

Implementing SBIRT in Residency Programs: Barriers, Bridges and Future Directions

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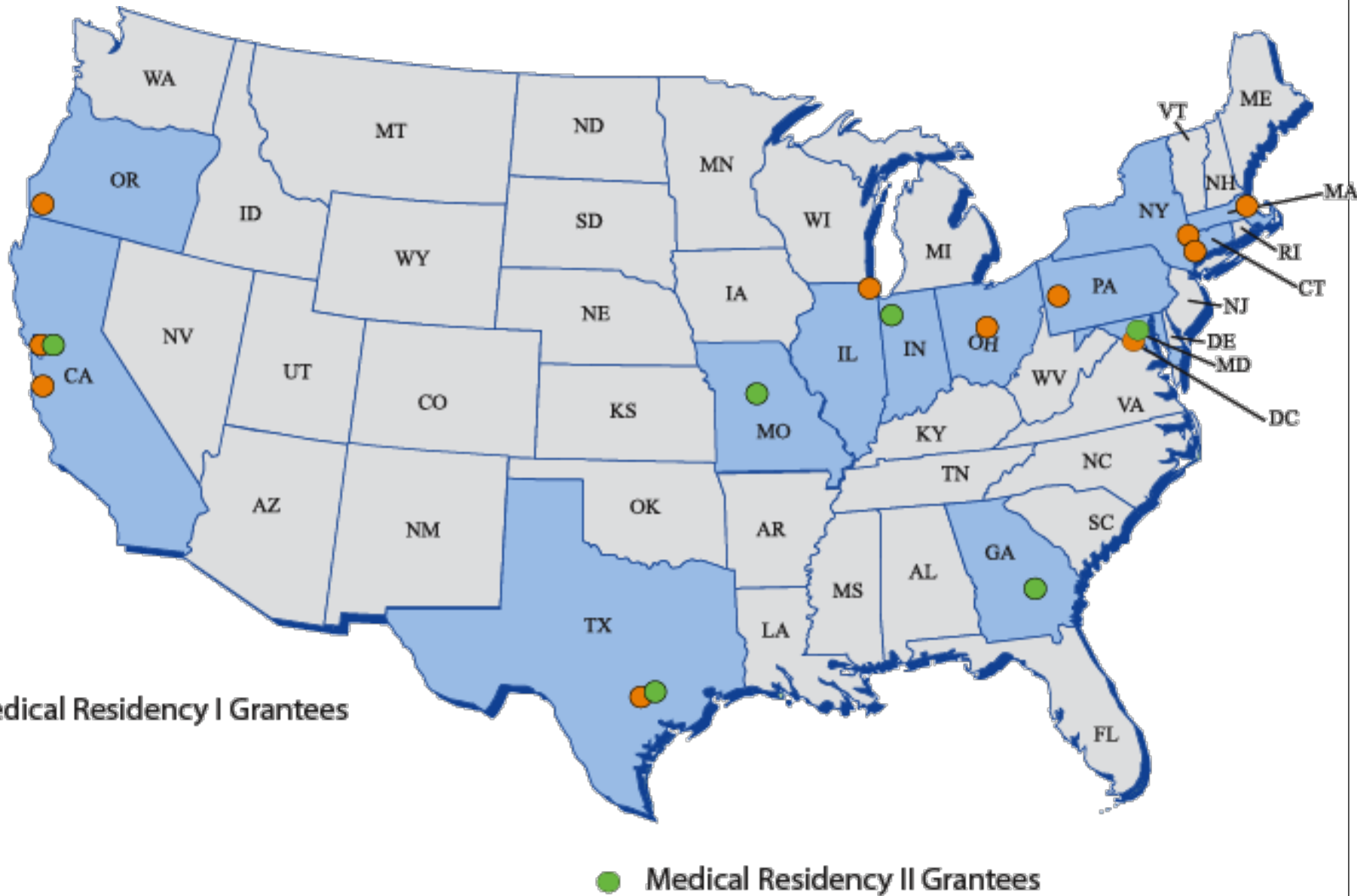
Funded by the Substance Abuse &
Mental Health Services Administration (SAMHSA)

Residency SBIRT Experience

- NIAAA-funded Georgia-Texas “Improving Brief Intervention” Project, 2005-2007
- Southeast Consortium on Substance Abuse Training (SECSAT), 2009-present
- **Funding:** Substance Abuse and Mental Health Services Administration (#1U79TI019542-01 & 1U79TI020278-01) and National Institute for Alcohol Abuse and Alcoholism (R25 AA014915-01A1).

