ODHIN PROJECT FACTSHEET

- WP7 –

ODHIN – highlights

In this factsheet, we note the **six core challenges facing the effective delivery of screening and brief advice for heavy drinking in primary health care,** and present **eight core opportunities for overcoming these challenges.**

Background

The ODHIN project[1] (Optimizing delivery of health care interventions) is a four-year project (2011-2014) co-financed under the under the 7th Framework Programme of the European Commission to study how best to increase the delivery of screening and brief advice programmes for heavy drinking in primary health care.

The project addressed five questions:

1. What are general practitioners' attitudes and views to delivering screening and brief advice programmes for heavy drinking?
2. What does the published scientific literature tell to us about the best ways to improve the volume of screening and brief advice programmes for heavy drinking delivered in primary health care?
3. Can we increase the volume of screening and brief advice programmes for heavy drinking delivered in primary health care by providing training and support, financial reimbursement and the use of internet-based brief advice programmes for identified heavy drinkers?
4. How cost effective are strategies to encourage primary health care providers to deliver screening and brief advice programmes for heavy drinking?
5. How can we assess screening and brief advice programmes for heavy drinking at the country level?

[1] http://www.odhinproject.eu.

Core challenges

1. Alcohol is a cause of more than 200 diseases and conditions (WHO, 2014), most of which present in primary health care – thus primary health care providers cannot avoid dealing with alcohol in routine clinical practice
2. Alcohol increases the risk of dying before the age of 70 years in a more or less dose response relationship (Rehm et al, 2014). At an intake of 20 grams of alcohol a day (similar to two standard drinks), 1 in 100 people will die before the age of 70 years due their alcohol consumption. Beyond 30 grams of alcohol a day, men are more likely to die than women for any given level of alcohol consumption. Reducing alcohol consumption reduces the subsequent risk of an alcohol caused death.
3. Brief advice from a primary health care provider is effective in reducing heavy drinking (an average reduction 38 grams of alcohol per week over and above control conditions from a pre-advice level of 313 grams per week - a 12% reduction) (O'Donnell et al, 2013).
4. Screening and giving brief advice delivered in primary health care is cost-effective when delivered both at next consultation and at next patient registration (see ODHIN's Deliverable 3.1 (Angus et al, 2013) for further details). When delivered at next patient registration, screening and brief advice is, in some jurisdictions, cost-saving.
5. Despite the health burden and evidence for effectiveness and cost effectiveness, only 11 per thousand adult patients who consulted their primary health care doctor in Catalonia, England, Netherlands, Poland and Sweden were given brief advice for heavy drinking, an estimated 1 in 30 of those who could have benefited from brief advice (see ODHIN's Deliverable 5.2 (The ODHIN TRIAL Consortium, 2014) for further details).
6. Despite the health burden and evidence for effectiveness and cost effectiveness, in general, health systems across Europe lack the infrastructures to support the delivery of screening and brief advice programmes, with less than half of 23 European countries considering that screening and brief advice programmes were integrated to at least some extent, and hardly any countries able to provide routine data on the extent to which screening and brief advice programmes were actually delivered in primary health care (see ODHIN's Deliverable 6.1 (Gandin et al, 2013) for further details).

Core opportunities for meeting these challenges

1. Primary health care physicians who report having received more training on managing alcohol problems report advising a higher number of heavy drinking patients – as do those who report being either able or inclined to deliver brief advice (see ODHIN's Deliverable 4.1 (Wojnar et al, 2014) for further details).
2. Primary health care physicians who hold strong views that doctors have a disease rather than a prevention model, or who believe that patients should be responsible for their own drinking report advising a lower number of heavy drinking patients (see ODHIN's Deliverable 4.1).
3. A systematic review of 29 studies found that professional oriented strategies, such as delivering education on screening and brief advice programmes to primary health care providers increases their screening and brief advice activities – a finding consistent with general practitioners' own views (see ODHIN's Deliverable 2.1 (Keurhorst et al, 2013) for further details). The impact of

professional oriented strategies on screening and brief intervention delivery is enhanced when supplemented with patient oriented strategies (e.g., patient education progammes) and when delivered comprehensively to multidisciplinary primary health care teams rather than singly to isolated professional groups.

4. The ODHIN five-country study found that, when compared with no education, education of primary health care providers in delivering screening and brief advice led to a two-thirds increase in the number of adult patients consulting their primary health care doctor who were given brief advice for heavy drinking during the three month period in which 2-3 hours of education was delivered, an effect that was still present six months later (two-fifths increase in the number of adult patients consulting their primary health care doctor who were given brief advice for heavy drinking with education as opposed to without) advice (see ODHIN's Deliverable 5.2).
5. Compared with no financial reimbursement of screening and brief advice activity, modest financial reimbursement given to primary health care providers led to a more than doubling in the number of adult patients consulting their primary health care doctor who were given brief advice for heavy drinking during the three month period in which financial reimbursement was given, an effect that disappeared when the financial reimbursement was stopped. A combination of training and support and financial reimbursement led to a trebling in the number of adult patients consulting their primary health care doctor who were given brief advice for heavy drinking during the three month period in which financial reimbursement was given (see ODHIN's Deliverable 5.2).
6. Although internet-based screening and brief advice programmes can reduce alcohol consumption amongst those drinkers who use them (Donoghue et al, 2014), the option of referral to an e-BI programme for patients screened positive did not change the number of adult patients consulting their primary health care doctor who were given brief advice for heavy drinking (see ODHIN's Deliverable 5.2).
7. The combined provision of training and support and financial reimbursement were found to be highly cost effective in leading to improved health outcomes in four out of the five jurisdictions studied, and, in three out of five jurisdictions studied, would lead to large resource savings of approximately €20 per adult over a 30 year time frame (see ODHIN's addendum to Deliverable 3.1 (Angus et al, 2014) for further details).
8. It is possible to assess the delivery of primary health care based screening and brief advice programmes for heavy drinking at jurisdictional level, although existing measures need to be supplemented with objective monitoring of the number of adult patients actually given a brief advice over a defined time period care (see ODHIN's Deliverable 6.1).

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