Center for Health Statistics

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

TOPICS IN HEALTH STATISTICS
January 2002 02-01

PREVENTIVE CLINICAL COUNSELING AMONG ADULTS IN NEW JERSEY: RESULTS FROM THE NEW JERSEY BRFSS, 1993-2000

Kenneth J. O'Dowd, Ph.D.

Abstract
This report examines the extent to which certain types of preventive clinical counseling are practiced in New Jersey. About one-third of New Jersey smokers and more than half of New Jersey adults in other key high-risk categories did not receive appropriate clinical counseling, according to the New Jersey BRFSS. Sociodemographic factors and general health status play a significant role in determining who gets counseling. Efforts to increase counseling should focus on otherwise healthy individuals in addition to those who are infirmed.

Introduction

Counseling is a key element of clinical preventive services that is often neglected in the primary care setting.[1] Major authorities currently recommend assessment and clinical counseling on a wide array of topics as part of the periodic health exam for all adults (depending on age and sex). These topics include: prevention of abuse of tobacco, alcohol, and other drugs; prevention of unintentional injuries and domestic violence; avoidance of sexually transmitted diseases and unintended pregnancy; use of calcium and folic acid supplements; oral health; nutrition and caloric intake; physical activity; postmenopausal hormone therapy; prostate cancer screening; and use of aspirin to prevent heart attacks.[2,3] Clinical guidelines have been assembled on the basis of recommendations by these authorities, who include federal health agencies, expert panels, national professional organizations, and voluntary health organizations.[2] Current evidence suggests that the most cost-effective counseling interventions are those focused on smoking cessation, problem drinking, sexually transmitted diseases, child safety practices (for parents of children under 4), infant feeding practices (for pregnant women and new mothers), and use of folic acid supplements (for women of childbearing age).[4]

The federal Healthy People 2010 initiative calls for increased preventive counseling in a number of areas, including smoking cessation, problem drinking, sexually transmitted diseases and unintended pregnancy, child safety practices, nutrition and physical activity, and management of menopause.[5] In addition, New Jersey's Health Wellness Promotion Act currently mandates that applicable health benefit plans include coverage for "an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles".[6]

In various years since 1993, the New Jersey Behavioral Risk Factor Survey has afforded the opportunity to estimate directly the extent to which health care providers routinely provide counseling to New Jersey adults on the following topics: smoking cessation, prevention of abuse of alcohol and other drugs, weight control, postmenopausal hormone therapy, and prostate cancer screening. Additional questions about counseling on sexually transmitted diseases were added to the survey in 2001.

NOTE: The New Jersey Behavioral Risk Factor Survey is part of the national Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey of adults aged 18 years and over. This survey is designed to monitor modifiable risk factors for chronic diseases and other leading causes of morbidity and death. The surveillance system is a cooperative effort between the national Centers for Disease Control and Prevention (CDC) and all states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. It has been in existence since 1984. The New Jersey Department of Health and Senior Services has been participating in the survey since 1991, collecting approximately 125 interviews per month through 1995 and nearly double that number since 1996. General design features and limitations of the BRFSS have been discussed elsewhere.[7]

Results

Counseling on Smoking Cessation

The prevalence of cigarette smoking among New Jersey adults has hovered around 20% over the last decade,[8] although the level varies significantly by age, education level, race/ethnicity, marital status, and health insurance status, among other characteristics.[9] Clinician counseling on smoking cessation has been shown to be effective, particularly among patients of lower socioeconomic status,[10] and increased physician counseling on smoking cessation is one of the current health objectives for the nation.[6]

Between 1996 and 1999, each current or former smoker in the New Jersey BRFSS was asked “Has a doctor or other health professional ever advised you to quit smoking?”. During that time period, about 42% of current adult smokers and recent quitters in New Jersey did not recall being advised by a health professional to quit smoking at any time within the past three years, and most of these individuals reportedly were never advised to quit smoking (Figure 1). Even among those adults who reported having a routine medical checkup within the past year, an estimated 30% of current smokers and recent quitters had apparently never been advised by a clinician to quit smoking, although there appears to have been a slight upward trend in cessation counseling in this group over this time period (Figure 2).

