Barriers and Beliefs Associated with Alcohol Use Screening Frequency by Pediatric Specialists

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Background

- Alcohol use is prevalent among youth with chronic medical conditions (Wisk & Weitzman, 2016)
- For youth with chronic medical conditions, alcohol use can exacerbate disease by interacting with medications and undermining treatment adherence (Weitzman et al. , 2015)
- Little is known about screening for alcohol use in subspecialty care settings

Objectives

- Ascertain the reported frequency of alcohol use (AU) screening frequency among pediatric specialists
- Elucidate the beliefs and barriers associated with AU screening frequency by subspecialists to identify leverage points for increasing screening

Methods

- Sample: U.S. endocrinologists and rheumatologists who regularly see patients aged 14-17 years
- Recruited through an online survey delivered through professional network mailing lists
- Descriptive statistics used to characterize the overall sample and chi-square tests to compare alcohol use screening frequency by sample characteristics
- Multinomial logistic regression to examine associations between barriers/beliefs and screening frequency

Results

- 272 survey responses (64.7%/35.3%) by pediatric endocrinologists/rheumatologists
- 39.3% screen for alcohol use annually or more
- 39.3% sometimes (< annually), and 21.3% rarely/never
- Screening frequency did not differ by specialty type
- On average, specialists reported 26.3 (std = 9.14) minutes of face-to-face time (average time provider spends directly with patient)

Table 1. Association between provider characteristics and screening frequency

		Screening frequency			
	Overall Sample N (%)	Annually or More N (%)	Sometimes N (%)	Rarely or Never N (%)	[a]p-value
Total	272 (100%)	107 (39.34%)	107 (39.34%)	58 (21.32%)	
Gender					0.2918
Male	83 (30.51)	28 (33.73)	33 (39.76)	22 (26.51)	
Female	189 (69.49)	79 (41.80)	74 (39.15)	36 (19.05)	
Specialty Type					0.2049
Endocrinology	176 (64.71)	76 (43.18)	64 (36.36)	36 (20.45)	
Rheumatology	96 (35.29)	31 (32.29)	43 (44.76)	22 (22.92)	
Years practiced					0.1607
<10 years	136 (50.00)	49 (36.03)	55 (40.44)	32 (23.53)	
11-15 years	42 (15.44)	24 (57.14)	13 (30.95)	5 (11.90)	
16-20 years	33 (12.13)	14 (42.42)	11 (33.33)	8 (24.24)	
21-25 years	25 (9.19)	8 (32.00)	9 (36.00)	8 (32.00)	
26 or more years	36 (13.24)	12 (33.33)	19 (52.78)	5 (13.89)	
Role					0.1933
Attending Physician	211 (77.57)	81 (38.39)	85 (40.28)	45 (21.33)	
Fellow	31 (11.40)	12 (38.71)	10 (32.26)	9 (29.03)	
NP or DNE	17(6.25)	11 (64.71)	4 (23.53)	2 (11.76)	
Other/Unknown	13 (4.78)	3 (23.08)	8 (61.54)	2 (15.38)	
Face-to-face time during visit, min (mean, std)	26.27 (9.14)	26.61 (8.68)	25.34 (9.56)	27.34 (9.21)	0.2721

[a]p-values were calculated using chi-square test or Kruskal-Wallis Test, as appropriate

