UPPL, Alcohol Exclusion Laws and Texas

Dr. Larry Gentilello
Professor of Surgery
University of Texas Southwestern Medical Center
Alcohol-Related Mortality

(CDC - MMWR, 2004)
Years of Potential Life Lost - YPLL’s

Alcohol - Related Diseases

(CDC - MMWR, 2004)
Years of Potential Life Lost - YPLL’s

Alcohol - Related Diseases

- Chronic Disease: 788,005
- Injuries: 2,279,322

(CDC - MMWR, 2004)
Alcohol and Trauma

(Gentilello, Am J Surg 1988)
Positive Alcohol Screens

- Ambulatory Medical
- Inpatient Medical
- Emergency Dept
- Outpatient Mental Health
- Inpatient Psychiatric
- Trauma Center

Sunday, August 16, 2009
Major Injury as a Unique Opportunity to Initiate Treatment in the Alcoholic

Larry M. Gentilello, MD, Pat Duggan, MS, CAC, Dean Drummond, Katy, Texas, Alan Tonnesen, MD, Houston, Texas, Eugene E. Degner, MD, Katy, Texas, Ronald P. Fischer, MD, PhD, R. Lawrence Reed II, MD, Houston, Texas
Severity of Alcohol Problems

Dependent drinking/Alcoholism
Harmful drinking/Abuse
Risky/Hazardous drinking
Safe drinking
abstinent