Figure 1. Smoking Cessation Counseling Among Current Smokers and Recent Quitters New Jersey, 1996-1999

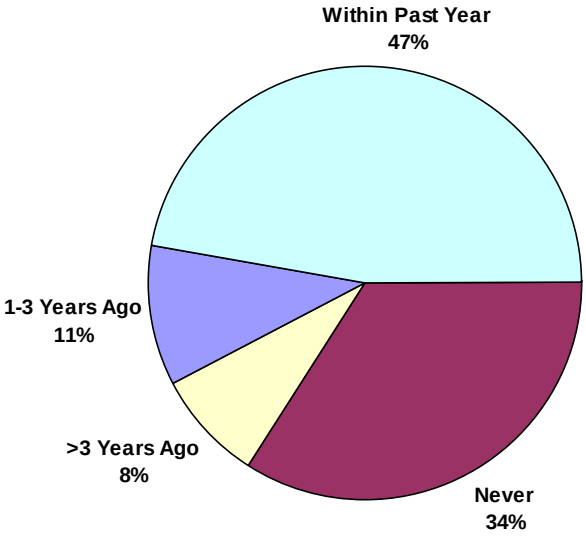
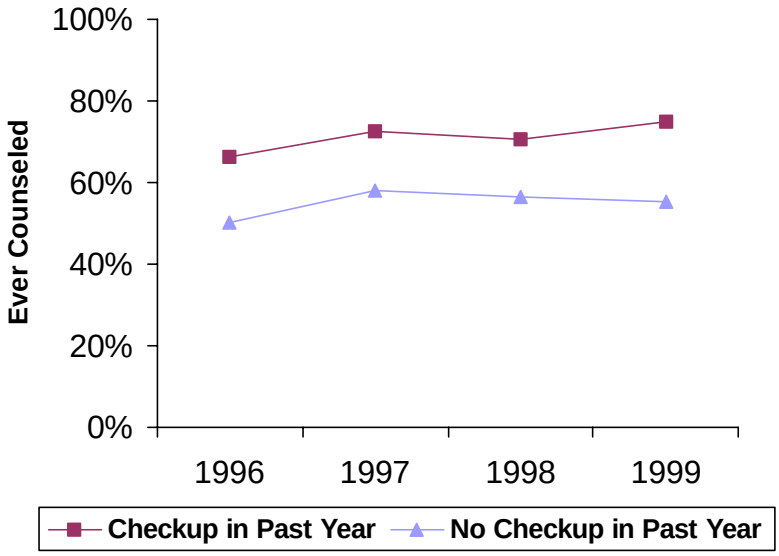


Figure 2. Smoking Cessation Counseling by Recency of Routine Medical Checkup New Jersey, 1996-1999

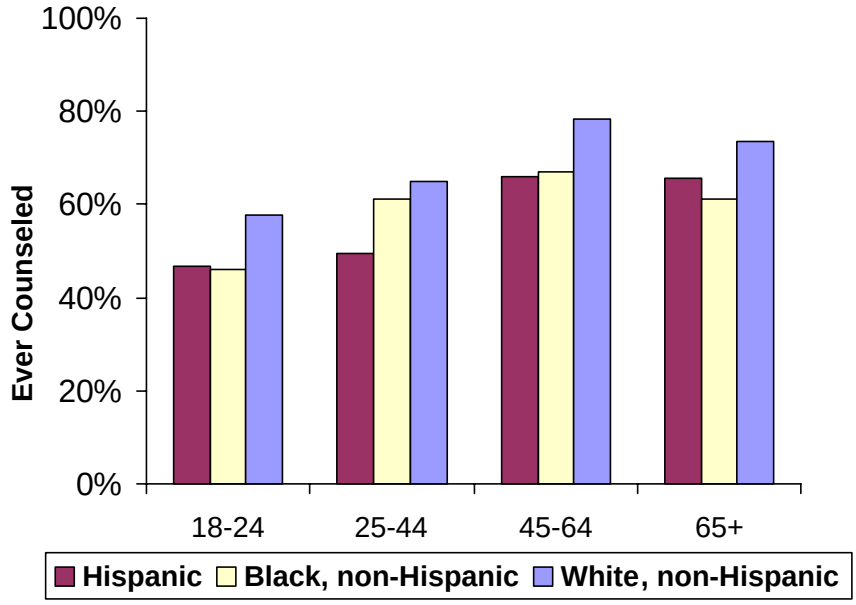


Data from New Jersey's Adult Tobacco Survey indicate that, as of 2000, about 65% of the adult smokers and recent quitters (excluding young adults aged 18-24) who had seen a doctor in the past year had been advised by their physicians to quit smoking.[11]