Figure 1. Likelihood (OR) of reporting barrier based on screening frequency

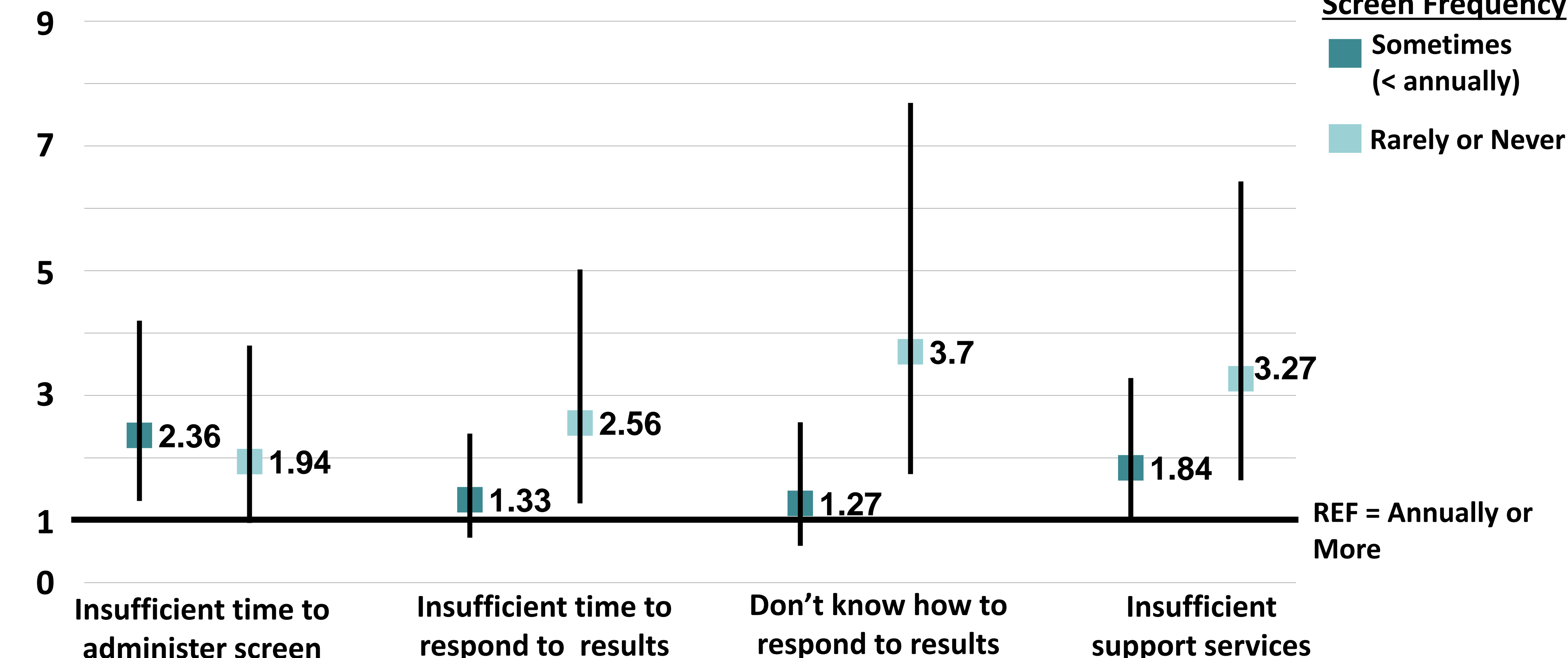
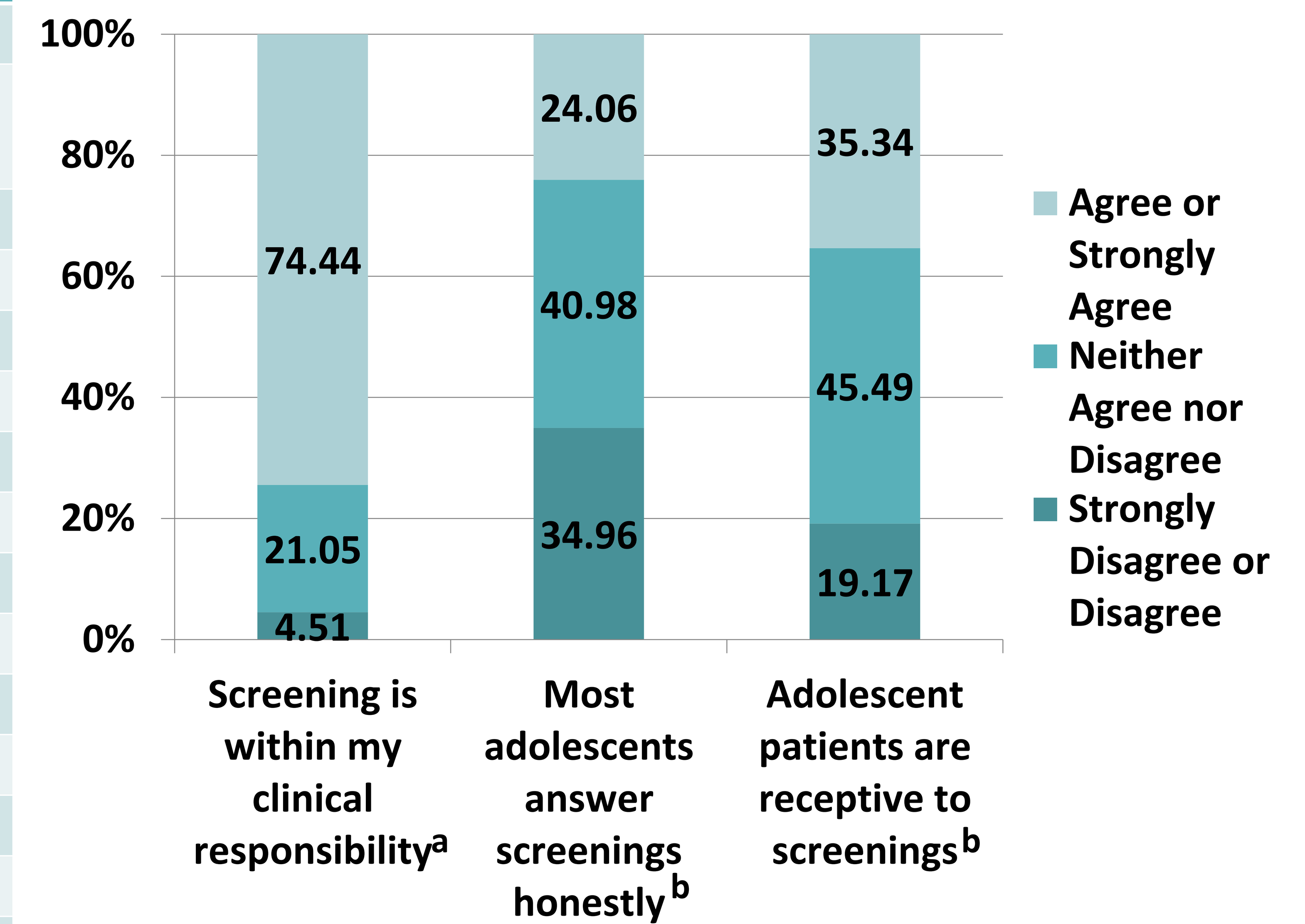


Figure 2. Screening beliefs among providers



[a] Agreeing that screening is within provider's clinical responsibility decreased likelihood of screening sometimes (<annually) (OR = 0.44, 95% CI:0.21-0.89) or rarely/never (OR =0.36, 95% CI:0.16-0.82).
[b] No association with screening frequency.

Discussion

- Structural barriers including insufficient time to administer and respond to AU screening, as well as insufficient support services were associated with decreased AU screening frequency.
- Not knowing how to respond to AU screen results was associated with decreased screening frequency.
- Beliefs regarding patients' receptivity and honesty were not associated with screening frequency.
- Specialists' beliefs regarding clinical responsibility to screen were associated with screening frequency.

Conclusion

- Efforts are needed to address structural barriers (time, support services) to screening and advance clinician knowledge/skill related to AU screening.

Contact Information and Funding

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