Overview of SAMHSA-funded Residency Training SBIRT projects, 2008-present

- 17 participating residency programs
- 5-year training initiatives (\$19 million)
- Online survey of program directors conducted in 2010-June 2011 (100% response rate)
- 2,867 total residents trained as of June 2011



Medical Specialties of Participating Residents (# of programs training in this area)

- Family Medicine (15)
- Internal Medicine (14)
- Pediatrics (12)
- Obstetrics and Gynecology (10)
- Psychiatry – Adult and Child (10)
- Emergency Medicine (7)
- Surgery – including Oral Maxillofacial, Trauma (4)
- Preventive Medicine (2)
- Infectious Disease (1)
- Anesthesiology (1)
- Podiatry (1)

Barriers to Residency SBIRT training identified by SBIRT Program Directors

- Obtaining adequate curriculum time for training (especially blocks of time)
- Inadequate numbers of faculty and resident role models
- Hard to maintain SBIRT focus on patients with at-risk substance use rather than advanced abuse & dependence
- Concerns re ability to sustain RESBIRT training after end of grant funding
- Need for evidence-based evaluation instruments & approaches for documenting resident SBIRT competency

Additional barriers identified by Mercer project staff

1. U.S. resident work hour regulations—negatively impact attendance at training conferences
2. Negative attitudes of administration, colleagues, residents & nurses
 - Binge drinking as normal behavior
 - Not viewing substance abuse training as a priority
3. Challenge of implementing SBIRT programs in residency clinics with multiple administrative “chains of command”
4. Lack of national training mandate-Substance abuse was just removed from RC guidelines for Family Medicine Residency Training

Additional barriers (cont.)

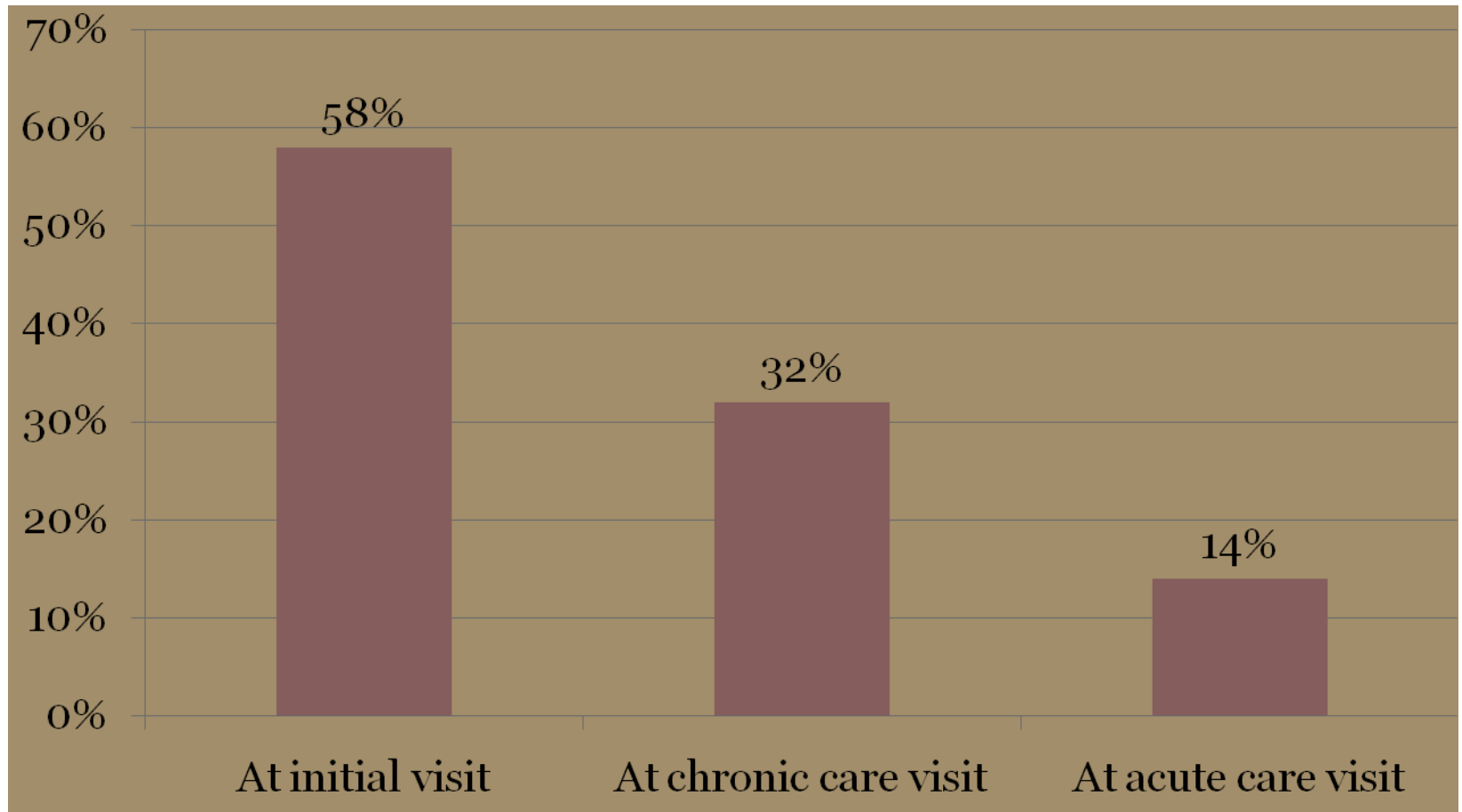
5. Negative impact of inconsistent nurse screening
 - Residents who rarely received positive screening information fail to develop adequate BI skills