The prevalence of smoking cessation counseling increases to some extent with age among persons 64 and under, according to the New Jersey BRFSS. At each age level, however, smoking cessation counseling appears to have been somewhat less prevalent among minority smokers and recent quitters

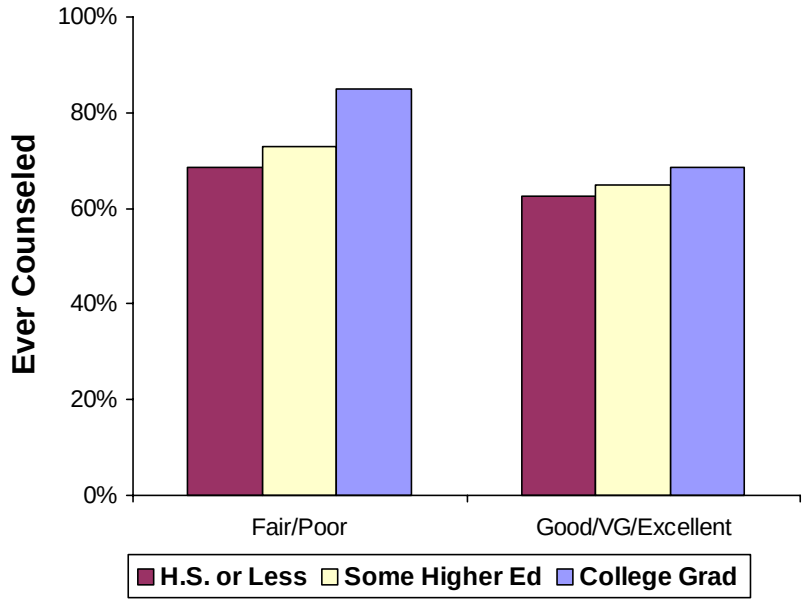
than among White, non-Hispanic smokers and recent quitters (Figure 3). Age-adjusted estimates of smoking cessation counseling during this time period are 62% (56%-68%*) for Black, non-Hispanic adults, 68% (66%-71%) for White, non-Hispanic adults, and 51% (43%-59%) for Hispanic adults. The lower reported levels of smoking cessation counseling for Hispanic adults are consistent with results from other surveys.[12]

Figure 3. Smoking Cessation Counseling by Age and Race/Ethnicity New Jersey, 1996-1999



The prevalence of smoking cessation counseling is greater among adult smokers reporting fair to poor health as opposed to those reporting good to excellent health. Among smokers in the fair to poor health status category, however, smoking cessation counseling appears to occur more often among those with higher education levels (Figure 4). Thus, approximately 85% (75%-92%) of college graduates in fair to poor health report counseling, compared with only about 68% (62%-74%) of those having a high school education or less.

Figure 4. Smoking Cessation Counseling by Health Status and Education
New Jersey, 1996-1999