severity
<table>
<thead>
<tr>
<th>TREATMENT MODALITY</th>
<th>Np</th>
<th>Nn</th>
<th>WEIn</th>
<th>MQS</th>
<th>SEV</th>
<th>CES</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Intervention</td>
<td>17</td>
<td>6</td>
<td>-26</td>
<td>13.0</td>
<td>2.5</td>
<td>+239</td>
<td>46</td>
</tr>
<tr>
<td>Social Skills Training</td>
<td>11</td>
<td>5</td>
<td>-15</td>
<td>11.1</td>
<td>3.8</td>
<td>+128</td>
<td>270</td>
</tr>
<tr>
<td>Motivational Enhancement</td>
<td>5</td>
<td>2</td>
<td>+6</td>
<td>13.6</td>
<td>3.0</td>
<td>+87</td>
<td>46</td>
</tr>
<tr>
<td>Community Reinforcement Approach</td>
<td>4</td>
<td>0</td>
<td>+6</td>
<td>13.3</td>
<td>3.0</td>
<td>+80</td>
<td>492</td>
</tr>
<tr>
<td>Behavior Contracting</td>
<td>4</td>
<td>0</td>
<td>+6</td>
<td>10.8</td>
<td>3.8</td>
<td>+73</td>
<td>164</td>
</tr>
<tr>
<td>Aversion Therapy, Nausea</td>
<td>3</td>
<td>3</td>
<td>+1</td>
<td>10.3</td>
<td>3.8</td>
<td>+34</td>
<td>1380</td>
</tr>
<tr>
<td>Client-Centered Therapy</td>
<td>3</td>
<td>1</td>
<td>+3</td>
<td>9.8</td>
<td>3.3</td>
<td>+34</td>
<td>738</td>
</tr>
<tr>
<td>Relapse Prevention</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>12.6</td>
<td>3.0</td>
<td>+34</td>
<td>433</td>
</tr>
<tr>
<td>Self-Help Manual</td>
<td>2</td>
<td>1</td>
<td>+1</td>
<td>12.7</td>
<td>3.0</td>
<td>+33</td>
<td>20</td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>10.3</td>
<td>3.6</td>
<td>+22</td>
<td>433</td>
</tr>
<tr>
<td>Covert Sensitization</td>
<td>3</td>
<td>5</td>
<td>-1</td>
<td>10.9</td>
<td>3.5</td>
<td>+18</td>
<td>328</td>
</tr>
<tr>
<td>Marital/Family Therapy, Behavioral</td>
<td>3</td>
<td>2</td>
<td>+2</td>
<td>13.4</td>
<td>3.6</td>
<td>+15</td>
<td>513</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>10</td>
<td>11</td>
<td>+7</td>
<td>10.8</td>
<td>3.8</td>
<td>+9</td>
<td>637</td>
</tr>
<tr>
<td>Behavioral Self-Control Training</td>
<td>14</td>
<td>16</td>
<td>+10</td>
<td>13.0</td>
<td>2.9</td>
<td>-07</td>
<td>105</td>
</tr>
<tr>
<td>Systematic Desensitization</td>
<td>1</td>
<td>2</td>
<td>-1</td>
<td>11.0</td>
<td>3.0</td>
<td>-07</td>
<td>120</td>
</tr>
<tr>
<td>Lithium</td>
<td>3</td>
<td>3</td>
<td>-1</td>
<td>11.3</td>
<td>3.8</td>
<td>-08</td>
<td>441</td>
</tr>
<tr>
<td>Marital/Family, Nonbehavioral</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>12.4</td>
<td>3.7</td>
<td>-22</td>
<td>513</td>
</tr>
<tr>
<td>Aversion Therapy, Electrical</td>
<td>6</td>
<td>9</td>
<td>-1</td>
<td>11.1</td>
<td>3.8</td>
<td>-25</td>
<td>410</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>0</td>
<td>4</td>
<td>-4</td>
<td>10.8</td>
<td>3.8</td>
<td>-41</td>
<td>738</td>
</tr>
<tr>
<td>Milieu Therapy</td>
<td>3</td>
<td>7</td>
<td>-3</td>
<td>11.7</td>
<td>3.6</td>
<td>-41</td>
<td>1960</td>
</tr>
<tr>
<td>Psychedelic Medication</td>
<td>2</td>
<td>6</td>
<td>-4</td>
<td>9.9</td>
<td>3.6</td>
<td>-45</td>
<td>637</td>
</tr>
<tr>
<td>Unspecified “Standard” Treatment</td>
<td>0</td>
<td>3</td>
<td>-3</td>
<td>10.7</td>
<td>3.0</td>
<td>-53</td>
<td>738</td>
</tr>
<tr>
<td>Videotape Self-Confrontation</td>
<td>0</td>
<td>6</td>
<td>-6</td>
<td>10.8</td>
<td>3.8</td>
<td>-77</td>
<td>548</td>
</tr>
<tr>
<td>Antianxiety Medication</td>
<td>1</td>
<td>7</td>
<td>-6</td>
<td>7.4</td>
<td>3.3</td>
<td>-79</td>
<td>637</td>
</tr>
<tr>
<td>Metronidazole</td>
<td>1</td>
<td>10</td>
<td>-9</td>
<td>9.6</td>
<td>3.7</td>
<td>-102</td>
<td>637</td>
</tr>
<tr>
<td>Relaxation Training</td>
<td>3</td>
<td>11</td>
<td>-7</td>
<td>11.1</td>
<td>2.8</td>
<td>-109</td>
<td>120</td>
</tr>
<tr>
<td>Confrontational Counseling</td>
<td>0</td>
<td>7</td>
<td>-7</td>
<td>12.4</td>
<td>2.9</td>
<td>-125</td>
<td>375</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>1</td>
<td>9</td>
<td>-8</td>
<td>11.3</td>
<td>3.1</td>
<td>-127</td>
<td>4050</td>
</tr>
<tr>
<td>General Alcoholism Counseling</td>
<td>1</td>
<td>15</td>
<td>-14</td>
<td>11.3</td>
<td>3.4</td>
<td>-214</td>
<td>738</td>
</tr>
<tr>
<td>Educational Lectures/Films</td>
<td>3</td>
<td>18</td>
<td>-14</td>
<td>9.9</td>
<td>2.2</td>
<td>-239</td>
<td>135</td>
</tr>
</tbody>
</table>
Drinking Pyramid

Types of Drinkers | Prevalence in US | Goals
--- | --- | ---
Alcohol Dependent | ~ 2 % | Referral to treatment
Risky or Harmful | ~ 23% | Brief Intervention
Low Risk or Abstinent | ~ 75% | No intervention
Hypothesis

