HCRC Teaching Guide
for Health Care Providers

Improving Hepatitis C Care

Reducing Alcohol Use With Brief Intervention

Department of Veterans Affairs

HCRC Teaching Guide for Health Care Providers

The Intervention:

A patient-centered approach to reduce alcohol use among patients with hepatitis C.

The Rationale:

- Abstaining from alcohol use is one of the most important factors in preserving liver health in individuals with hepatitis C.
- Brief interventions have been found to be cost-effective ways to reduce alcohol consumption.
- A non-confrontational, patient-centered approach in addressing drinking problems increases the likelihood that the patient will discuss the relevant incentives and barriers associated with behavior change.

The Process:

1. Present the Motivational Counseling Card to the patient and ask them which one of the topics they would like to discuss.
2. Reflect the patient's concerns and/or answer questions regarding their topic of interest.
3. Ask the patient's permission to discuss their alcohol use.
4. Meet the patient "where they are" regarding their drinking, while providing relevant information about the impact of alcohol use and hepatitis C on the liver (using the "Hepatitis C and Alcohol" brochure, which is part of this toolkit) and personalizing advice.
5. Use the 0–10 rating scale questions described in this guide to raise the importance of changing drinking behavior for the patient and to raise the patient's confidence in their ability to change.
6. Elicit patient goals and set up follow-up.

Improving Hepatitis C Care: Reducing Alcohol Use With Brief Intervention

Purpose of this Guide:

This Teaching Guide can help you learn ways to discuss alcohol use with patients who have hepatitis C. The enclosed motivational counseling card is one of many tools you can use to help patients with hepatitis C reduce or eliminate alcohol consumption. Because hepatitis C infection is associated with worse liver disease outcomes among drinkers, diagnosis of hepatitis C infection and monitoring of liver function provide "teachable moments" for brief, effective interventions to motivate patients to cut back or eliminate alcohol use.

The HCRC Brief Intervention for Alcohol Use Reduction and Hepatitis C Toolkit includes the following resources:

- Motivational Counseling Card with provider scripts
- HCRC Teaching Guide for Health Care Providers
- Patient Education Brochure "Hepatitis C and Alcohol"
- Drinking Diary Card and Change Plan Template (wallet card)
- "Motivation" DVD: Behavior Change Counseling in Chronic Care from University of Washington GHC "Take Care to Learn" (2003)

Who can use these tools effectively?

Anyone who provides direct care to patients with the hepatitis C virus (HCV). Many patients with chronic HCV infection are seen regularly in Specialty Clinics such as Hepatology/Gastroenterology, Infectious Disease, and Addiction and Mental Health, as well as Primary Care Clinics. Addressing patient issues such as alcohol or substance use may be routine for you or may make you feel uncomfortable if it's not part of your usual practice. Time is also a potential barrier to addressing these issues in busy clinics, so this toolkit was developed to show you how you can incorporate brief motivational interventions into almost any patient encounter.

Why target alcohol use?

It is not known whether any level of alcohol consumption is safe for people infected with HCV. Continuing to use alcohol in any quantity may be risky, and moderate-heavy drinkers are clearly at higher risk for cirrhosis and advanced liver disease (Peters & Terrault, 2002; Loguercio et al., 2000). Active drinkers are less likely to complete antiretroviral treatment for hepatitis C and thus have poorer outcomes from available therapies (Anand et al., 2006). One of the most important behavior changes that anyone with chronic hepatitis C can make is to stop drinking alcohol. However, making this change or any lifestyle change is really in the hands of the patient, not the provider.

Helping patients reduce or abstain from drinking alcohol requires a different set of skills from managing patients with more acute problems. Although rates of substance abuse screening in primary care have improved in recent years, advice to reduce or abstain from drinking occurs infrequently (Burman et al., 2004). Studies suggest that even brief interventions can have a positive impact on reducing alcohol consumption.

Keep in mind that most patients referred for substance abuse treatment evaluation don't follow up on their own, so another potential positive outcome from this ongoing motivational enhancement approach may be for your patient to ultimately accept a referral for substance abuse specialty evaluation and/or treatment, and keep appointments.

