Managed Care Plans' Requirements for Screening for Alcohol, Drug, and Mental Health Problems in Primary Care

Deborah W. Garnick, ScD; Constance M. Horgan, ScD; Elizabeth L. Merrick, PhD, MSW; Dominic Hodgkin, PhD; Della Faulkner, MA; and Stephanie Bryson, MSW

Objective: To determine managed care organizations' (MCOs) requirements for screening for alcohol, drug, or mental health problems in primary care settings.

Study Design: A telephone survey was used to gather information on the 3 largest commercial products offered by MCOs. Products included health maintenance organizations, preferred provider organizations, and point-of-service plans.

Methods: Managed care organizations were asked whether their products required screening for alcohol, drug, or mental health problems in primary care settings. Chi-square tests were performed to ascertain whether screening requirements, the distribution of practice guidelines, and the topics addressed in those guidelines varied by product type and contracting with specialty behavioral health vendors. The data were weighted to produce national estimates.

Results: Only 14.9% of the products surveyed required any alcohol, drug, or mental health screening by primary care practitioners. Slightly more than half of all the products surveyed distributed practice guidelines that addressed mental illness, and about one third distributed substance abuse practice guidelines.

Conclusions: Although the feasibility, utility, and effectiveness of screening are increasingly recognized, few MCOs currently require alcohol, drug, or mental health screening by primary care physicians in any of their product types.

(Am J Manag Care 2002;8:879-888)

Undiagnosed and untreated substance abuse and mental health disorders are currently at the center of public health awareness and are now recognized as a key cause of disability. As much as 28% to 30% of the adult US population has either an active psychiatric disorder or addictive disorder over the course of a year.[1,2] However, many people who need treatment for such disorders do not receive care.[3,4] Patient visits to primary care clinicians offer opportunities to identify alcohol, drug, or mental health problems and to treat or refer those who need care. Brief screening instruments, well established for alcohol and drug problems, are increasingly available for mental health problems as well, but several surveys of physicians have indicated that these instruments are not used widely.[5,6]

No previous studies have provided national estimates of managed care organizations' (MCOs') policies related to screening and treatment of alcohol, drug, and mental health problems in primary care settings, even though 92% of people with employer-sponsored health insurance are covered by MCOs.[7] Moreover, this study is the first to relate screening requirements to the types of products within MCOs. It is also the first to relate screening requirements to contracting arrangements, whether they be internal, or "carve outs" to specialty managed behavioral healthcare organizations (MBHOs), or comprehensive networks (including both general and behavioral health providers).

To explore this issue, we conducted a nationally representative survey of MCOs to assess the extent to which screening in primary care settings is required in their 3 largest commercial products. Specifically, we addressed the following questions related to screening for alcohol, drug, or mental health problems:

How often is screening required in primary care settings for 3 specific products (health maintenance

From the Schneider Institute for Health Policy, Heller Graduate School, Brandeis University, Waltham, Mass.

This research was supported by grants from the National Institute on Drug Abuse (#RO1 DA10915), the National Institute on Alcohol and Abuse and Alcoholism (#RO1 AA10869), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Some of the information in this report was presented at the 2001 Annual Meeting of the American Public Health Association, October 24, 2001, Atlanta, Ga.

Address correspondence to: Deborah W. Garnick, ScD, Schneider Institute for Health Policy, Heller Graduate School, MS 035, Brandeis University, Waltham, MA 02454-9110. E-mail: garnick@brandeis.edu.

organizations [HMOs], preferred provider organizations [PPOs], or point-of-service plans [POS])?

Does the prevalence of screening depend on the product type and contracting arrangements (eg, internal provision of behavioral health services, carve-out contracts with MBHOs, or comprehensive network contracts)?

Are managed care products that require screening more likely to provide support for primary care practitioners in the form of practice guidelines on how to treat or refer the patients they identify?

Primary Care Practitioners' Roles in Detection and Screening

Primary care practitioners have a unique opportunity to recognize substance abuse and mental health problems at early stages and to treat or refer patients for care.[8,9] From 20% to 40% of all patients seen in primary care settings are thought to have diagnosable psychiatric disorders or distress sufficient to interfere with daily functioning.[10,11] Among people who receive mental health treatment through the formal US healthcare system in a given year, roughly half are seen by primary care practitioners in general medical care settings.[12]

A large body of research documents the difficulty that primary care practitioners have in detecting mental disorders, including anxiety and depression, across a broad range of patients.[13-15] Reporting on their confidence in their ability to diagnose patients' problems, only 19.9% of primary care physicians surveyed in 1999 thought they were prepared to diagnose alcoholism, whereas 16.9% thought they were prepared to diagnose illegal drug disorders and 30.2% thought they were prepared to diagnose prescription drug abuse.[6]

The use of more effective screening tools in primary care has been proposed to assist primary care practitioners in recognizing and accurately diagnosing substance abuse and mental problems, thus providing the first step in reducing the burden of untreated addiction. Several standardized instruments for alcohol and drug abuse,[16] as well as for psychiatric disorders,[17] have now been evaluated for reliability, validity, effectiveness, and feasibility in primary care settings.