6. Negative impact of opportunistic resident screening—typically the most advanced dependent patients are identified, resulting in difficult interviews, lack of resident confidence, and continuing treatment pessimism

Resident surveys tell us more about SBIRT barriers

Method: Baseline questionnaire surveys from 155 Family Medicine and Internal Medicine residents beginning Mercer's RESBIRT training programs in 2010

How frequently do residents screen for alcohol misuse? In what kind of visits?



What alcohol screening instruments are used?

- **CAGE—n=99 (64%)**
- **Quantity/Frequency Questions—n=74 (48%)**
- **Single Alcohol Screening Question (SASQ)—
n=22 (14%)**
- **AUDIT or AUDIT-C—n=7 (5%)**

How confident & successful are residents in performing BI?

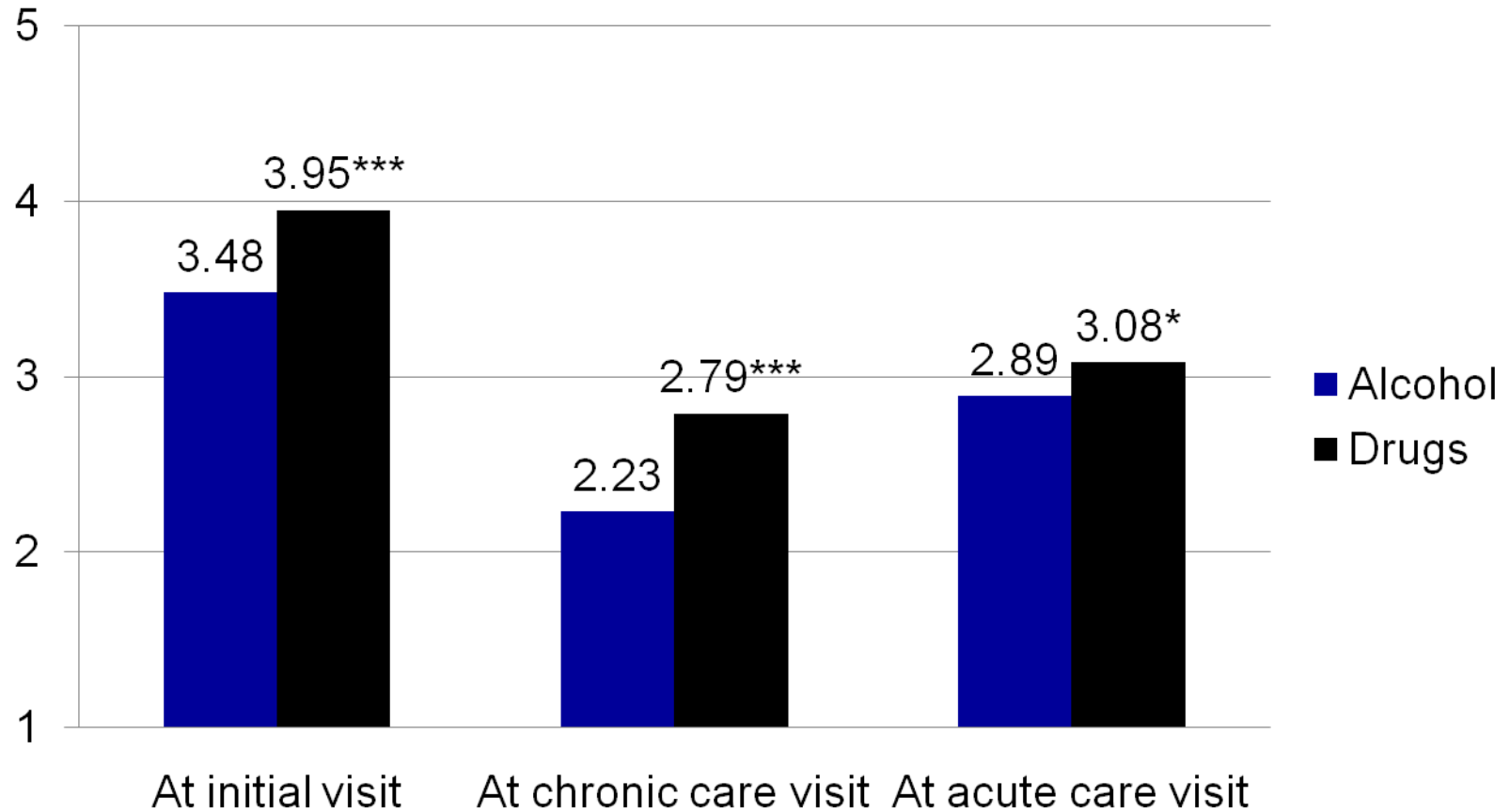
- **21% felt confident they could help patients cut down or quit alcohol**
- **16% reported they had been successful helping patients cut down or quit alcohol**