5A's of Behavioral Counseling

Assess	Evaluate alcohol consumption patterns
Advise	Help patients to reduce or abstain from alcohol with personally relevant recommendations
Agree	Set specific, feasible goals collaboratively
Assist	Anticipate barriers, problem-solve solutions
Arrange	Schedule follow-up contacts, use resources

What is a Brief Intervention for Alcohol Use?

A brief intervention consists of at least one 5–15 minute session of patient-centered behavior change counseling, with at least one follow-up, as summarized by the U.S. Preventive Services Task Force on behavioral counseling interventions (USPSTF, 2004). The specific content of counseling sessions reported in the literature varies, but generally brief intervention counseling

sessions contain: patient-centered assessment, concerned feedback and advice, collaborative goal-setting, plus further assistance and follow-up, often by telephone. (See the sample scripts on the back of your motivational counseling card.)

The "5A's" (ASSESS, ADVISE, AGREE, ASSIST, and ARRANGE) is a useful organizational construct for clinical counseling on behavioral and preventive health care issues. This is a patient-centered approach recommended by USPSTF and has already been used to train physicians and other health care staff for a variety of problems. It was first applied to smoking cessation and has been incorporated into the Agency for Healthcare Research and Quality (AHRQ) tobacco use cessation guidelines as well as the USPSTF Behavioral Counseling Guidelines (Whitlock et al., 2004).

Surveys show that the last 2 A's (ASSIST and ARRANGE) are done less frequently than the first 3. This toolkit will show you ways to accomplish all of these within your practice setting.

Does Brief Intervention Work?

Systematic reviews of studies on the efficacy of brief interventions to reduce risky or harmful alcohol use (misuse) have shown good efficacy (Whitlock et al., 2004; Moyer et al., 2002). Evidence of the benefits of screening and brief intervention for alcohol misuse indicates that they are a cost-effective way of reducing alcohol consumption and related problems (Wutzke et al., 2002).

- A recent meta-analysis of brief alcohol intervention in primary care settings found that groups receiving the intervention reduced their alcohol consumption at 6 and 12 month follow-up, demonstrating a mean pooled difference of –38g of ethanol (approximately 4 drinks) per week (Bertholet et al., 2005).

- The World Health Organization (WHO) Brief Intervention Study Group found that 5 minutes of brief counseling were as effective as 20 minutes of counseling (WHO Brief Intervention Study Group, 1996).

- A review of good-quality controlled clinical trials found that patients who received brief multi-contact behavioral counseling (initial session up to 15 minutes and at least 1 follow-up) reduced alcohol intake 13–34% more than controls (WHO, 1996).

- After one year, hazardous drinkers receiving brief intervention (BI) significantly decreased alcohol use and had fewer bed days of care

relative to controls. Further, after 4 years, for every $1 spent on BI, the health care system saved $4.30 (Fleming et al., 2002).

Alcohol-dependent heavy drinkers have been shown to be most successful in reducing alcohol use when followed over time with multiple contacts, through an integrated outpatient treatment model (Willenbring & Olson, 1999), including hepatology clinics using team treatment models (Lieber et al., 2003). Brief intervention can enhance and support specialized addiction services by enhancing motivation to change or to sustain change.

What is the AUDIT-C?

The AUDIT-C is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C questions are:

Q1: How often did you have a drink containing alcohol in the past year?

Answer	Points
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4

Q2: How many drinks did you have on a typical day when you were drinking in the past year?

Answer	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4

Q3: How often did you have six or more drinks on one occasion in the past year?

Answer	Points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

The AUDIT-C is scored on a scale of 0–12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm

What about screening for alcohol use?

A positive screen for alcohol use for a patient with HCV can be an opportunity to provide information about alcohol and liver disease. When this information is linked to the patient's personal health through review of reported symptoms or liver function test results, the patient's perception of its importance may increase. Brief screening measures for alcohol misuse are available for routine assessment. VA clinics now use the "AUDIT-C" for screening. The AUDIT-C is a more sensitive indicator of alcohol misuse or hazardous drinking than the CAGE because it is sensitive to both alcohol abuse and risky alcohol use, and it consists of just 3 questions (see page 4 for AUDIT-C).