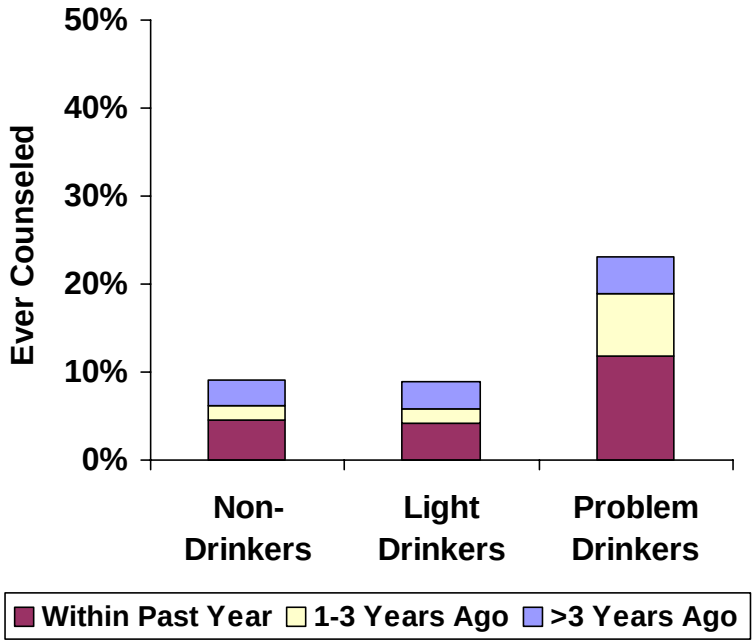


Counseling on Alcohol and Other Drug Use

Nearly one in seven New Jersey adults reports consuming five or more drinks on a single occasion during the previous month.[8] A significant portion of these drinkers consume more than two drinks per day, on average.[9] Routine case-finding and counseling by clinicians have been shown to be effective in reducing alcohol consumption and alcohol-related problems. Screening to detect problem and hazardous drinking has been recommended as a part of the periodic health exam for all adults,[1] and increased physician counseling to reduce alcohol consumption among adults with excessive alcohol consumption is one of the current health objectives for the nation.[6]

In 1999, all respondents to the New Jersey BRFSS were asked "Has a doctor or other health professional ever talked with you about alcohol use?". Overall, about eleven percent of adults reportedly ever discussed alcohol use with a health professional. Among those characterized as light drinkers based on their reported alcohol intake within the past month, only about nine percent ever had any type of discussion about alcohol use with a health professional, while even among those identified as "problem drinkers" (i.e., consuming either a total of 60 or more drinks during the past month or a total of 5 or more drinks on any one occasion during the past month), only about 23 percent (18%-29%) reportedly ever had any type of discussion about alcohol use with a health professional (Figure 5).

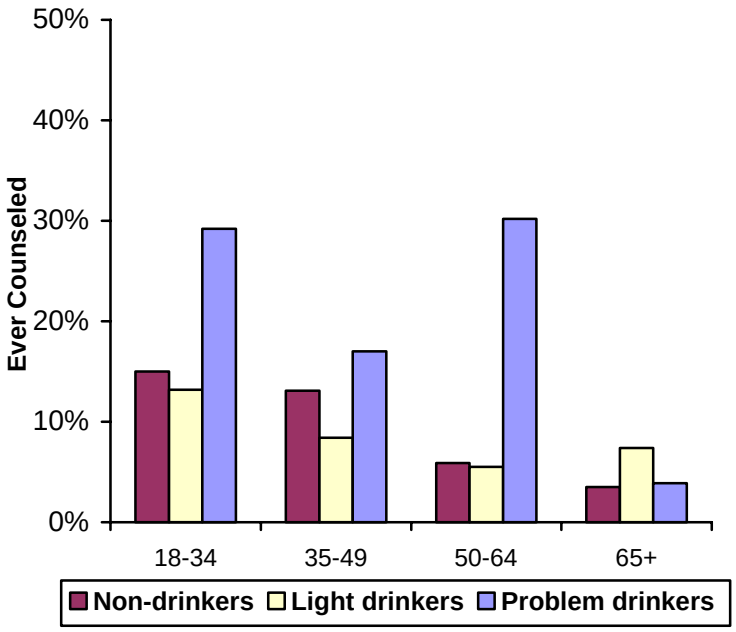
Figure 5. Recency of Counseling on Alcohol Use Among Adults by Drinking Status
New Jersey, 1999



With respect to adults who had a routine checkup in the past year, only about ten percent reportedly ever had a discussion about alcohol use with a health professional. Among light drinkers who had a routine checkup in the past year, only about nine percent reportedly ever had a discussion about alcohol use with a health professional, while among "problem drinkers" who reported a routine checkup in the past year, only about 24% (18%-32%) reportedly ever had a discussion about alcohol use with a health professional.