Screening Instruments

Alcohol. Screening instruments for problem drinking appear to have adequate sensitivity and specificity to warrant widespread use in primary care. A 1996 report of the US Preventive Services Task Force[18] recommended that primary care physicians screen all adult and adolescent patients for problem drinking, using clinical interviews and standardized questionnaires such as the CAGE (Cut down, Annoyed, Guilty, Eye-opener) questionnaire or AUDIT (Alcohol Use Disorders Identification Test).

Depression and Drug Abuse. Unlike alcohol use questionnaires, available depression and drug abuse screening instruments lacked sufficient evidence of effectiveness to gain support for routine use from the US Preventive Services Task Force in 1996. Rather, the Task Force recommended that clinicians retain a high index of suspicion for those at high risk for mental health disorders or drug abuse symptomatology and acknowledged that the development of newer, multidisorder screening instruments promised better effectiveness and feasibility.[18] In May 2002, the Task Force recommended ". . . screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up."[19,20]

Expressing a different view for substance abuse, the consensus panel that developed the treatment improvement protocol on substance abuse services for primary care clinicians, published in 1997, recommended that all patients be screened periodically and routinely for substance abuse disorders using the AUDIT, CAGE, or CAGE-AID (CAGE Adapted to Include Drugs).[21] In addition, for depression in particular, a recent review article, published in 2000, recommended screening of selected patients whose profiles suggest increased risk.[22]

Screening and Outcomes

Alcohol screening followed by brief counseling has demonstrated positive patient outcomes, reducing alcohol consumption in problem drinkers.[23,24] Clinical trials of mental health screening failed to show significant improvements in patient outcomes from screening alone. A consensus in the literature suggests, however, that screening remains a necessary component of a comprehensive approach to mental health disorders, which includes detection, diagnosis, treatment, and follow-up.[17]

Additionally, newer instruments with good sensitivity and specificity for multiple conditions and realistic administration time, such as the multisymptom PRIME-MD, are now being evaluated. In early trials, the PRIME-MD was reported to improve detection and initiation of treatment for mental disorders in primary care settings.[25] In a recent study of routine screening using the PRIME-MD in a net-

work of high-risk, low-income urban primary care centers, participating primary care clinicians reported that 29% of positive screens for psychiatric conditions influenced their assessment or treatment,[26] suggesting that use of the PRIME-MD potentially led to improved diagnosis, treatment, and follow-up.

Prevalence of Screening

Most of the studies that document the prevalence of screening by primary care physicians show low screening rates in surveys of providers[5,27,28] and interviews with substance-abusing adolescents and their parents.[29] The most recent national survey of primary care physicians in 1999 found that fewer than one third reported that they ever administered a standard alcohol or drug use screening instrument or felt confident diagnosing prescription drug abuse.[6] Another survey conducted in 1997-1998 reported that 68% of physicians usually or always ask new patients about illicit drug abuse and 88% about alcohol abuse, although the use of standard screening protocols was less common.[30,31]

Practice Guidelines

The potential for screening to lead to improved outcomes can be realized only if primary care practitioners also are knowledgeable about providing brief interventions, prescribing appropriate medications, seeking specialty consultation, and referring patients to specialty care. Practice guidelines (defined as "systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical services") have been published recently in all of these areas, with several produced by the US federal government's Center for Substance Abuse Treatment.[19,32–35] However, there is consensus that to be effective in changing providers' behavior, guidelines must take into account providers' practice organization and external environment.[36]

METHODS

The data source for this study was the nationally representative Brandeis Survey on Alcohol, Drug, and Mental Health Services in MCOs. We surveyed 434 MCOs in 60 market areas nationwide regarding their commercial managed care products offered in 1999, obtaining a 92% response rate. Each MCO was asked to provide information about its top 3 commercial managed care products. The survey instrument included an administrative module containing items regarding contracting arrangements, benefits, and provider payment, and a clinical module that addressed utilization management, treatment entry mechanisms, prescription drug formularies, quality improvement, and other clinically oriented topics.