Another question with clinical implication is: "Have you ever been in alcohol treatment or attended AA for a drinking problem?" This question can lead to important information, including current alcohol use, likelihood of alcohol dependence, discussion of past successes, and options for current or renewed support for substance use disorder treatment and abstinence efforts. Availability of support from friends and family are important facilitators of change. Support and past experience can influence confidence in one's ability to change behavior.

Although the initial alcohol screening may take place in a different clinic, any provider who sees patients with hepatitis C is in a position to motivate and support those patients to change drinking behavior by using the hepatitis C diagnosis as a "teachable moment," and linking the patient's drinking with observed liver health parameters. Open-ended questions can provide information about past experience with similar changes and support from friends and family, which can affect the patient's confidence in ability to change.

How does this approach fit in with other behavioral counseling guidelines?

This approach fits in with the VA/DOD clinical practice guidelines (CPG) for Treatment of Substance Use Disorders (SUDS CPG). See http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm for a decisional tree from the SUDS CPG. According to these guidelines, the medically stable patient who screens positive for alcohol abuse should have results summarized and presented to him/her by the provider with information to "educate the patient about the problem." If SUD specialty clinic referral is indicated, the patient is referred; if not, a brief intervention is recommended with ongoing support and follow-up. Unfortunately, often the post-screening interventions stop with advice (or less), and SUD specialty referrals are often refused. This guide pro-

vides information on how to deliver the recommended brief intervention effectively with the goals of reducing hazardous drinking or facilitating successful referrals to SUD specialty clinics for more focused evaluation and treatment.

I. Approaching the topic: "Dancing versus wrestling"

How often have you given advice that wasn't followed, or that resulted in the patient telling you what you want to hear, giving "yes, but…" responses, or even avoiding you later? One way of thinking about your approach to the discussion of behavior change is "we want to dance, not wrestle." "Wrestling" ends with a winner and a loser (or 2 losers!). "Dancing" means that the patient is taking the "lead" and doing most of the talking, and the provider is "following the lead" by eliciting information from the patient about the patient's motivations for change instead of just delivering information (lecturing) to the patient about how to change. Clinical experience has shown that allowing the patient to "lead" will decrease the likelihood of resistance and defensiveness, and can provide an opening for discussion of problem behavior, such as alcohol use.

II. Setting the stage: Creating a dance floor

- Create an environment where the patient feels comfortable talking about alcohol or other health-related issues. Be non-judgmental, use open-ended questions and eye contact. Consider asking permission to go over these issues. Just being seated at the patient's eye-level can make a difference.

- Use the motivational counseling card (see page 8) to provide the patient with choices in the discussion topic. Even though the selected topic may not seem directly relevant to your concern about alcohol use (e.g., "stress"), chances are good that what the patient reveals in a discussion of stress will be relevant to risky alcohol use and the personalized plan to come later.

- Remember that persons vary in their readiness to change. Creating the opening for dialogue about this issue may be the first step for this person to even consider changing.

- Recognize that a successful visit may not end with any immediate action, but a follow-up call or visit and review of the previous discussion signals your concern and the importance of this issue to the patient's health.

Keys to Change

In addition to creating a safe environment for this discussion, these elements are key to change:

1. A sense of the importance of change
2. A sense of confidence about one's ability to change
3. A support system (friends, family, providers)

III. Let the dance begin: Make the first step positive

Open the conversation in a positive way. When the visit starts with what has gone well rather than what has not, it is easier to help the patient with their motivation for change. A positive start can be initiated with something as simple as a positive observation from the medical record or personally, no matter how small (a kept appointment, or even completing their laboratory tests). Use of the motivational counseling card included in this toolkit has been found to be helpful in beginning discussion about important lifestyle issues, and was well-received by both patients and providers for other chronic diseases such as diabetes and asthma (Stott et al., 1995). The card looks like a checklist of various behaviors that may impact their liver disease in a positive or negative way. The patient is asked which of the topics they want to discuss, so there is an opportunity for the patient to indicate what they think is important.

Recently, the motivational counseling card was revised to help teach primary care providers to use this patient-centered behavioral approach as part of the University of Washington's "Take Care to Learn" project, supported by the Robert Wood Johnson Foundation. This program was effective and was rated highly by providers (Debbie Ward, 2005, personal communication).