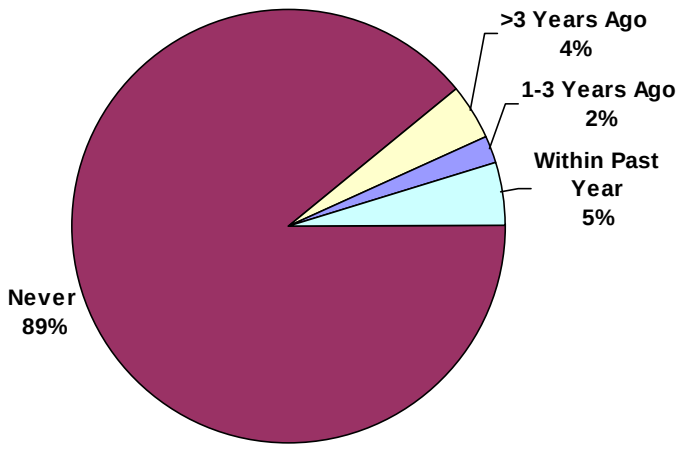
The likelihood of having had a discussion about alcohol use with a health professional declines to some extent with age in all drinking categories (Figure 6). Overall, among persons aged 18 to 34 who had a routine checkup in the past year, about 18% (13%-24%) reportedly ever had a discussion about alcohol use with a health professional, while among persons aged 65 and over, only about 7% (4%-12%) reportedly ever had such a discussion with a health professional.

Figure 6. Counseling on Alcohol Use Among Adults by Age and Drinking Status
New Jersey, 1999



In 1999, all respondents to the New Jersey BRFSS were also asked "Has a doctor or other health professional ever talked with you about drug abuse?". Only about 11% of adults reportedly ever had such counseling (Figure 7). Even among those adults who had a routine checkup within the past year, results were virtually identical, with 5% having had such counseling within the past year, 2% having had it within the past one to three years, 3% having had it more than three years ago, and 90% never having had it.

Figure 7. Drug Abuse Counseling Among Adults
New Jersey, 1999



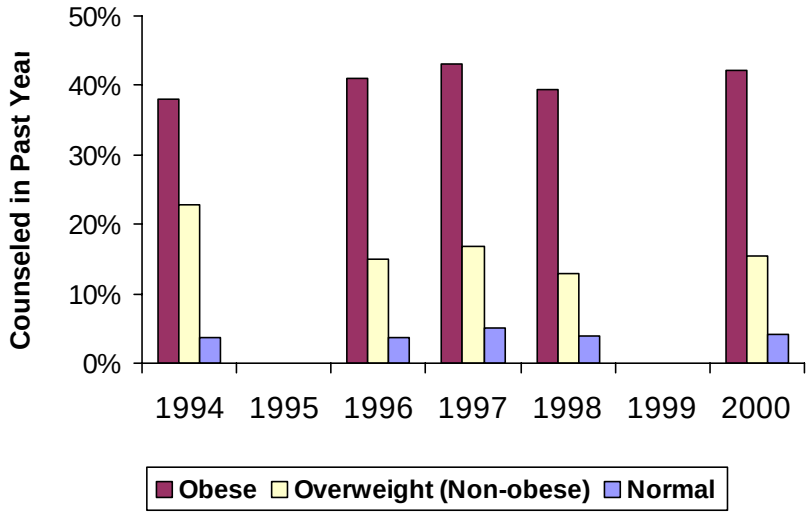
Counseling on Weight Control

Clinical counseling "to promote balanced caloric intake and energy expenditure" has been recommended

for all adults[1]. Clinical counseling to promote regular physical activity has also been recommended for all adults, and increased counseling to promote physical activity is one of the health objectives for the nation.[6] Previously reported data from the New Jersey BRFSS suggest that clinical advice about weight control *per se* has little association with actual behavior among overweight adults[13], although recent evidence suggests that even brief counseling by health professionals can be effective in increasing physical activity among sedentary adults.[14]