Sampling

This study is linked to the Community Tracking Study (CTS), a major longitudinal study conducted in the same market areas by the Center for Studying Health System Change.[37] The CTS sample design contained separate strata for large metropolitan, small metropolitan, and nonmetropolitan market areas. Within strata, nearly all sites were selected randomly with probability proportional to size (with a few sites selected with certainty). The primary sampling units for our survey were the 60 market areas selected for the CTS to be nationally representative. Our second sampling stage consisted of selecting MCOs within the market areas. MCOs serving multiple markets were defined as separate MCOs for the study and data were collected with reference to the specific market area.

Within each market area, the initial sample frame was based on CTS household survey respondents' information on their health plan as well as on verification from insurers and health plans. This effort provided a listing of more than 1000 entities categorized as MCOs across the 60 sites. Based on information from Web searches and industry directories, we excluded entities that were exclusively indemnity plans as well as MCOs that were no longer operating within a given market area. This exclusion left 944 MCOs on the list, which served as the sample frame for our study. We stratified the sampling allocation of MCOs within market area into 2 categories: PPO only and HMO/other (including HMO only and multiproduct) and drew a stratified random sample.

Of the 720 market-specific MCOs that were selected from the sample frame, 473 were eligible for the study because they had more than 300 subscribers in the market area, offered comprehensive healthcare products, were not limited to Medicaid/Medicare enrollees, and offered HMO, PPO, or POS products. Of these 473 eligible MCOs, 434 (92%) responded. Because MCOs often offer multiple products, they reported on 787 eligible managed care products. The 752 products for which

the MCOs completed the clinical portion of the survey provide the basis for this analysis. When products were similar, such as 2 PPOs with only minor differences in patient copayment levels, we combined these into 1 PPO product. The national estimates in this paper were weighted for selection probability and nonresponse.

Overall, 40.6% of products were HMOs, 35.7% were PPOs, and 23.7% were POSs. The products varied by behavioral health contracting arrangement: 59.8% had specialty contracts, 15.5% had comprehensive contracts that included general medical and behavioral health services, and 24.7% had internal arrangements.

Questions Asked

Regarding screening, we asked whether primary care practitioners were required to use standard screening questionnaires for detecting alcohol, drug, and mental health problems for at least some of their patients. When respondents indicated that mental health screening was required, we asked whether it was required for any of the following 5 subgroups: all patients on a periodic basis, new patients at first visit, patients with specified symptoms or trigger conditions, patients within specified age groups, and patients identified by clinical judgment.

To assess the relationship between screening in primary care and support for primary care practitioners' provision of treatment, we also asked if written practice guidelines specifically for substance abuse or mental health treatment in primary care were available and if so, whether they were distributed to primary care practitioners. In addition, we asked about specific topics addressed in the written guidelines: provision of brief interventions; prescribing and monitoring medications for alcohol, drug abuse, or mental health problems; consulting with specialty (substance abuse or mental health) practitioners; criteria for referring to specialty care; provision of educational materials to patients; and, for substance abuse clients, referral to mutual help resources.

Statistical Analysis

The results presented here are weighted to be representative of MCOs' commercial managed care products in the United States. Data were weighted to account for the MCOs' differing probability of selection and for nonresponse. The software package SUDAAN[38] was used to allow correction of standard errors for the complex survey design. Chi-square tests were used to test the significance of differences across product type and contracting arrangement.

RESULTS

Only 14.9% of managed care products required any type of screening for alcohol, drug, or mental health problems in primary care settings (**Table 1**). Both alcohol screening (required by 9.1% of products) and mental health screening (required by 8.1% of products) were required significantly more often than drug abuse screening (required by only 2.0%) of products. The small percent of products that required drug abuse screening was a subset of those that also required alcohol screening. The same products did not usually require both mental health and alcohol screening, as evidenced by the fact that only 2.3% of products required both.

For mental health, the 8.1% of products that required screening also reported on the types of patients for whom screening was required (data not shown). More than 90% of products requiring mental health screening allow clinical judgment to determine the primary care practitioner's decision to conduct mental health screening, whereas 62.5% required screening for all new patients. The most often-cited trigger conditions for mental health screenings were sleep difficulties, chronic pain, and the presence of a substance abuse problem.

Differences Across Types of Products and Contracts

Point-of-service products are most likely to require screening for mental health problems, whereas PPO products are least likely (**Table 2**). Health maintenance organizations were less likely than POS products to require mental health screening, but this apparent difference may be influenced by the relatively large number of HMO products (23.1%) whose response was missing or "don't know." For alcohol, HMO products were less likely to require screening in primary care settings than PPO or POS products.

