top three causes of preventable deaths in the U.S., yet less than one-third of patients who visit a primary care clinician ever discuss alcohol use, Jonas and team said.

"Historically, implementation efforts to increase the adoption of evidence-based screening and brief counseling for unhealthy alcohol use in primary care have relied on one-time training sessions, stand-alone educational programs, or EHR [electronic health record] prompts," they wrote. "However, these approaches often failed to create lasting change due to insufficient support, lack of follow-through, and competing clinical demands."

"The approach used [here], including practice facilitation and building off of social learning theory, provides tailored support that incorporates a range of techniques to enable integration of evidence-based practices into routine workflows, allowing practices to overcome initial barriers to start-up and sustainment," they explained.

In an accompanying editorial, Alison N. Huffstetler, MD, and Alex H. Krist, MD, MPH, of Virginia Commonwealth University in Richmond, noted that "while ideally, all people with unhealthy use would receive counseling, this improvement is clinically meaningful and shows that primary care can effectively deliver this preventive service."

While counseling is challenging and time-consuming, they suggested future practice facilitation efforts could leverage motivational interviewing, especially "micro-motivational interviewing," a 30- to 60-second dialogue "during which the clinician elicits a small amount of change talk from the patient," as a "high-yield option to improve counseling and decrease alcohol use."

This study was one of six grantees funded by the Agency for Healthcare Research and Quality EvidenceNow initiative, which aims to incorporate practice facilitation in primary care settings per recommendations from the U.S. Preventive Services Task Force.

Two other grantees, in Washington State and Virginia, documented similarly positive findings, the authors noted.

Practices were eligible for the study if 10 or fewer physicians and advanced practice professionals worked at a single clinic and if they had not previously received facilitation services related to unhealthy alcohol use. They received 12 months of practice facilitation.

Practice facilitators reported 280 facilitation encounters, with a mean of 15.5 encounters per practice. About half of encounters (49.6%) occurred over video, 25.7% over email, 22.1% in person, and 2.5% over the phone. On average, video encounters lasted 34 minutes and in-person encounters lasted 60.3 minutes.

In total, 54,294 patients participated from February 2020 to September 2023. The mean number of adult patients per practice was 3,386.2, and the mean number of weekly adult patient visits was 315. The majority of practices had two to five clinicians, most were clinician-owned, and 47.6% had at least one behavioral health clinician working in the practice.

Weighted data indicated that most patients were ages 40 to 59 or 60 to 75 years. On average, 51.7% were women, 40.1% were Black, 52% were white, and 7% were Hispanic or Latino.

A limitation of the study was the withdrawal of 11 practices before the facilitation phase (mainly due to pandemic-related factors), which may have resulted in a remaining cluster of more "highly motivated" practices, Jonas and team noted. Also, practice facilitation was manually tracked by facilitators and may be subject to self-report bias. Finally, the findings may not be generalizable to other states.

Shannon Firth has been reporting on health policy as MedPage Today's Washington correspondent since 2014. She is also a member of the site's Enterprise & Investigative Reporting team. Connect:

Disclosures

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The study authors reported no conflicts of interest.

Huffstetler and Krist also reported no conflicts.

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Secondary Source

JAMA Network Open

Source Reference: Huffstetler AN, Krist AH "Open primary care clinic doors to practice facilitation" JAMA Netw Open 2026; DOI: 10.1001/jamanetworkopen.2025.53485.

1 Comment