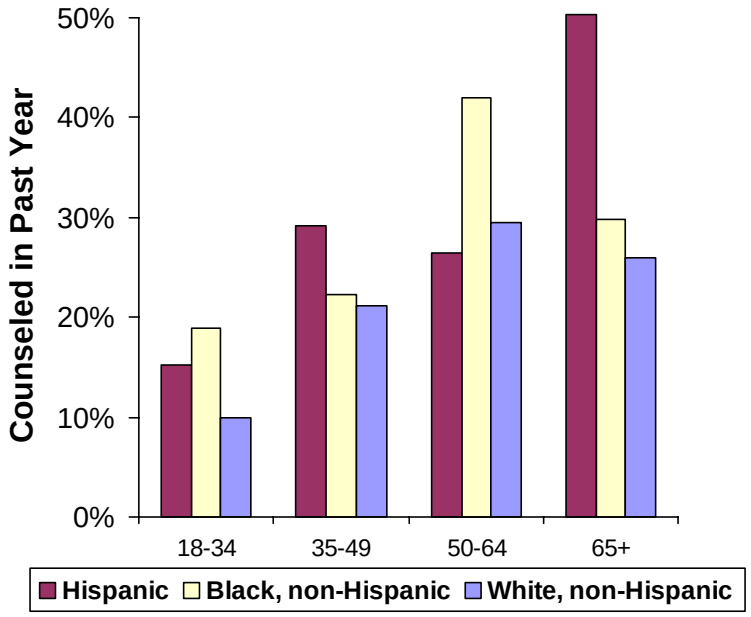
In 1994, 1996-1998, and 2000, each respondent in the New Jersey BRFSS was asked "In the past 12 months, has a doctor, nurse, or other health professional given you advice about your weight?". During these years, only about 40% of obese adults and 15% of overweight (non-obese) adults recalled being advised by a health professional to maintain or lose weight within the past 12 months. Even among those who specifically indicated having a routine medical checkup in the past year, only about 45% of obese adults and 20% of overweight (non-obese) adults recalled being advised by a health professional to maintain or lose weight during the past year. There appears to have been little change in weight control counseling among adults over this time period (Figure 8).

Figure 8. Weight Control Counseling Among Non-Pregnant Adults by Weight Status
New Jersey, 1994-2000



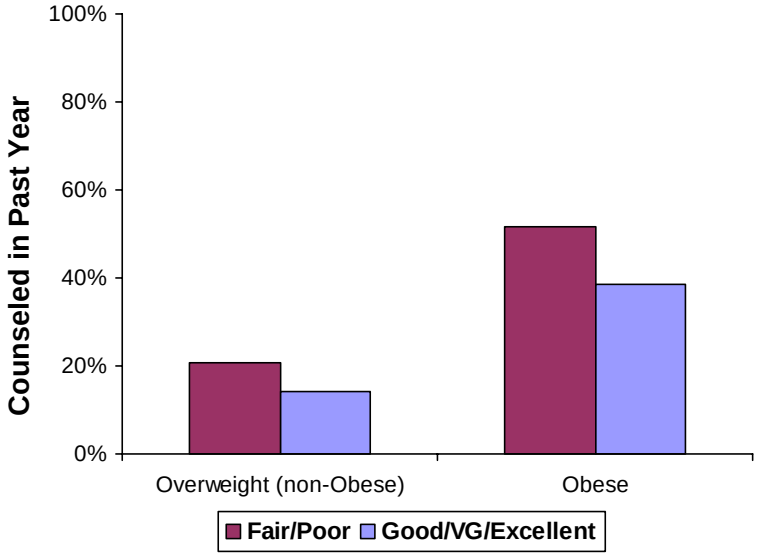
Weight control counseling among New Jersey adults varies to some extent by race/ethnicity, as well as by age (Figure 9). Age-specific estimates of weight control counseling among overweight adults were 13% for adults aged 18-34, 22% for adults aged 35-49, 31% for adults aged 50-64, and 27% for adults aged 65 and over. Age-adjusted estimates of weight control counseling among overweight adults for the period 1996-2000 were 29% (25%-33%) for Hispanic adults, 25% (22%-29%) for Black, non-Hispanic adults, and 20% (18%-21%) for White, non-Hispanic adults.

Figure 9. Weight Control Counseling Among Overweight Adults by Age and Race/Ethnicity New Jersey, 1996-2000



Weight control counseling among New Jersey adults also varies by self-perceived health status (Figure 10). Among obese individuals, approximately 52% (46% to 57%) of those in fair to poor health report weight control counseling, as opposed to approximately 39% (35% to 42%) of those in good to excellent health. Among overweight (non-obese) individuals, approximately 21% (17%-25%) of those in fair to poor health report weight control counseling, as opposed to only about 14% (13% to 15%) of those in good to excellent health.

