Sustaining SBIRT Implementation in the Clinical Setting

Suyen Schneegans MA, Glenn P. Malone MS, Shruthi Vale MS, Janet F. Williams MD, Sandra Burge PhD, Nancy Amodei PhD
University of Texas Health Science Center at San Antonio
The Departments of Pediatrics and Family & Community Medicine

Introduction

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to early intervention for persons with or at risk for substance use disorders. The overall purpose of Project S-START (SBIRT-South Texas Area Residency Training) is to expertly train a cadre of resident physicians in SBIRT techniques to detect and manage patients with or at risk for substance use disorders. Project S-START is a 5-year multidisciplinary training curriculum which targeted 671 resident physicians from six medical specialties across South Texas: Pediatrics, Family Medicine, Internal Medicine, Surgery, Obstetrics/Gynecology, Psychiatry.

In addition to enhancing knowledge, attitudes and the implementation of SBIRT practices during the residency program, we examined whether the training efforts led to the continued implementation of SBIRT practices post-graduation.

Objectives

- Physicians will demonstrate continued implementation of SBIRT practices post-graduation.
- Implementation practices will be consistent across substance use categories (i.e., tobacco, alcohol, other abused substances).

Methods

Post-graduate physicians from Pediatrics, Family & Community Medicine and Internal Medicine departments were administered surveys via paper forms or SurveyMonkey database. Survey items were used to assess frequency of participants’ SBIRT practices (i.e., Screening, Brief Intervention, and Referral to Treatment) appropriate to individuals with or at risk for substance use and abuse.

Item stems prompted physician response to percentages of implementation for a patient age group, and number of times of implementation per week/monthly for tobacco, alcohol, and other substances use.

Responses for Screening:
- Frequency of implementation was measured via percentages:
  - 1 = None (0%)
  - 2 = Some (1-33%)
  - 3 = About half (34-55%)
  - 4 = Most (56-75%)
  - 5 = All or nearly all (76-100%)

Responses for Brief Intervention and Referral to Treatment:
- Frequency of implementation was measured via times per week/month:
  - 1 = Never
  - 2 = About one or two times per month
  - 3 = About once per week
  - 4 = 2-4 times per week
  - 5 = More than 4 times per week

Sample Characteristics

Post-graduate physicians participated in a survey-administered evaluation of the SBIRT training program.
- 43 participants filled out a 12-month follow-up survey
- 36 participants filled out a 24-month follow-up survey
- 3 medical departments participated – Pediatrics, Family Medicine, and Internal Medicine (See Figures 1 & 2.)

SBIRT Implementation

Physicians:
- Significantly reported higher scores for screening for tobacco use compared to alcohol and other substances use;
- For brief intervention, significant differences were found for tobacco cessation and alcohol use compared to other substance use;
- For referral to treatment, no significant differences were reported.

Note: All significance reporting is, p < .05.

Results

Implementation of SBIRT practices continued post-graduation.
- At 12-months, physicians showed significant differences in screening and brief intervention across substance use categories.
- At 24-months, SBIRT practices for most substances showed slight (not significant) decreases compared to 12-month levels.
  - Though implementation decreased, SBIRT patterns reported at 12- and 24-months were similar. (See Figures 3 & 4.)
  - Similar to 12-month levels, significant differences were reported for screening & brief intervention across substances.

Conclusions & Implications

Physicians consistently report implementation of SBIRT practices post-graduation; however, slight decreases in SBIRT practices over time suggest that reinforcing measures should be employed to ensure sustained practices.

Since screening for tobacco use was significantly greater compared to screening for alcohol and other substance use across 12- and 24-month evaluations, SBIRT training and reinforcement should be designed to ensure that all substance use is screened routinely and effectively in the practice setting. Tobacco use screening may occur more often since both physicians and patients have greater comfort with ‘normalized’ health risk screening of this ‘legal’ drug use. As providers and patients become similarly comfortable with routine alcohol and other drug screening, SBIRT practices should also improve. Electronic health record systems that cue SBIRT practices, facilitate documentation within routine care, and link to coding and billing can effectively reinforce SBIRT as part of patient care best-practices, and promote equitable implementation across tobacco, alcohol and other substance use.

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