Alcohol interventions as a routine component of trauma care will reduce subsequent alcohol intake, and decrease the rate of trauma recidivism.
Trauma Recidivism - HMC

injury recurrence

- intervention
- control

North

days follow-up

Sunday, August 16, 2009
Trauma Recidivism - Statewide

injury recurrence

<table>
<thead>
<tr>
<th></th>
<th>intervention</th>
<th>control</th>
<th>North</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.0125</td>
<td>0.0250</td>
<td>0.0375</td>
</tr>
<tr>
<td>0.0500</td>
<td>0.0250</td>
<td>0.0375</td>
<td>0.0500</td>
</tr>
<tr>
<td>days follow-up</td>
<td>0</td>
<td>250</td>
<td>500</td>
</tr>
</tbody>
</table>

Sunday, August 16, 2009
Changes in Alcohol Intake

-30.0  |  -16.3  |  -2.5  |  11.3  |  25.0

1  |  2  |  3  |  0  |  0  | -14.1  | -17.9  | -21.6

Changes at 6 month follow-up:
-14.1
Changes at 12 month follow-up:
-21.6

(p = 0.01)
Other Outcomes

- Any traffic violation: .83
- Moving violation: .84
- DUI violation: .77
- Any arrest: .56
- Alcohol related arrest: .50

Sunday, August 16, 2009
Other Outcomes

- any traffic violation: 0.83
- moving violation: 0.84
- DUI violation: 0.77
- any arrest: 0.56
- alcohol related arrest: 0.50

Sunday, August 16, 2009
Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals

A Cost Benefit Analysis

Larry M. Gentilello, MD,* Beth E. Ebel, MD, MPH,† Thomas M. Wickizer, MPH, PhD,‡
David S. Salkever, PhD,§ and Frederick P. Rivara, MD, MPH¶

Objective: To determine if brief alcohol interventions in trauma centers reduce health care costs.

Summary Background Data: Alcohol-use disorders are the leading cause of injury. Brief interventions in trauma patients reduce subsequent alcohol intake and injury recidivism but have not yet been widely implemented.

Methods: This was a cost-benefit analysis. The study population consisted of injured patients treated in an emergency department or admitted to a hospital. The analysis was restricted to direct injury-related medical costs only so that it would be most meaningful to hospitals, insurers, and government agencies responsible for health care costs. Underlying assumptions used to arrive at future benefits, including costs, injury rates, and intervention effectiveness, were derived from published nationwide databases, epidemiologic, and clinical trial data. Model parameters were examined with 1-way sensitivity analyses, and the cost-benefit ratio was calculated. Monte Carlo analysis was used to determine the strategy-selection confidence intervals.

Results: An estimated 27% of all injured adult patients are candidates for a brief alcohol intervention. The net cost savings of the intervention was $89 per patient screened, or $330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of $3.81 for every $1.00 spent on screening and intervention. This finding was robust to various assumptions regarding probability of accepting an intervention, cost of screening and intervention, and risk of injury recidivism. Monte Carlo simulations found that offering a brief intervention would save health care costs in 91.5% of simulated runs. If interventions were routinely offered to eligible injured adult patients nationwide, the potential net savings could approach $1.82 billion annually.

Conclusions: Screening and brief intervention for alcohol problems in trauma patients is cost-effective and should be routinely implemented.


Alcohol intoxication is the leading risk factor for injury.1–3 As a result, it offers the most promising and obvious target for injury-prevention programs. Brief alcohol interventions in trauma patients have been shown to reduce subsequent alcohol intake and injury recidivism.4–8 Given accumulating evidence to support their use, a variety of expert and consensus group panels have concluded that the scientific basis for their routine provision in hospitals and emergency departments has been established, and it is time to move towards national implementation.7,9–16
Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals
A Cost Benefit Analysis

Larry M. Gentilello, MD,* Beth E. Ebel, MD, MPH,†¶ Thomas M. Wickizer, MPH, PhD,‡
David S. Salkever, PhD,§ and Frederick P. Rivara, MD, MPH¶¶