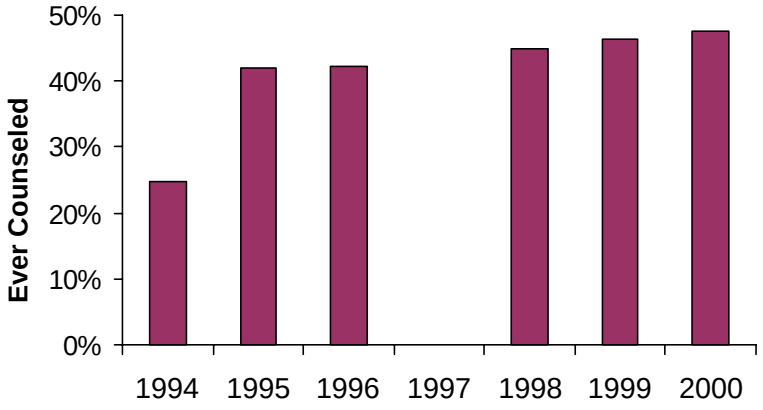
Figure 10. Weight Control Counseling by Weight Classification and Perceived Health Status New Jersey, 1996-2000



Counseling on Estrogen Replacement

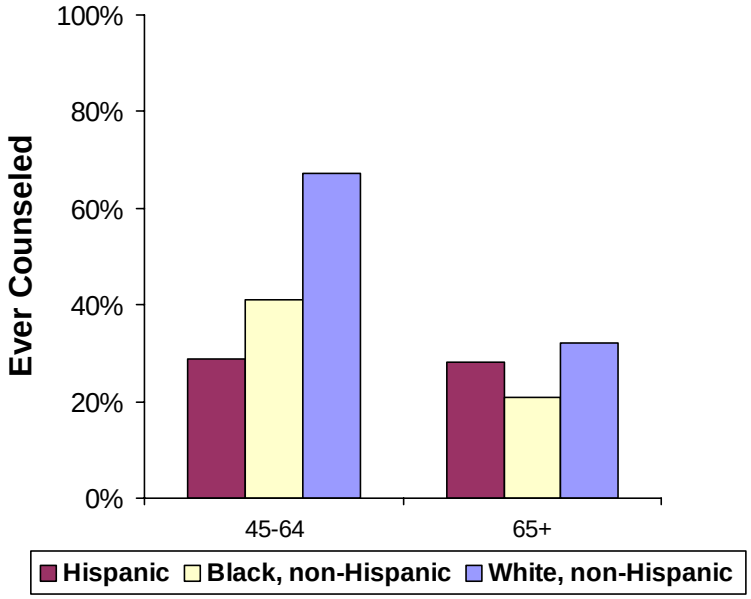
The United States Preventive Services Task Force currently recommends that all peri- and postmenopausal women be counseled about the potential benefits and risks of postmenopausal estrogen replacement.[1] Counseling about the "management of menopause" is also one of the objectives of Healthy People 2010.[5] Starting in 1994, all women respondents in the New Jersey BRFSS were asked "Have you ever been counseled by a doctor, a nurse, or other health professional about the benefits and risks of using estrogen replacement therapy for the prevention of osteoporosis?". Fewer than half of menopausal women report having such a discussion with a health care provider, although there appears to be a slightly increasing trend over the past decade (Figure 11). (Data for women aged 45 and over are unavailable for 1997.)

Figure 11. Counseling About Estrogen Replacement Among Postmenopausal Women New Jersey, 1994-2000



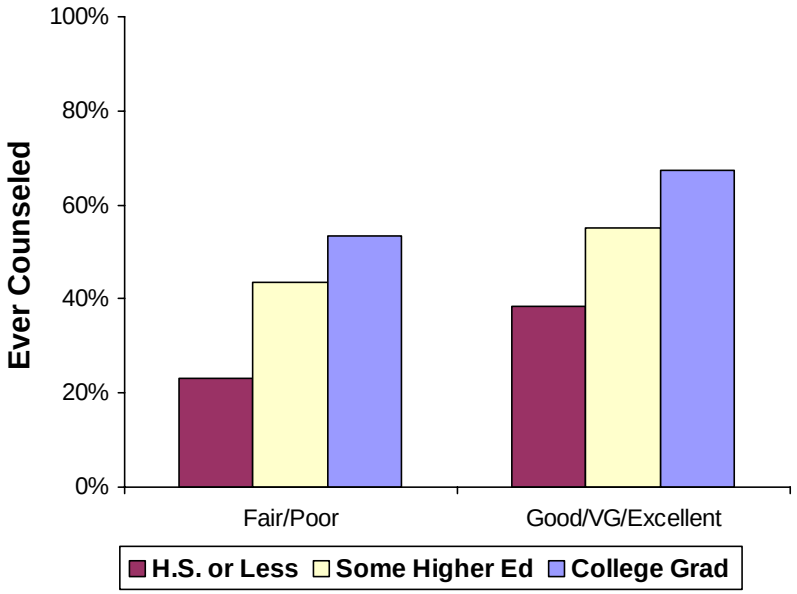
Counseling about estrogen replacement among New Jersey women decreases significantly with age. For White, non-Hispanic women, in particular, there is a large decline in counseling among older women, with only about 32% of women aged 65 and over reporting such counseling compared with about 67% of women in the 45-64 age group (Figure 12).