Sample Script:

PROVIDER: Here is a card with some topics that are important to your health. No one does all these things perfectly. Which one of these do you want to discuss?

PATIENT: Well, I haven't used drugs in years, but I still have a lot of stress in my life...

WAYS TO MANAGE YOUR Hepatitis C

- These topics are very important to your health
- Alcohol is the single biggest threat to your liver health
- No patients do these perfectly
- It's best to work on one at a time
- You won't be pushed into changing

Which one do YOU want to discuss?

- ☐ ALCOHOL
- ☐ OTHER DRUG USE
- ☐ STRESS
- ☐ SMOKING

- ☐ HEPATITIS C TREATMENT
- ☐ LABS & FOLLOW-UP
- ☐ ACTIVITY & FOOD
- ☐ SUPPORT

PROVIDER: Sounds like you were able to make some significant changes in your life… what helped you accomplish this? [explore personal strengths, past successes despite stressors]

IV. First steps in the "dance": Use of the counseling card

Since most of the topics can be related to alcohol use, the provider can use the patient responses to the card to link with alcohol use assessment and tailored feedback. [continued from above discussion]

PROVIDER: Alcohol is the single biggest threat to your liver, and I think it's really important to understand how alcohol impacts hepatitis C. Is it okay with you if we talk about this today?

PATIENT: Well, I guess so. But I don't drink near as much as I used to before I found out I have HCV.

PROVIDER: That's a great start, cutting back. Unfortunately, we don't really know how much you can drink without making your liver disease worse. We do know that a person who drinks and has hepatitis C has a much higher risk of cirrhosis or liver scarring compared to a non-drinker, and drinkers are less likely to benefit from antiviral treatment.

The patient education brochure, "Hepatitis C and Alcohol," can be used to illustrate and help explain these points.

PROVIDER: Your liver enzymes are elevated and this is part of why I think it's important for us to talk about this.

Review liver biopsy results, complaints of fatigue or nausea, lab values or whatever helps customize your feedback to what is important to the patient and may be linked to alcohol use.

PROVIDER: What do you think?

PATIENT: I didn't realize even beer could hurt my liver. Maybe I could cut back some more? I really don't want to get sick.

Listen, reflect, summarize—the patient just made a motivational statement—you could just repeat it.

PROVIDER: You don't really want to get sick and think you could cut back some more...

Assist with goal-setting.

PROVIDER: How much do you think you could cut back, realistically?

Ideas for discussion:

Here are some strategies that might work for you:

- Ask about the patient's general health, then substance use. You could then follow this by: "I wonder, how does your use of alcohol fit in here?"
- Ask the patient to rate how important a change in their drinking is to them personally, and how confident they feel in making that change. (See the next section for a rating scale and sample script for this.)
- Ask if there is anything that they are doing—or trying to do—differently as a result of their hepatitis C? Why?
- Ask about lifestyle and stressors, and then ask what they do when they find themselves in stressful situations.
- Ask the patient to compare past alcohol use with current use.
- Ask the patient to compare their current alcohol use with their ideal use, and reflect discrepancies.

V. Moving with the music: Measuring importance and confidence

It is important to set realistic goals and support change, no matter how small. One way to assess how ready someone might be to make a change is to ask the patient to use a scale of zero to ten to indicate how important it is to make the change, and how confident they are about making the change. Then ask why they chose that number in order to learn more about their motivation for change. Work with the patient to set realistic goals and support the change, no matter how small.

Ideas for discussion:

One common issue for patients reluctant to change their alcohol use is that alcohol is seen as a way of managing or coping with stress. It is often helpful to validate this. Ask them what drinking does for them. You will often

hear things like "helps me relax," "helps me forget," and "makes me feel better." These comments should trigger a discussion of how bad stress feels for the patient and how he or she has been struggling (in a motivated way) to manage it. This can lead to discussing better or healthier ways to manage stress.

Consider this scenario:

(Adapted from Bilsen in "Motivational Interviewing" by Miller and Rollnick, Chapter 15, pp. 214–219)

A patient who states that "others" think he has a problem, even though he doesn't think he does. He has been referred to a mid-level provider to talk about his liver health.

