



Full length article

HIV primary care providers—Screening, knowledge, attitudes and behaviors related to alcohol interventions



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ABSTRACT

Background: Alcohol has particularly harmful health effects in HIV-infected patients; therefore, HIV clinics are an important setting for integration of brief alcohol intervention and alcohol pharmacotherapy to improve patient outcomes. Current practices of alcohol screening, counseling, and prescription of pharmacotherapy by HIV providers are unknown.

Methods: We conducted a cross-sectional survey of HIV providers from 8 HIV clinical sites across the United States. Surveys queried knowledge and use of alcohol screening, brief advice, counseling and pharmacotherapy, confidence and willingness to prescribe pharmacotherapy and barriers to their use of alcohol pharmacotherapy. We used multivariable logistic regression to examine provider factors associated with confidence and willingness to prescribe pharmacotherapy.

Results: Providers ($N = 158$) were predominantly female (58%) and Caucasian (73%); almost half were infectious disease physicians and 31% had been in practice 10–20 years. Most providers (95%) reported always or usually screening for alcohol use, although only 10% reported using a formal screening tool. Over two-thirds never or rarely treated alcohol-dependent patients with pharmacotherapy themselves. Most (71%) referred alcohol-dependent patients for treatment. Knowledge regarding alcohol pharmacotherapy was low. The major barrier to prescribing pharmacotherapy was insufficient training on use of pharmacotherapy. Provider confidence ratings were positively correlated with their practice patterns. **Conclusions:** HIV providers reported high rates of screening for alcohol use, though few used a formal screening tool. Most providers referred alcohol dependent patients to outside resources for treatment. Few reported prescribing alcohol pharmacotherapy. Increased training on alcohol pharmacotherapy may increase confidence in prescribing and use of these medications in HIV care settings.

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1. Introduction

Alcohol misuse includes a spectrum of severity, from hazardous/risky use, defined as a “quantity or pattern of alcohol consumption that places patients at risk for adverse health events” which includes binge drinking, to alcohol abuse and/or dependence that result in adverse physical and psychological health effects (Reid et al., 1999). Alcohol misuse is prevalent among HIV-infected individuals, and is associated with decreased antiretroviral therapy uptake, adherence, and virologic suppression (Galvan et al., 2002; Samet et al., 2004; Braithwaite et al., 2005; Chander et al., 2006, 2008). Unfortunately, patient engagement and retention in traditional alcohol treatment services is poor in both HIV-infected and uninfected persons. Across the life span, fewer than 15% of persons with alcohol misuse ever receive any kind of formal alcohol treatment (Office of Applied Studies, 2009). To address this gap, screening and brief alcohol intervention (SBI) has been developed and tested for delivery in primary care and emergency room settings and has been shown to reduce alcohol misuse and improve health-related outcomes (Kaner et al., 2009). Brief alcohol intervention and motivational interviewing based interventions have also been effective in reducing alcohol use in HIV care settings (Hasin et al., 2013; Chander et al., 2015).

In addition to SBI, there are several FDA-approved pharmacotherapies with demonstrated efficacy in reducing alcohol consumption. A recent systematic review and meta-analysis (Jonas et al., 2014) of 122 randomized controlled trials highlighted the effectiveness of these therapies. Yet fewer than one in five alcohol treatment clinics offers alcohol pharmacotherapy to their patients (Ducharme et al., 2006). To broaden engagement and retention in treatment, there has been considerable interest in trying to move alcohol services into main stream medical practice in a model similar to that adopted for treatment of depression. However, despite a good evidence base for both SBI and alcohol pharmacotherapy for the treatment of alcohol misuse, these interventions also remain underused in primary care settings (Jonas et al., 2014).