Figure 12. Counseling About Estrogen Replacement by Age and Race/Ethnicity
New Jersey, 1996-2000



Counseling about estrogen replacement also varies significantly by education level, as well as by self-perceived health status (Figure 13). Among college graduates in good to excellent health, approximately 68% (63% to 72%) report estrogen replacement counseling, while among those having a high school education or less and reporting fair to poor health, only about 23% (19% to 28%) report estrogen replacement counseling.

Figure 13. Counseling About Estrogen Replacement by Health Status and Education
New Jersey, 1996-2000



Counseling on Prostate Cancer Screening

Given the controversy over the potential risks and benefits of mass screening for prostate cancer using measurement of prostate specific antigen (PSA), a number of authorities have recommended that clinicians

routinely provide counseling about the test to asymptomatic men aged 50 and over.[15] In 1999, all male respondents over 40 years of age in the New Jersey BRFSS were asked "Has doctor or other health professional ever talked with you about any kind of screening test or exam to check for prostate cancer?". Approximately half (45%-56%) of men aged 50 and over reported having such a discussion.

Discussion

About one-third of New Jersey smokers and more than half of New Jersey adults in other key high-risk categories did not receive appropriate clinical counseling, according to the New Jersey BRFSS. Secular trends show modest improvement at best over the past decade.

Both race/ethnicity and socioeconomic status appear to play significant roles in determining who gets preventive clinical counseling in New Jersey. White, non-Hispanic adults reportedly are more likely to get counseling about some health issues (such as smoking cessation) but less likely to get counseling about other issues (such as weight control). Adults with higher levels of education reportedly are more likely to get counseling about issues such as smoking cessation and estrogen replacement. Multivariable analyses (not shown) suggest that these associations exist regardless of health insurance status and frequency of routine checkups.

General health status also appears to be a significant determinant of who gets preventive clinical counseling in New Jersey, with persons who perceive themselves to be in fair to poor health reportedly more likely to get counseling about smoking cessation and weight control (but not estrogen replacement) than persons who perceive themselves to be in good to excellent health. Thus, preventive clinical counseling appears to be often taking place in the form of secondary rather than primary prevention, which implies lost opportunities to reinforce important public health messages among the general public. Innovative new counseling programs such as New Jersey Quitnet, New Jersey Quitline, and New Jersey QuitCenters, three smoking cessation programs funded by New Jersey's Comprehensive Tobacco Control Program, may help shift the balance towards primary prevention, however, inasmuch as they are targeted towards the general public.[16]

*Prevalence estimates given as ranges in this report represent approximate 95% confidence intervals for the underlying population-based statistics, taking into account the random error introduced by sampling. These confidence intervals were calculated from variance estimates generated by the statistical software package SUDAAN, used for surveys such as the BRFSS which incorporate complex sampling designs.[17] Where a 95% confidence interval is not presented, the “margin of error” (computed as the standard error of the estimate multiplied by 1.96) is expected to be less than 3%. "Age-adjusted" prevalence estimates are standardized using the estimated age distribution of the United States population in 2000.

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For further information regarding the New Jersey BRFSS, please access http://www.state.nj.us/health/chs/brfss.htm on the Internet or contact:

Georgette Boeselager, M.S., R.D.
BRFSS Coordinator
Center for Health Statistics
New Jersey Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360

Telephone: (609) 984-6702