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Provider Screening for Adolescent Alcohol and Other Drug Use at Jefferson Health: Why It's Important and How We Can Improve

Alcohol and substance use is common among U.S. adolescents. Close to 70% of high school seniors have tried alcohol, approximately 50% have taken an illegal drug, and more than 20% have used a prescription drug for nonmedical purposes.[1] Not only are there significant morbidity and mortality costs associated with adolescent alcohol and drug use, alcohol and drug use at an early age is a significant predictor of substance use disorders in adulthood. Research has shown those who begin drinking before the age of 15 are *six times* more likely to have alcohol dependence or abuse in their later years, compared to those who start drinking at or after the age of 21.[2] In addition, young adults who use alcohol and marijuana are two to three times more likely to subsequently abuse prescription opioids.[3]

Preventing alcohol and other drug use and abuse during the adolescent years circumvents significant public health problems, such as deaths from motor vehicle accidents, alcohol poisonings and suicides, as well as public health problems in adulthood, such as adult alcohol use disorder, with an estimated 88,000 annual deaths.[4]

Pediatricians and family care providers have a number of opportunities to screen adolescents for substance use, including annual examinations, acute care visits, sports physicals, and health and behavioral problems that may be alcohol or drug related.[5] The American Academy of Pediatrics (AAP) recommends that pediatricians provide adolescents with substance abuse education and screening for alcohol and other drug use during routine clinical care by incorporating the universal use of Screening, Brief Intervention and/or Referral to Treatment (SBIRT) guidelines designed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).[6] However, in national and state studies, the prevalence of adolescent alcohol and other drug use screening among providers is low, as is the use of validated tools during screening.[7-10]

At Thomas Jefferson University, all medical, physician assistant and pharmacy students are being trained in the use of SBIRT, as part of a three-year grant, with the goal of reducing the impact of substance abuse in families and communities both local and afar.[11] Despite this initiative, there are no administrative policies to foster or promote the use of SBIRT in current Jefferson practices. The number of Jefferson providers conducting screenings and the frequency in which they are conducting them is unknown.

To study adolescent screening (the first step in SBIRT) for alcohol and other drug use among Jefferson providers, an online survey was administered to a convenience sample of 44 Jefferson pediatric and family care providers in the fall of 2016. The goal of this survey was to identify what proportion of Jefferson providers currently screen their adolescent patients for alcohol and other drug use, as well as what screening tools they use and what screening barriers they encounter.

Frequency of Screening Adolescents for Alcohol and Other Drug Use

Providers were asked if they screened adolescents for alcohol and other drug use "always," "usually," "about half the time," "sometimes" or "never" during a routine visit. All providers reported some level of screening for both alcohol and drug use. Forty-one percent of providers "always" screened adolescents for alcohol use during a routine visit; 38.6% "usually" screened; 11.4% screened "about half the time;" 9.1% screened "sometimes;" and zero respondents "never" screened. Drug screening followed a similar trajectory.

The majority of respondents (70%) reported they did not use a specific tool when screening their adolescent patients. They simply asked questions regarding: 1) the type and frequency of alcohol and drug consumption, 2) the drug and alcohol use among their peers and at school and 3) whether they had been offered alcohol/drugs. Only two providers reported use of a validated screening tool, such as the CRAFFT,[12] the only validated screening tool created specifically for adolescents. Seventy-three percent of providers had neither heard of nor used the CRAFFT.

Barriers and Facilitators to Screening Adolescents for Alcohol and Other Drug Use

The top three barriers to screening were "insufficient time" (70.5%), followed by the "need to triage competing medical problems" (52.3%) and "lack of treatment resources" (18.2%).

Qualitative responses to facilitators that would assist providers in improving universal screening at Jefferson included: 1) increasing time for well-child visits to 30 minutes as opposed to 15 minutes, 2) making resources available for positive screens, 3) involving support staff, and 4) building tools into Epic (Jefferson's electronic health record system) to support screening. Forty-three percent

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of providers would prefer screening be conducted by other staff in the practice prior to seeing the patient.

Providers seemed receptive to a day-long SBIRT training; 34% of providers noted they "would attend" and 50% said they "might attend." A half-day training would be less time consuming and likely to produce more favorable results.

Author Recommendations to Increase Screening among Jefferson Providers

1. Computerized pre-visit screenings are recommended to increase the proportion of providers currently screening for alcohol and other drug use and to facilitate standardization among Jefferson practices. Studies have shown a computer-assisted screening instrument can improve detection of at-risk alcohol drinking behavior and has higher compliance from both health care providers and patients.[13] Eighty-four percent of surveyed providers would consider adding electronic screening to their practices depending upon cost and how it could be integrated into their workflow. Delivering screening electronically would also assist with time management, the number one barrier noted by physicians to screening patients.

2. Pediatric providers should form an SBIRT Change Team to organize efforts to standardize and strengthen clinical SBIRT processes by: 1) making recommendations to maximize screening rates, 2) incorporating the use of a validated screening tool, 3) advocating for screening tools and/or reminders to be included in Epic (Jefferson's EHR system), and 4) supporting training for current providers and support staff.

3. Focus groups should be conducted to gain a deeper understanding of the current screening practices taking place in the Jefferson Health system and how SBIRT can be implemented into Jefferson providers' current workflow.

The results of this study showed a significant gap between the AAP's guidelines and current Jefferson practices. Incorporating clinical guidelines for adolescent alcohol and other drugs use into the Jefferson Health system that included validated screening tools, techniques and resources, would lead to more optimal physician screening practices.

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