Raise Importance

On a scale of 0–10, how IMPORTANT is it to you to (change)?

Why did you give it (number) and not (lower number)?

What would it take to give it a (higher number)?

0 1 2 3 4 5 6 7 8 9 10

Raise Confidence

On a scale of 0–10, how CONFIDENT are you that you can change successfully?

Why did you give it (number) and not (lower number)?

What would it take to give it a (higher number)?

0 1 2 3 4 5 6 7 8 9 10

PROVIDER: Hello, your file shows that this appointment was made after you received your hepatitis C test results a few weeks ago. What can I do for you today?

PATIENT: It was not my choice. My wife and the doctor I saw last week wanted me to talk to someone because they think that I have a drinking problem and they said that the liver clinic won't even talk to me about treatment for hepatitis C until I talk to someone about my drinking. I think that this is a total waste of time, but I came so they would get off my back.

PROVIDER: Well, thank you for keeping this appointment despite the circumstances. Can you tell me what your wife and your other doctor considered so important that you needed to see someone about?

Positive restructuring: The patient is a busy man, and this makes it even more admirable that he sacrifices his time to do something he considers useless at the moment. You can empathize with client while at the same time eliciting more information from him.

PATIENT: It is stupid, really. There is not much to tell. I have a good job, which I have had for years. In fact, I have been working full-time since I got out of the service. I am the breadwinner for the family and I work very hard. I don't know what the big deal is if I drink a beer or two occasionally. I have been drinking for over 20 years. I don't know what the big deal is now.

PROVIDER: It sounds like work and family are very important to you—and that they are related to one another. It also sounds like you really make these a priority and work hard at doing both as best you can—and that this is something that you have been doing for a long time. Relaxing with a beer gives you the energy to do both. It seems as if your wife and doctor have a different opinion. Could you tell me a bit more about the differences of opinion?

Again, positive restructuring and reflection of a conflict. Drinking beer is presented in a positive context.

PATIENT: Sometimes I can't stand all the pressures that are put on me. Nothing seems to give me a chance to relax. But I don't drink so much that they should call me an alcoholic.

PROVIDER: . . . An alcoholic.

Simple reflection (parroting).

PATIENT: *(Angry)* Yes, an alcoholic! I try to do my best and this is what I get out of it—being accused of alcoholism.

PROVIDER: Just to summarize: If I understand you correctly, you have come to see me in order to discuss these differences of opinion between you and your wife and your other provider. They seem to think that there is a problem connected with your drinking. You, yourself, think that there is no problem whatsoever with your drinking. Your wife and doctor seem to you to be completely out of line with their accusations.

Summarizing, empathizing with patient and some amplified reflections.

PATIENT: I am not saying that I shouldn't drink less, but I am not an alcoholic.

In this scenario, the patient starts off as very defensive—and rightfully so: his wife and another provider have labeled him as an alcoholic, even though this has been a part of his lifestyle and behavior for his entire adult life. He is certainly not willing to enter the "dance floor" at this point. However, by the end of this 2–3 minute discussion, he is no longer on the defensive. This was an opportunity for the role of his drinking to be re-framed, which gives the patient an opportunity to talk about it in a different, positive context. This opens the door for you to discuss this further and possibly set up another brief time—or even use the rating questions about "Importance" and "Confidence" to further elicit the patient's thoughts about drinking less.

VI. Missteps on the dance floor

It is important to acknowledge that most conversations providers have with patients do not sound like the scripts in this Teaching Guide. Often patients feel pessimistic and may even start wrestling (arguing) with the provider. Here are a couple of common patient missteps and ways to handle them while still maintaining the dance.

Patient misstep #1: Helplessness

Suggested approach: When patients are feeling pessimistic, acknowledge that change is hard. Help patients identify what has led to successful change in the past, and reflect their observations or insights.

Patient misstep #2: Resistance

Suggested approach: When the provider and patient are arguing (wrestling), stop and briefly summarize the discussion. Get back to dancing!

As providers we want the best for our patients, but sometimes we become more invested in the patient making a change than the patient is. You might notice yourself engaging in one of these common missteps.

Provider misstep #1: Lecturing

Suggested approach: When the provider realizes the patient is being bombarded with information, stop and ask the patient a question such as: "What do you think of this?"