Most Common Reported Barriers to Discussing Alcohol Use

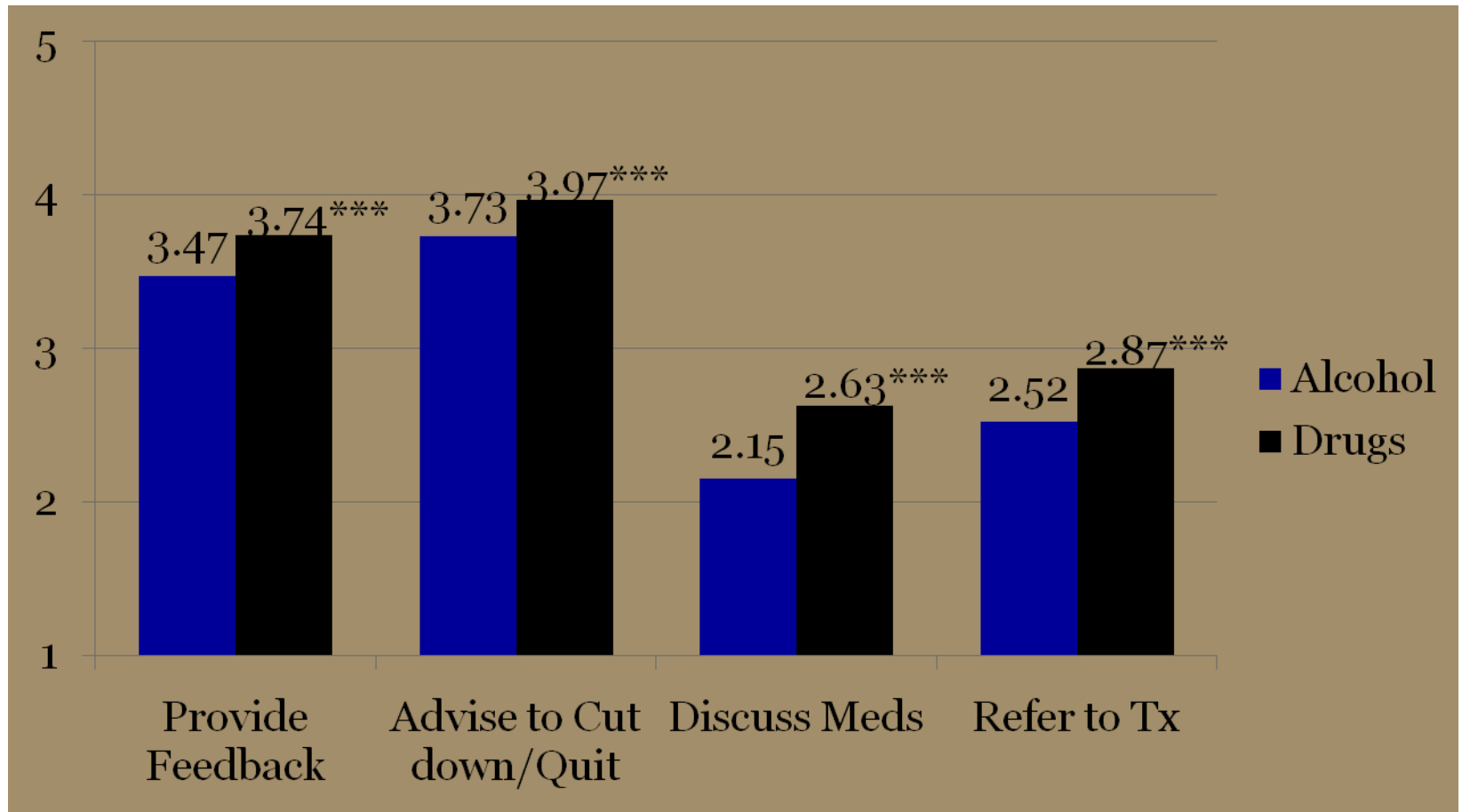
- **Lack of adequate training—56%**
- **Intervention unlikely to make a difference—43%**
- **Too busy to talk to patients about alcohol use—37%**
- **Little financial reimbursement—32%**
- **Discussing alcohol is uncomfortable—28%**
- **Discussing alcohol threatens a good doctor-patient relationship—25%**