Products that carve out behavioral health services to MBHOs are significantly less likely to require screening for mental health problems than products that provide services internally or have comprehensive contracts. Again, this difference may be an artifact of the larger number of "don't know" responses among the specialty products. In terms of alcohol screening, products with comprehensive contracts were significantly more likely to require screening than either products with

specialty contracts or internal provision. For products that are part of multiproduct MCOs, almost all that require alcohol screening require it across all product types (data not shown).

Support for Treatment in Primary Care

It is key that managed care products that require screening also support primary care practitioners so that they can deal with the clinical issues that screening may uncover. One way is to provide practice guidelines specifically for the treatment of mental health or substance abuse in primary care settings.

Table 1. Percent of Managed Care Products Requiring Screening in Primary Care for Mental Health, Drug, or Alcohol Problems

	Screening Required in Primary Care % (SE)		
Type of Screening	**Yes**	**No**	**Don't Know/Missing**
Mental health	8.1 (2.1)*	79.6 (2.4)	12.4 (1.0)
Alcohol abuse	9.1 (1.7)*	87.4 (2.4)	3.5 (0.9)
Drug abuse	2.0 (0.4)	91.1 (1.4)	7.0 (1.4)
Both mental health and alcohol or drug abuse	2.3 (0.9)	94.1 (1.1)	3.6 (0.9)
Any mental health or substance abuse	14.9 (2.2)	81.8 (2.6)	3.4 (0.9)

Weighted total n = 6059. Totals may not add to 100% because of rounding.
*Significantly different from drug abuse, $P < .01$ level.

Table 2. Screening for Mental Health and Alcohol Problems by Product Type and Contracting Arrangement

		Product Type % (SE)			Contracting Arrangement % (SE)		
Screening Required for:	**n**	**HMO**	**PPO**	**POS**	**Specialty Contract**	**Comprehensive Contract**	**Internal Provision**
Mental health							
Yes	490	8.3 (1.9)*†	4.8 (1.4)	12.6 (4.1)*	4.1 (1.7)§‖	14.0 (3.1)	13.9 (4.1)
No	4821	68.6 (2.2)	91.2 (2.4)	80.8 (4.0)	77.8 (2.0)	78.3 (4.5)	84.7 (4.1)
Don't know/missing	748	23.1 (1.2)	4.0 (1.2)	6.5 (1.9)	18.1 (1.2)	7.7 (2.7)	1.4 (0.4)
Total	6059	100%	100%	100%	100%	100%	100%
Alcohol							
Yes	552	6.9 (1.3)*‡	10.7 (2.1)	10.5 (2.1)	8.1 (2.0)§	14.5 (2.4)	8.3 (2.1)§
No	5295	88.8 (2.2)	88.4 (2.1)	83.5 (3.5)	86.4 (3.0)	84.8 (2.5)	91.4 (2.1)
Don't know/missing	212	4.4 (1.2)	0.8 (0.4)	6.1 (1.9)	5.6 (1.5)	0.7 (0.8)	0.3 (0.2)
Total	6059	100%	100%	100%	100%	100%	100%

Totals may not add to 100% because of rounding.
*Significantly different from PPO, $P < .01$.
†Significantly different from alcohol screening = yes, $P < .01$.
‡Significantly different from POS, $P < .01$.
§Significantly different from comprehensive contract, $P < .01$.
‖Significantly different from internal, $P < .01$.
HMO indicates health maintenance organizations; PPO, preferred provider organization; POS, point-of-service plans.

Distribution of Guidelines. For products that had practice guidelines in primary care, we asked if they also distributed these guidelines. For those products that required screening, all or almost all that had practice guidelines also distributed them (**Table 3**).

Slightly more than half of all the products surveyed (51.0%) distributed practice guidelines that addressed mental illness, and about one third (32.2%) distributed substance abuse practice guidelines (Table 3).

When we looked at the relationship between screening and the use of practice guidelines, we found that more than half of the products that screened for mental health (53.8%) and for alcohol problems (54.8%) also used and distributed practice guidelines (Table 3). Among products that did not require mental health screening, 58.4% used and distributed practice guidelines, whereas among products that did not require alcohol screening, only 31.1% used and distributed practice guidelines.

Topics Addressed in Practice Guidelines. For products that distributed practice guidelines, we compared the topics covered in the guidelines between those products that required screening and those that did not (**Table 4**). Among products with required mental health screening, 85% or more distributed guidelines addressing the provision of brief interventions, consulting with specialty practitioners, and patient education. Only 60.7% distributed guidelines addressing criteria for referral to specialty care, and 65.5% distributed guidelines addressing the prescribing and monitoring of psychotropic medications. The percent of products with each guideline topic was not significantly different for those products that did not require mental health screening.