Objective: To determine if brief alcohol interventions in trauma centers reduce health care costs.
Summary Background Data: Alcohol-use disorders are the leading cause of injury. Brief interventions in trauma patients reduce subsequent alcohol intake and injury recidivism but have not yet been widely implemented.
Methods: This was a cost-benefit analysis. The study population consisted of injured patients treated in an emergency department or admitted to a hospital. The analysis was restricted to direct injury-related medical costs only so that it would be most meaningful to hospitals, insurers, and government agencies responsible for health care costs. Underlying assumptions used to arrive at future benefits, including costs, injury rates, and intervention effectiveness, were derived from published nationwide databases, epidemiologic, and clinical trial data. Model parameters were examined with 1-way sensitivity analyses, and the cost-benefit ratio was calculated. Monte Carlo analysis was used to determine the strategy-selection confidence intervals.
Results: An estimated 27% of all injured adult patients are candidates for a brief alcohol intervention. The net cost savings of the intervention was $89 per patient screened, or $330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of $3.81 for every $1.00 spent on screening and intervention. This finding was robust to various assumptions regarding probability of accepting an intervention, cost of screening and intervention, and risk of injury recidivism. Monte Carlo simulations found that offering a brief intervention would save health care costs in 91.5% of simulated runs. If interventions were routinely offered to eligible injured adult patients nationwide, the potential net savings could approach $1.82 billion annually.
Conclusions: Screening and brief intervention for alcohol problems in trauma patients is cost-effective and should be routinely implemented.

Alcohol intoxication is the leading risk factor for injury. As a result, it offers the most promising and obvious target for injury-prevention programs. Brief alcohol interventions in trauma patients have been shown to reduce subsequent alcohol intake and injury recidivism. Given accumulating evidence to support their use, a variety of expert and consensus group panels have concluded that the scientific basis for their routine provision in hospitals and emergency departments has been established, and it is time to move towards national implementation.
The trauma center must have a mechanism to identify patients who are problem drinkers.

The trauma center must have a mechanism to provide an intervention for patients identified as problem drinkers.
Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later

Bertha K. Madras a,*, Wilson M. Compton b, Deepa Avula c, Tom Stegbauer c, Jack B. Stein c, H. Westley Clark c

a White House Office of National Drug Control Policy, Office of Demand Reduction, 750 17th Street N.W., Washington, DC 20503, USA

b Division of Epidemiology, Services and Prevention Research, National Institute on Drug Abuse, National Institutes of Health, Department of Health and Human Services, Neuroscience Center, 6001 Executive Boulevard, Rockville, MD 20892-9561, USA

c Substance Abuse and Mental Health Services Administration, Department of Health and Human Service, 1 Choke Cherry Road, Rockville, MD 20857, USA

Received 15 April 2008; received in revised form 28 August 2008; accepted 29 August 2008
# Reimbursement for SBI

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
<th>Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial Insurance</strong></td>
<td>CPT 99408</td>
<td>Alcohol and/or drug use structured screening and brief intervention services; 15-30 minutes</td>
<td>$33.41</td>
</tr>
<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or drug use structured screening and brief intervention services; greater than 30 minutes</td>
<td>$65.51</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>G 0396</td>
<td>Alcohol and/or drug use structured screening and brief intervention services; 15-30 minutes</td>
<td>$29.42</td>
</tr>
<tr>
<td></td>
<td>G 0397</td>
<td>Alcohol and/or drug use structured screening and brief intervention services; greater than 30 minutes</td>
<td>$57.69</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>H 0049</td>
<td>Alcohol and/or drug screening</td>
<td>$24</td>
</tr>
<tr>
<td></td>
<td>H 0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 minutes</td>
<td>$48.00</td>
</tr>
</tbody>
</table>
Joint Commission Undertakes Development of Standards for SBI

To further advance the expansion of the continuum of healthcare to include SBI, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) has decided to undertake the development of standards for screening and brief intervention for alcohol and other drugs. The Joint Commission standards are generally developed with input from healthcare professionals, providers, measurement experts, consumers, government agencies and employers. As such, because of your expertise on SBI, you are being asked to collaborate with the Joint Commission in the development of standards and quality improvement for SBI.
The Seal: Darkness within the circle represents the condition in which a person finds himself or herself when dependent on or addicted to alcohol, nicotine or other drugs. The candle represents the physician whose skill, compassion and knowledge of the science of Addiction Medicine assists the addicted or drug dependent individual and family find new life, signified by the rays of light.