Given the particularly harmful effects of alcohol misuse in HIV-infected patients, HIV clinics are an important setting for integration of SBI and alcohol pharmacotherapy. They provide long-term care to their patients, integrate a variety of specialty services, frequently have expanded funding for prescription medications, and often provide intensive case management models that promote outreach to and retention of patients. However, there are barriers to integration of alcohol screening, counseling and pharmacotherapy into HIV care, including increased demands on already busy providers, and lack of training on and familiarity with alcohol pharmacotherapy.

Given the potential benefits of reducing alcohol misuse among HIV-infected patients, the aims of the current study were to: (1) characterize current practice patterns related to alcohol screening, advice, counseling and pharmacotherapy; (2) examine providers' knowledge, attitudes and beliefs about these alcohol interventions; and (3) identify HIV provider barriers to prescribing alcohol pharmacotherapy for HIV-infected patients. The goal of this study was to inform the development of strategies to facilitate implementation of alcohol interventions in HIV primary care clinics.

2. Material and methods

2.1. Study design

This was a cross-sectional survey of HIV providers across the United States. The survey was administered between January, 2013 and March, 2014.

2.2. Participants

Participants included attending physicians, fellows, medical residents, nurse practitioners, and physician assistants working in 8 HIV clinics. The selected sites are part of the Center for AIDS Research (CFAR) Network of Integrated Clinical Systems (CNICS), including University of Alabama, Birmingham; University of Washington, Seattle; University of California San Francisco; Harvard University Fenway Clinic, Boston; Johns Hopkins University, Baltimore; University of California, San Diego; Case Western Reserve Hospital, Cleveland; and University of North Carolina, Chapel Hill. A list of provider email contact information was provided by each clinic.

2.3. Survey

The composition of the survey was largely based on prior research by Harris and Sun (2012), the Physician's Competence in Substance Abuse Test (PCSAT) and (Alford et al., 2008) items were added to specifically assess alcohol pharmacotherapy, a primary focus of our study. The survey addressed four areas of alcohol intervention: screening, brief advice, counseling and pharmacotherapy. Across these four areas, providers were asked to report on their current practice patterns and their confidence and willingness to engage in each intervention type. In addition, the survey included 17 knowledge items on alcohol interventions and 4 items specifically addressing potential barriers to their use of alcohol pharmacotherapy. Items were answered using Likert scales; scale anchors were modified according to the nature of the item. For example, practice items were rated on a 5-point Likert scale (i.e., never, rarely, sometimes, usually, always). Knowledge items were rated on a 7-point Likert scale from “strongly disagree” to “strongly agree”, with the center of the scale anchored by “Don't know.” Willingness and confidence items were rated on a 10-point Likert scale from not at all to extremely. Barriers to use of alcohol pharmacotherapy were rated on a 5-point scale from not a barrier to very major barrier.

This survey was designed and conducted prior to the launch of the American Psychiatric Association Diagnostic and Statistical Manual 5 (APA DSM 5), and therefore used the terms alcohol abuse and dependence, the diagnostic nomenclature of DSM IV. In the survey, items on referral to alcohol treatment and pharmacotherapy referenced patients with alcohol abuse or dependence. Items on the use of brief advice and counseling referenced patients with hazardous/risky drinking, that is, persons with a quantity or pattern of alcohol consumption that places patients at risk for adverse health events.

The survey was intended to be ten minutes in length and providers could elect to receive a \$10 gift card for their participation. This study was approved by the JHU Institutional Review Board (IRB) and the IRBs at the study sites. The introduction to the survey assured participants that their responses were anonymous and data would not be provided back to the clinic directors. Completion of the survey served as consent for participation.

2.4. Survey distribution

Within 2 weeks preceding survey distribution, clinic directors sent out an email to their provider network informing them of the upcoming survey and encouraging participation. An email inviting survey participation was sent to a total of 269 HIV primary care providers across the 8 CNICS sites. Each provider's email included a unique link to access an electronic survey hosted by Survey Monkey. Reminder emails were sent approximately 2, 4, and 6 weeks following the initial survey distribution.

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