Provider misstep #2: Cheerleading

Suggested approach: When the provider is being more enthusiastic about change than the patient, stop and return responsibility for change to the patient. A useful format to keep discussions patient-centered is: Ask the patient what goals are most important to him/her, and relate health to that goal.

VII. Summary

A patient-focused approach means understanding that the patient will ultimately make all the decisions and be responsible for their lives. Their behavior makes sense if you understand their motivations and what is important to them. Even seemingly self-destructive behavior must perform some useful function or address some important need or the patient would not continue doing it. If you can start with a health or lifestyle issue identified as most important to the patient, later you can ask permission to move toward discussion of other issues such as alcohol use that you feel are also important to the patient's health.

Brief Intervention Toolkit: Components for Patients

In addition to the Counseling Card, this toolkit contains two items meant to facilitate frank discussions about alcohol and hepatitis C: One is a tri-fold patient brochure entitled, "Hepatitis C and Alcohol," and the other is a wallet card that serves as both a "Drinking Diary Card" and a convenient template for patients to make a "Change Plan." These items are meant to be given to patients who are interested in taking them. (Your supply can be replenished when close to depletion.)

Patient Education Brochure: "Hepatitis C and Alcohol"

A growing body of literature highlights the risk of heavy alcohol consumption on liver disease progression. This tri-fold patient brochure attempts to capture findings from the most relevant literature and present them in a way that is easily understandable for patients. When the opportunity presents itself in the discussion, use this brochure to explain scientific evidence that highlight the dangers of heavy alcohol use on liver disease and/or the rationale behind certain clinical recommendations (e.g., why a period of abstinence is often recommended before attempting antiviral therapy for hepatitis C). Here is a summary of the relevant empirical data illustrated in the brochure:

- Liver disease progression after infection with hepatitis C proceeds at a slow pace with highly variable outcomes, with only a minority of patients experiencing severe, life-threatening liver disease. However, complications such as cirrhosis and hepatocellular carcinoma appear aggravated by behavioral factors such as heavy alcohol use (Alter & Seeff, 2000).

- The amount of hepatitis C viremia in the bloodstream (as indicated by serum HCV RNA) has been correlated with alcohol intake ($r = .26$), and this relationship was independent of other factors such as age, sex, and route of viral contamination (Pessione et al., 1998).

- While duration of hepatitis C infection was found to be strongly associated with rate of fibrosis progression, patients identified as heavy drinkers (50g of alcohol per day or more) showed significantly higher rates of fibrosis progression than light- or non-drinkers ($p<.001$; Poynard, Bedossa, & Opolon, 1997).

- A recent meta-analysis (Hutchinson, Bird, & Goldberg, 2005) found that heavy drinkers consuming at least 210-560g of alcohol per week (about 2 to 6 standard drinks per day) are 2.33 times more likely to develop cirrhosis than light- or non-drinkers (95% confidence interval, 1.67–3.26).

- Sustained viral response (SVR) to interferon therapy for hepatitis C has been shown to be inversely related to the degree of alcohol consumption and positively associated with duration of abstinence prior to initiating therapy. Only 3 out of 36 (or 1 in 12) patients defined as heavy drinkers prior to starting interferon treatment had successfully cleared hepatitis C virus 6 months after conclusion of antiviral therapy, and none of 17 patients who drank heavily within one month of starting interferon demonstrated a 6 month SVR (Ohnishi et al., 1996).

- An analysis of 726 veterans undergoing antiviral treatment for hepatitis C found that recent alcohol use resulted in a greater proportion discontinuing treatment (40% vs. 26%) (Anand et al. 2006).

Drinking Diary Card and Change Plan Template (Wallet Card)

One intervention that can be effective for patients in early stages of changing their drinking habits is to have them self-monitor their alcohol consumption. The wallet cards included in the toolkit provide the patient a means to record their alcohol use over a 4-week period. Typically, this is done by converting whatever alcoholic beverages are consumed during the day to a certain number of "standard drinks." A standard drink is defined as:

- 12 ounces of beer

- 4 ounces of wine

- 1.5 ounces of liquor

The act of measuring a behavior is in itself an intervention. Patients who use the Drinking Diary Card will have a more concrete understanding of how much alcohol they are consuming on either a regular or episodic basis. They may also use this information to understand some of the social contexts or special occasions in which they drink heavily. From a harm-reduction perspective, any decrease in alcohol consumption will likely lessen the risk of liver damage to some degree. This exercise in self-monitoring can serve as a valuable first step in making reductions in the amount of alcohol the patient consumes per occasion or over time.