The Motto (Science, Skill, Compassion) represents ABAM’s purpose in certifying physicians.
GOOD NEIGHBORS:
Reducing Drug Demand along the Mexican Border

Larry M. Gentilello, MD
Professor of Surgery, Management, Policy, and Community Health

GOAL: To reduce the demand for drugs in Border States and create the foundation for national demand reduction.

Objectives:
1. To reduce the demand for drugs in four border states by 20% in five years
2. To create the necessary means to extend the strategy to other states over the following ten years

Rationale:
The U.S. Secretary of State considers the violence in Mexico as a shared responsibility resulting in part from our “insatiable demand for drugs.” The President has stated, “we have been fighting with one hand behind our back because demand reduction is grossly under-funded, and not as effective as it needs to be.”

The besiegement of regions of Mexico threatens to destabilize our country’s third leading trading partner, and raises drug use to the level of a national security concern. Much of the violence has already spilled into U.S. border cities and beyond. The magnitude of the problem and new public awareness provides an opportunity for federal leadership to assist communities in broadly adopting efforts to reduce the use of addictive substances.

Currently available evidence-based, public health approaches to drug use have the ability to reduce demand in border regions by 10-20% in the next three years, and are ready to be used “off the shelf.” Subsequent extension nationally will have similar results, benefiting the public health and allowing more focused approaches to interdiction, producing a more stable situation on both sides of the border.
There are enough positive findings related to SBIRT inform public policy. Meetings with hospital administrators, legislators, community health coordinators, public health officials, state and local politicians, judicial officials, and educators in the Texas, New Mexico, Arizona, and California border regions could lay the groundwork for rapid implementation.

SBIRT programs could be rapidly implemented in hospitals, large primary care clinics, community health, and community mental health, HIV/STD clinics, educational systems, and faith based health oriented organizations. Potential cities in Texas include the major border cities of Brownsville, Del Rio, Eagle Pass, El Paso, Laredo and McAllen. In New Mexico, cities might include Columbus, Santa Teresa, and Antelope Wells, and Albuquerque. In Arizona, the cities of San Luis, Lukeville, Sasabe, Nogales, Naco, and Douglas are potential SBIRT implementation cites. California border cities might include San Diego, Otay Mesa, Tecate, Calexico, and Andrade.

Focusing on these regions as an initial step conveys a message directly to the public that the U.S. considers it priority policy to reduce drug demand by absorbing screening, intervention, and when needed, referral to treatment. It will set the stage for moving beyond pilot and demonstration projects, and towards mainstreaming SBIRT into medical practice, residency training, and medical curricula.
There are enough positive findings related to SBIRT inform public policy. Meetings with hospital administrators, legislators, community health coordinators, public health officials, state and local politicians, judicial officials, and educators in the Texas, New Mexico, Arizona, and California border regions could lay the groundwork for rapid implementation.

SBIRT programs could be rapidly implemented in hospitals, large primary care clinics, community health, and community mental health, HIV/STD clinics, educational systems, and faith based health oriented organizations. Potential cities in Texas include the major border cities of Brownsville, Del Rio, Eagle Pass, El Paso, Laredo and McAllen. In New Mexico, cities might include Columbus, Santa Teresa, and Antelope Wells, and Albuquerque. In Arizona, the cities of San Luis, Lukeville, Sasabe, Nogales, Naco, and Douglas are potential SBIRT implementation cites. California border cities might include San Diego, Otay Mesa, Tecate, Calexico, and Andrade.