What about SBIRT for Drug Abuse?

Comparison of Frequency of Screening for Alcohol or Drug Misuse (mean score on 1 to 5 scale)



Comparison of Frequency of Intervention and Referral for Alcohol vs. Drugs when Screen is Positive (mean score on 1 to 5 scale)



Good News!

- **SBIRT training is working**
- **Almost all 2,900 residents report they are doing BIs**
- **Evidence base for what works is slowly building**

Bridges to Building an Effective Residency SBIRT Program

1. Identify & train champions—faculty, residents, nurses
2. Know & teach SBIRT's evidence base--helps gain buy-in from residents, faculty and administration
3. Offer funding for startup where feasible-pay for faculty & staff time during start-up

Bridges to Building an Effective Residency SBIRT Program

4. Build broad-based institutional support by meeting with leadership from multiple sectors and building a multi-disciplinary implementation teams (Implementation Guide)
5. Use time-efficient SBIRT tools & approaches
 - Single question screens
 - Two-item assessment for AUDs
 - Brief advice interventions

Bridges to Building an Effective Residency SBIRT Program

6. Support flexibility in local SBIRT implementation
7. Teach relationship-building BI approaches such as Motivational Interviewing (all 17 RESBIRT programs)
8. Implement effective universal screening approaches—screen all patients every 6-12 months & prompt clinicians to perform BIs

Bridges to Building an Effective Residency SBIRT Program

9. Use creative approaches to acquiring curriculum time— combining live training with web training, training during resident orientation periods
10. Maximize skills practice, observation & feedback - reinforcement over time
11. Help develop effective, efficient EMR tools--easy to access, hard to ignore
12. Facilitate sharing of success stories by both patients & clinicians
13. Take advantage of opportunities created by U.S. opioid abuse epidemic--teach prevention, detection & management using buprenorphine

Future Directions in SBIRT Residency Training & Implementation

1. Lobby to make SBIRT training a required component of residency training
2. Support major faculty development initiatives
3. Develop validated instruments for evaluating resident competency in SBIRT
4. Test Quality Improvement approaches to improving performance of SBIRT systems in residency clinics
5. Conduct effectiveness trials comparing brief advice and MI-based brief interventions

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References

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- Seale JP, et al, "Implementing alcohol screening & brief intervention in US primary care residency programs: Lessons learned," presented at the ISBRA biannual meeting, Paris, France, September 2010
- Miller et al, "Primary care residents' comfort & experience with alcohol screening & brief intervention," presented at the SGIM annual meeting, 2011.
- Johnson et al, "Baseline differences in residents' attitudes & behaviors in delivering SBIRT services to at-risk alcohol and drug users," presented at CPDD annual meeting, Orlando, FL, June 2011