Regardless of whether or not they required alcohol screening in primary care settings, most products that distributed substance abuse practice guidelines included those that addressed the provision of brief interventions, consulting with specialty practitioners, and the provision of educational materials to patients. Of the products that did not require alcohol screening, about 95% distributed practice guidelines addressing referral to mutual help resources or prescribing and monitoring medications, compared with only 10.0% of products requiring alcohol screening. In contrast, products that required alcohol screening in primary care settings were significantly more likely than those that did not to distribute guidelines addressing criteria for referring out to specialty care (97.8% compared with 24.3%).

DISCUSSION

Few managed care products in our study required early detection and prevention activities in primary care settings, despite growing evidence of the effectiveness of screening for substance abuse and mental health problems in primary care. Statistically significant differences across product type and contracting arrangement may not be meaningful in a policy sense because the overall level of required screening was never above 15% for any category. Furthermore, the differences may not be real in an empirical sense because

Table 3. Screening in Primary Care for Mental Health and Alcohol Problems as Related to the Distribution of Practice Guidelines

Screening Required for:	n	Practice Guidelines in Primary Care % (SE)			
		Guidelines Used and Distributed	Guidelines Used But Not Distributed	Guidelines Neither Used Nor Distributed	Don't Know/Missing
Mental health					
Yes	490	53.8 (3.9)	1.1 (1.0)	45.1 (4.0)	0.0 (0.0)
No	4821	58.4 (2.8)	1.5 (0.4)	40.1 (2.8)	0.0 (0.0)
Don't know/missing	749	1.8 (0.6)	0.0 (0.0)	15.4 (7.0)	82.8 (7.0)
Total	6059	51.0 (2.3)*	1.3 (0.3)	37.5 (2.8)	10.2 (1.0)
Alcohol					
Yes	552	54.8 (7.8)	0.0 (0.0)	45.2 (7.8)	0.0 (0.0)
No	5295	31.1 (2.7)	11.1 (1.3)	49.8 (3.8)	7.9 (1.1)
Don't know/missing	213	0.0 (0.0)	0.0 (0.0)	3.9 (2.0)	96.1 (2.0)
Total	6059	32.2 (2.5)	9.7 (1.2)	47.8 (3.4)	10.3 (1.0)

*Significantly different from alcohol, $P < .01$.

of the relatively large proportion of HMOs that did not know if screening is required.

Yet, regardless of whether or not a product required screening, slightly more than half distributed practice guidelines to support the provision of mental health services in primary care settings. Half of those that required screening for alcohol problems, and almost a third of those that did not, distributed practice guidelines related to substance abuse services.

Reasons for Low Rates of Required Screening

Explanations for low rates of screening being required by MCO products may be found at both the practitioner and the organizational levels. Although our survey did not address this issue directly, reluctance to screen for alcohol, drug, or mental health problems among primary care practitioners may filter back to the organizational level and influence MCOs' decisions not to require screening if they want to minimize the "hassle factor" for primary care practitioners in their network. Managed care organizations may be reluctant to overburden providers with yet more requirements, given that increased demands on providers have been a long-standing complaint under managed care arrangements.

The primary care practitioners may be reluctant to embrace screening for several reasons. First, they may be confused about recommendations from national panels that are mixed in terms of sometimes recommending screening for mental health problems and always recommending screening for alcohol problems. Second, information about the advantages of alcohol screening, which all expert reports recommend, may be slow to reach some primary care practitioners. Third, many primary care practitioners may not know how to treat patients who screen positive or may be afraid of asking direct or "toxic" questions about alcohol or drug abuse or mental health issues that might offend or even drive away some patients. Fourth, primary care practitioners may prefer to use other methods to obtain information such as information from a spouse or significant other and blood or urine tests.[27]

At the organization level, managed care administrators may believe that screening is occurring on a more informal than formal basis, therefore making any requirement for screening unnecessary. Moreover, given an average annual disenrollment of 28%,[39] commercial MCOs may have little incentive to require screening that could result in a longer-term medical cost offset from such preventive measures and early identification.[40] Debate exists about the appropriate role of PPOs regarding clinical performance. Some argue that PPOs are administrative entities that hold no responsibility for clinical performance, and thus would not be expected to require screening, whereas others contend that as MCOs, PPOs do bear such responsibility.[41]

Table 4. Screening by Practice Guideline Topics for Products Requiring Distribution of Practice Guidelines (Weighted)