Focusing on these regions as an initial step conveys a message directly to the public that the U.S. considers it priority policy to reduce drug demand by absorbing screening, intervention, and when needed, referral to treatment. It will set the stage for moving beyond pilot and demonstration projects, and towards mainstreaming SBIRT into medical practice, residency training, and medical curricula.
Uniform Accident and Sickness Policy Provision Law (UPPL)

“The insurer shall not be liable for any loss sustained in consequence of the insured’s being intoxicated or under the influence of any narcotic”

Source: National Association of Insurance Commissioners, 1947
Effect of the Uniform Accident and Sickness Policy Provision Law on Alcohol Screening and Intervention in Trauma Centers

Larry M. Gentilello, MD, Anthony Donato, MPP, Susan Nolan, Robert E. Mackin, Franesa Liebich, David B. Hoyt, and Richard A. LaBrie, EdD,

Background: Alcohol screening and intervention in trauma centers is widely recommended. The Uniform Accident and Sickness Policy Provision Law (UPPL) exists in most states, and allows insurers to refuse payment for treatment of injuries in patients with a positive alcohol or drug test. This article analyzed the UPPL’s impact on screening and reimbursement, measured the knowledge of legislators about substance use problems in trauma centers, and determined their opinions about substance use-related exclusions in insurance contracts for trauma care.

Methods: A nationwide survey of members of the American Association for the Surgery of Trauma was conducted. A separate survey of legislators who are members of the Senate, House, or Assembly and serve in some leadership role on committees responsible for insurance in their state was also performed.

Results: Ninety-eight trauma surgeon and 56 legislator questionnaires were analyzed. Surgeons’ familiarity with the UPPL was limited; only 13% believed they practiced in a UPPL state, but 70% actually did. Despite lack of knowledge of the statute, 24% reported an alcohol- or drug-related insurance denial in the past 6 months. This appeared to affect screening practices; the majority of surgeons (51.5%) do not routinely measure blood alcohol concentration, even though over 91% believe blood alcohol concentration testing is important. Most (82%) indicated that if there were no insurance barriers, they would be willing to establish a brief alcohol intervention program in their center. Legislators were aware of the impact of substance use on trauma centers. They overwhelmingly agreed (89%) that alcohol problems are treatable, and 80% believed it is a good idea to offer counseling in trauma centers. As with surgeons, the majority (53%) were not sure whether the UPPL existed in their state, but they favored prohibiting alcohol-related exclusions by a 2:1 ratio, with strong bipartisan support.

Conclusions: The study documents strong support for screening and intervention programs by both trauma surgeons and legislators. Surgeons experience alcohol-related insurance denials but are not familiar with the state law that sanctions this practice. A majority of legislators are also not familiar with the UPPL but support elimination of insurance statutes that allow exclusion of coverage for trauma care on the basis of intoxication.

Key Words: Trauma, Injury, Alcohol, Intervention, Insurance, Trauma centers

Effect of the Uniform Accident and Sickness Policy Provision Law on Alcohol Screening and Intervention in Trauma Centers

Larry M. Gentilello, MD, Anthony Donato, MPP, Susan Nolan, Robert E. Mackin, Franesa Liebich, David B. Hoyt, and Richard A. LaBrie, EdD,

Background: Alcohol screening and intervention in trauma centers is widely recommended. The Uniform Accident and Sickness Policy Provision Law (UPPL) exists in most states, and allows insurers to refuse payment for treatment of injuries in patients with a positive alcohol or drug test. This article analyzed the UPPL's impact on screening and reimbursement, measured the knowledge of legislators about substance use problems in trauma centers, and determined their opinions about substance use-related exclusions in insurance contracts for trauma care.

Methods: A nationwide survey of members of the American Association for the Surgery of Trauma was conducted. A separate survey of legislators who are members of the Senate, House, or Assembly and serve in some leadership role on committees responsible for insurance in their state was also performed.

Results: Ninety-eight trauma surgeons and 56 legislator questionnaires were analyzed. Surgeons' familiarity with the UPPL was limited; only 13% believed they practiced in a UPPL state, but 70% actually did. Despite lack of knowledge of the statute, 24% reported an alcohol- or drug-related insurance denial in the past 6 months. This appeared to affect screening practices; the majority of surgeons (51.5%) do not routinely measure blood alcohol concentration, even though over 91% believe blood alcohol concentration testing is important. Most (82%) indicated that if there were no insurance barriers, they would be willing to establish a brief alcohol intervention program in their center. Legislators were aware of the impact of substance use on trauma centers. They overwhelmingly agreed (89%) that alcohol problems are treatable, and 80% believed it is a good idea to offer counseling in trauma centers. As with surgeons, the majority (53%) were not sure whether the UPPL existed in their state, but they favored prohibiting alcohol-related exclusions by a 2:1 ratio, with strong bipartisan support.