On the back of the Drinking Diary Card is a template for making a Change Plan. Research on goal-setting has shown that goals are more likely to be pursued and accomplished when they are made explicit, achievable, and public (i.e., with a verbal commitment). The Change Plan provides a mechanism for patients to state their behavior change goals explicitly and problem-solve about how to realize them. The questions posed by the Change Plan Template are:

- "My specific goal is to . . ."
- "The steps I plan to take in changing are . . ."
- "Challenges that might interfere:"
- "How I will handle these challenges:"
- "I will know my plan is working if . . ."

Change Plans are meant for patients in later stages of change about their drinking, for they presume that the patient is willing to make some attempt at behavior change. If you hear your patient making positive statements about reducing or quitting drinking (i.e., "change talk"), it may be an appropriate time to introduce this wallet card to discuss the specific steps and possible barriers associated with making that change.

Brief Intervention Toolkit components for patients:

- Review patient's goals at end of session, and schedule next visit or call
- Become a local clinical champion of this approach, have residents or colleagues sit in with you
- Use the scripts initially, customize to your own style and tempo
- Send us suggestions on how to make this better, let us know what you are using, what's working, what's not
- Train residents, interns, affiliated staff in brief intervention

- Visit the VA HCRC website at http://www.hepatitis.va.gov/ for the latest information on hepatitis C, useful materials for patient and staff education, clinical practice updates, and links to BI training and CME opportunities

- Watch for trainings in brief intervention or motivational interviewing techniques at your professional meetings (see weblinks below)

- See the National Center for Health Promotion and Disease Prevention (NCP) website http://www.prevention.va.gov/Health_Promotion.asp for patient education materials on prevention topics of interest to your patients, including weight management and physical activity materials

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Additional resources for brief intervention skill-building

1. Web-based training in Brief Intervention for Primary Care Providers:
   - The Alcohol Clinical Training Project (ACT) http://www.bu.edu/act/
   - CMEs available. This program and video demo can be downloaded to your computer to be viewed through Windows Media Player, or view it from home using RealPlayer.
2. Resources for clinicans, trainers, researchers: http://www.motivationalinterviewing.org/

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About VA Programs in Hepatitis C

The Department of Veterans Affairs (VA) leads the country in hepatitis C screening, testing, treatment, research and prevention. VA is the largest single provider of medical care to people with hepatitis C infection in the United States.

The National Hepatitis C Program works to ensure that veterans with or at risk for hepatitis C receive the highest quality health care services from the VA system. Led by the VA's Public Health Strategic Healthcare Group (PHSHG) and carried out by VA medical facilities across the country, the hepatitis C program makes use of a comprehensive approach to hepatitis C prevention and treatment that includes screening, testing and counseling, patient and provider education, optimal clinical care, and management of data to continuously improve program quality.

The Hepatitis C Resource Centers (HCRCs), a part of the National Hepatitis C Program, develop best practices in clinical care delivery, patient education, provider education, prevention, and program evaluation that can be used by the entire VA health care system and other medical care systems. They function as field-based clinical laboratories for the development, testing, evaluation, and dissemination of new and innovative products and services for improving the quality of hepatitis C clinical care and education in every VA medical facility.

VA provides extensive information on hepatitis C for health care providers, veterans and their families, and the public at http://www.hepatitis.va.gov.

NOTE: This HCRC initiative ("Improving Hepatitis C Care: Reducing Alcohol Use With Brief Intervention") is based on the University of Washington's "Take Care to Learn" training project and teaching guide ("Motivation: Behavioral Change Counseling in Chronic Care"). Adapted with permission, Drs. Debbie Ward and Daniel Lessler, Principal Investigators.

The VA Hepatitis C Resource Center Program and National Hepatitis C Program Office

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