		Topics Addressed in Practice Guidelines					
Screening Required for:	n	Provision of Brief Interventions	Referral to Mutual Help Resources	Prescribing and Monitoring Medications	Consulting With Specialty Practitioners	Criteria for Referring out to Specialty Care	Provision of Educational Materials to Patients
Mental health							
Yes	263	84.9 (4.9)	NA	65.5 (14.3)	92.7 (2.4)	60.7 (13.8)	92.5 (3.7)
No	2827	93.6 (2.2)	NA	80.8 (2.2)	96.0 (0.8)	52.8 (3.7)	85.1 (3.2)
Alcohol							
Yes	303	96.0 (2.6)	10.0 (6.8)*	10.0 (6.8)*	97.8 (1.9)	97.8 (1.9)*	96.0 (2.6)
No	1649	96.0 (1.3)	96.2 (1.3)	94.7 (1.2)	96.1 (1.1)	24.3 (5.5)	81.0 (5.3)

*Significantly different from alcohol screening = no, $P < .01$.
NA indicates not applicable.

Ways to Increase Requirements for Screening in Primary Care

Given these barriers, how might MCOs be encouraged to require and monitor screening for alcohol, drug, and mental health problems in primary care settings? The answer probably lies in a multifaceted approach including performance measures, financial incentives, and practitioner education.

Performance Measures. Borrowing from general medicine, the direct way to promote greater screening, diagnosis, treatment, and follow-up among MCOs is to specify the use of screening instruments in accreditation standards. The National Committee on Quality Assurance (NCQA) currently includes cervical cancer, breast cancer, cholesterol, and chlamydia screening as part of its performance measure set.[42] For alcohol screening, the Foundation for Accountability has developed a measure that directly evaluates, through a mailed survey to enrollees, the proportion of plan members reporting at least one office visit in the past year who were asked by their plan provider about alcohol use.[43]

An indirect approach is to adopt performance measures that focus on utilization rates such as the current NCQA measures on utilization rates for chemical dependency and mental health or the proposed Washington Circle measure on substance abuse identification.[44] The MCOs would have incentives to identify more enrollees if they felt that attention was being paid to the fact that their rates of identification of enrollees with substance abuse and mental health problems were less than the local population prevalence (adjusted for the age and gender distribution of their enrollees).

Financial Incentives. Capitated payments from MCOs to providers have the potential to encourage prevention and early intervention, including screening. However, achieving this goal would require that the capitation rate be sufficient and that providers have broad control over patient care, have patients under their care for a long time, and have adequate managerial skills and infrastructure.[45] Considering screening in primary care, several of these assumptions may not reflect reality, eg, providers report that some capitation rates are too low, primary care providers may not control the course of care when behavioral health is carved out to specialty vendors, and enrollee turnover may be high in some plans. Thus, the potential to increase screening through financial incentives, either in the form of capitated payments or in other approaches, depends on careful design that addresses each of these issues.

Practitioner Education. With the recent consensus that alcohol screening followed by brief intervention in primary care settings should be promoted, dissemination strategies have begun to be designed. These strategies range from efforts to educate physicians and nurses to improve their understanding of alcohol issues to changes in organizational structure to integrate alcohol screening with other clinical activities.[24]

Study Limitations

One limitation in interpreting our results lies in the way we worded our question on screening. Based on extensive cognitive and pilot testing of the instrument, we asked if products are "required to use standard screening questionnaires for at least some of their patients." This wording of our survey question may have led to a conservative estimate of the proportion of managed care products requiring screening in primary care because some MCOs may suggest screening or use nonstandard questionnaires, which would lead to an underestimate of prevalence. Alternatively, the wording "at least some" may lead to an overestimate if some products use screening only for a limited portion of patients but still answered yes to the question. In addition, a relatively large proportion of medical directors responded, "don't know" regarding requirements for screening. It seems reasonable that this response is indicative of a lack of focus on alcohol, drug, or mental health screening in those MCOs, but this assumption is only conjecture.

Furthermore, our goal was to capture MCOs' requirements in terms of screening in primary care, but it is important to recognize a general limitation of a survey of organizations. That is, we do not know about practitioners' actual behavior because even among the products that require screening, primary care practitioners may not adhere to that requirement and, even in products in which screening is not required, some practitioners may do so.

CONCLUSIONS

The small proportion of MCOs that require screening in primary care now are leaders in identifying enrollees in need of substance abuse or mental health services. Unfortunately, the majority is missing an opportunity to improve the identification of enrollees who need alcohol, drug, and mental health services. Despite a clear consensus on screening for alcohol abuse since the late 1990s,

MCOs have not yet begun to require such screening by primary care practitioners. Thus, the results reported here represent a baseline, one that can be used to begin to track future requirements for screening in primary care.