Conclusions: The study documents strong support for screening and intervention programs by both trauma surgeons and legislators. Surgeons experience alcohol-related insurance denials but are not familiar with the state law that sanctions this practice. A majority of legislators are also not familiar with the UPPL but support elimination of insurance statutes that allow exclusion of coverage for trauma care on the basis of intoxication.

Key Words: Trauma, Injury, Alcohol, Intervention, Insurance, Trauma centers

UPPL Status as of 2009

- Never Adopted*
- Repealed/Amended Since 2001
- Repeal Efforts Ongoing
- No Current Repeal Efforts
Where Does Texas Stand?

The repeal of the law has been introduced during the last three legislative sessions by Representative Craig Eiland (D) Galveston

It was supported by Texas Senator Rodney Ellis (D) Houston in 79th Session

Currently UPPL Repeal has not been filed in the 81st Session of TX Legislature
The Connection To Trauma

• Texas has more trauma centers than any other state
• Trauma Centers are most affected by this law
• Alcohol Exclusion laws affect all, regardless of type of insurance
Financial Costs in Our State

• Failure to do SBI in trauma centers could cost TX businesses and residents $889 million each year in health care expenses

Estimated Annual Savings from Treating Texas Emergency Patients for Alcohol Problems

<table>
<thead>
<tr>
<th>Payer</th>
<th>Patients in ER with alcohol problems</th>
<th>Costs of not routinely screening and treating ER patients</th>
<th>Savings if screening and brief treatment were routine practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>171,321</td>
<td>$303,880,383</td>
<td>$60,133,671</td>
</tr>
<tr>
<td>Medicaid</td>
<td>90,538</td>
<td>$160,591,624</td>
<td>$31,778,838</td>
</tr>
<tr>
<td>Medicare</td>
<td>24,601</td>
<td>$43,636,422</td>
<td>$8,634,951</td>
</tr>
<tr>
<td>Other/No Insurance</td>
<td>214,702</td>
<td>$380,826,958</td>
<td>$75,360,402</td>
</tr>
<tr>
<td>Total</td>
<td>501,162</td>
<td>$888,935,387</td>
<td>$175,907,862</td>
</tr>
</tbody>
</table>

*Goplerud E. et al. [http://www.ensuringsolutions.org.](http://www.ensuringsolutions.org)
Effects in Our Communities: We All Pay Indirectly

• We all Pay - Law enforcement, businesses, schools, the general public

• AEL threatens public health
  – It discourages alcohol screening and treatment
  – It contributes to drunk driving
  – It may deter injured individuals from seeking medical treatment
Effects in Our Communities

• Impedes Law Enforcement
  – Allows drunk drivers to escape detection
  – Only 4% of drunk drivers in crashes are arrested if they go to the hospital
  – “safe haven” effect of the ER.
Normal Drinkers are at Risk

A woman was celebrating her anniversary at a restaurant. She consumed a few glasses of champagne. While hailing a cab in the rain she caught her heel in the pavement and fell, breaking her ankle. At the ER they noted alcohol on her breath. The insurer denied payment even though the woman did not break the law, nor was she drunk.
Who Should Care

To name a few....

• Hospitals
• Chambers of Commerce
• Law Enforcement
• Businesses
• Faith-based Organizations
• Trauma Centers
• Parents

...... All of Us
What Can You Do?

- Write a letter to your representative
- Educate the community about UPPL
- Educate your local chamber of commerce
- Write a letter to the editor

Remember: This is a state-level issue so it must be addressed at the state-level in order for change to happen
Stay Involved

Join with Texans Standing Tall in our efforts to educate community members and decision makers on this critical issue.

www.TexansStandingTall.org