It is crucial to recognize that screening is desirable but not sufficient to ensure that patients are identified and receive the treatment they need. The MCOs that supply primary care practitioners with guidance on how to treat or refer patients with substance abuse or mental health problems recognize this need. Until screening is universally required, however, and monitoring is put in place to ensure that the requirements are followed, too many enrollees needing treatment will not be identified or helped.

Acknowledgments

We acknowledge the contributions of Robert Cenczyk, BA, David Goldin, MA, Galina Zolotusky, MS, Grant Ritter, PhD, and Frank Potter, PhD.

REFERENCES

1. Regier DA, Narrow WE, Rae DS, Mandersheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders services system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry.* 1993;50:85-94.

2. Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Arch Gen Psychiatry.* 1994;51:8-19.

3. Harwood H, Sullivan K, Malhotra D. Data analysis identifies major disparities in alcohol treatment across various groups. *Frontlines: Linking Alcohol Services Research and Practice.* June 2001:3-5, 7.

4. Woodward A, Epstein J, Gfroerer J, Melnick D, Thoreson R, Willson D. The drug abuse treatment gap: Recent estimates. *Health Care Financ Rev.* 1997;18(3):5-17.

5. Duszynski K, Nieto F, Valente C. Reported practices, attitudes, and confidence levels of primary care physicians regarding patients who abuse alcohol and other drugs. *Maryland Med J.* 1995;44:193-202.

6. The National Center on Addiction and Substance Abuse at Columbia University. Missed opportunity: National survey of primary care physicians and patients on substance abuse. May 2000. Available at: http://www.casacolumbia.org/publications1456/publications_show.htm?doc_id=29109. Accessed August 1, 2002.

7. Gabel J, Levitt L, Pickreign J, et al. Job-based health insurance in 2000: Premiums rise sharply while coverage grows. *Health Aff.* 2000;19(5):144-151.

8. Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry.* 2001;58:55-61.

9. Haverkos HW, Stein MD. Identifying substance abuse in primary care. *Am Fam Physician.* 1995;52:2029-2035.

10. Barrett JE, Barrett JA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. *Arch Gen Psychiatry.* 1988;45:1100-1106.

11. Higgins E. A review of unrecognized mental illness in primary care. *Arch Fam Med.* 1994;3:908-917.

12. Kessler R, Berglund P, Zhao S, et al. The 12-month prevalence and correlates of serious mental illness. In: Mandersheid R, Sonnenschein M, eds. *Mental Health, United States, 1996.* Rockville, MD: Center for Mental Health Services; 1996:59-70. DHHS publication SMA 96-3098.

13. Wells KB, Hays RD, Burnam MA, Rogers W, Greenfield S, Ware JE Jr. Detection of depressive disorder for patients receiving prepaid or fee-for-service care: Results from the Medical Outcomes Study. *JAMA.* 1989;262:3298-3302.

14. Heneghan A, Silver EJ, Bauman L, Stein R. Do pediatricians recognize mothers with depressive symptoms? *Pediatrics.* 2000;106:1367-1373.

15. Von Korff M, Shapiro S, Burke JD, et al. Anxiety and depression in a primary care clinic: Comparison of Diagnostic Interview Schedule, General Health Questionnaire, and practitioner assessment. *Arch Gen Psychiatry.*1987;44:152-156.

16. McPherson TL, Hersch RK. Brief substance use screening instruments for primary care settings: A review. *J Subst Abuse Treat.* 2000;18:193-202.

17. Joseph RC, Hermann RC. Screening for psychiatric disorders in primary care settings. *Harv Rev Psychiatry.* 1998;6:165-170.

18. US Preventive Services Task Force. *Guide to Clinical Preventive Services.* 2nd ed. Rockville, MD: US Preventive Services Task Force, US Department of Health and Human Services; 1996.

19. US Preventive Services Task Force. Recommendations and rationale—screening for depression. Available at: http://www.ahcpr.gov/clinic/3rduspstf/depression/depressrr.html. Accessed August 1, 2002.

20. Pignone MP, Gakynes BN, Rushton JL, et al. Screening for depression in adults: a summary of the evidence for the US Preventive Services Task Force. *Ann Intern Med.* 2002;136(10): 765-776.

21. Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians.* Rockville, MD: Public Health Service, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services; 1997. Treatment Improvement Protocol (TIP) Series 24.

22. Whooley MA, Simon GE. Managing depression in medical outpatients. *N Engl J Med.* 2000;343:1942-1950.

23. Freeborn DK, Polen MR, Hollis JF, Senft RA. Screening and brief intervention for hazardous drinking in an HMO: Effects on medical care utilization. *J Behav Health Serv Res.* 2000;27: 446-453.

24. Babor TF, Higgins-Biddle JC. Alcohol screening and brief intervention: Dissemination strategies for medical practice and public health. *Addiction.* 2000;95:677-686.

25. Spitzer RL, Williams JB, Kroenke K, et al. Utility of a new procedure for diagnosing mental disorders in primary care. The PRIME-MD 1000 Study. *JAMA.* 1994;272:1749-1756.

26. Hermann RC, Joseph R, Bor D. Improving the detection of mental disorders in primary care. In: Dickey B, Sederer LI, eds. *Achieving Quality in Psychiatric and Substance Abuse Practice.* Washington, DC: American Psychiatric Press, Inc; 2001:325-337.

27. Townes PN, Harkley AL. Alcohol screening practices of primary care physicians in eastern North Carolina. *Alcohol.* 1994;11: 489-492.

28. Spandorfer JM, Israel Y, Turner BJ. Primary care physicians' views on screening and management of alcohol abuse: Inconsistencies with national guidelines. *J Fam Pract.* 1999;48:899-902.

29. Friedman LS, Johnson B, Brett AS. Evaluation of substance-abusing adolescents by primary care physicians. *J Adolesc Health Care.* 1990;11:227-230.

30. Friedmann PD, McCullough D, Chin MH, Saitz R. Screening and intervention for alcohol problems: A national survey of prima-

ry care physicians and psychiatrists. *J Gen Intern Med.* 2000;15: 84-91.

31. Friedmann PD, McCullough D, Saitz R. Screening and intervention for illicit drug abuse: a national survey of primary care physicians and psychiatrists. *Arch Intern Med.* 2001;161:248-251.

32. Birmaher B, Brent DA, Benson RS. Summary of the practice parameters for the assessment and treatment of children and adolescents with depressive disorders. American Academy of Child and Adolescent Psychiatry. *J Am Acad Child Adolesc Psychiatry.* 1998;37:1234-1238.

33. Practice guideline for treatment of patients with substance use disorders: Alcohol, cocaine, opioids. American Psychiatric Association. *American Journal of Psychiatry.* 1995;152(11 suppl):1-59.

34. *Major Depression, Panic Disorder and Generalized Anxiety Disorder in Adults in Primary Care.* Bloomington, MN: Institute for Clinical Systems Improvement (ICSI); 1999.

35. Winters KC. *Screening and Assessing Adolescents for Substance Use Disorders. Treatment Improvement Protocol (TIP) Series 31.* Rockville, MD: Public Health Service, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services; 1999. DHHS publication SMA 99-3282.

36. Solberg LI, Brekke ML, Fazio CJ, et al. Lessons from experienced guideline implementers: Attend to many factors and use multiple strategies. *Jt Comm J Qual Improv.* 2000;26:171-188.

37. Kemper P, Blumenthal D, Corrigan JM, et al. The design of the community tracking study: A longitudinal study of health system change and its effects on people. *Inquiry.* 1996;33: 195-206.

38. Research Triangle Institute. *SUDAAN User's Manual: Release 8.0.* Research Triangle Park, NC: Research Triangle Institute; 2001.

39. National Committee on Quality Assurance. National results for selected 2000 HEDIS® and HEDIS/CAHPS® measures. Available at: http://www.ncqa.org/Pages/Programs/HEDIS/stability00.htm. Accessed April 2, 2001.

40. Katon W, Von Korff M, Lin E, et al. Distressed high utilizers of medical care: DSM III-R diagnoses and treatment needs. *Gen Hosp Psychiatry.* 1990;12:355-362.

41. Kleinman L. Conceptual and technical issues regarding the use of HEDIS and HEDIS-like measures in preferred provider organizations. *Med Care Res Rev.* 2001;58(suppl 1):37-57.

42. National Committee on Quality Assurance. *State of Managed Care Quality Report.* Washington, DC: National Committee on Quality Assurance; 2000.

43. Foundation for Accountability. *FACCT Quality Measures—Alcohol Misuse.* Portland, OR: Foundation for Accountability; 1998. Available at: http://www.facct.org/measures/existing_measures/alcohol.htm. Accessed August 1, 2002.

44. McCorry F, Garnick DW, Bartlett J, Cotter F, Chalk M. Developing performance measures for alcohol and other drug services in managed care plans. Washington Circle Group. *Jt Comm J Qual Improv.* 2000;26:633-643.

45. Dudley RA, Luft HS. Managed care in transition. *N Engl J Med.* 2001;344:1087-1092.