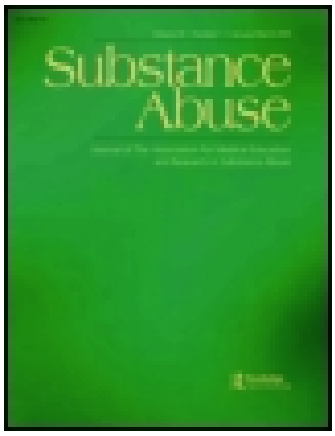

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SBIRT Implementation: Moving Beyond the Interdisciplinary Rhetoric

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EDITORIAL

SBIRT Implementation: Moving Beyond the Interdisciplinary Rhetoric

New hospital accreditation measures are currently under consideration by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that would require screening, brief intervention, and referral to treatment (SBIRT) for hospital inpatients with problem alcohol and tobacco use (1). These potential measures, which are undergoing a 6-month pilot testing phase until September of 2010, provide the opportunity to consider expanding our notions of where alcohol misuse can and ought to be addressed, and who can and ought to be addressing it. SBIRT implementation into other settings, by a variety of providers, could directly support the early identification and management of unhealthy alcohol use and enhance the continuity of care for patients in need of specialty alcohol treatment services.

Yet despite evidence for the effectiveness of SBIRT in primary and emergency/trauma care in reducing use and the related harm of alcohol and other drugs of abuse, SBIRT uptake and implementation has been notoriously slow. An emerging body of literature aims to facilitate SBIRT implementation (2, 3), and several implementation guides are available (4). These guides promote interdisciplinary SBIRT planning and implementation teams, and additional calls have been made for the inclusion of other health care professionals in SBIRT practices. However, our effectiveness research, training programs, funding mechanisms, and our overall expectations focus almost exclusively on *physician* acceptance and delivery of SBIRT.

Addressing unhealthy alcohol use should be increasingly conceptualized as a shared responsibility across provider disciplines and practice settings. To encourage wider dissemination and adoption of SBIRT, other health care professionals should be targeted to implement SBIRT practices. With the exception of recent work in the emergency/trauma care setting, models of SBIRT delivery that extend outside of primary care and/or feature prominent roles for health care providers other than physicians are relatively uncommon. This is despite the awareness that physician-level barriers have stalled implementation of SBIRT. A variety of provider-, system-, and patient-level barriers to SBIRT delivery exist; though not exclusively, the majority are provider-level barriers identified from the physician perspective. These include concerns about a lack of time and training for performing SBIRT, the perception or presence of more compelling clinical issues, and concerns about patient privacy and potential damage to the patient-provider relationship. Additionally, providers may perceive that screening and intervention for unhealthy alcohol use is simply

ineffective, unsatisfying, uncomfortable, or not within their role responsibilities (2, 3, 5).

Implementation models that capitalize on the availability and skill sets of other disciplines such as nursing, social work, and psychology have received limited consideration. Nurses, for example, appear well positioned to deliver SBIRT as part of an interdisciplinary approach for addressing unhealthy alcohol use. Nurses typically possess existing skill sets in health promotion, patient education, and interpersonal communication; a high degree of predictable, extended patient contact; sheer presence as the largest segment of health care professionals, and traditional practice style that is highly congruent with SBIRT principles. Nurses have effectively delivered SBIRT in primary care and emergency/trauma settings to a limited extent in Europe and the United States (2, 6, 7), and the Emergency Nurses' Association formally endorses this role for emergency and trauma care nurses (8). Additionally, in studies examining alcohol interventions for medical inpatients (including those with significant effects) delivery of the intervention was often performed by research or staff nurses (9–11).

Nurse-led SBIRT has been demonstrated to be just as effective as physician-led SBIRT, yet more cost-effective, with nurses significantly more likely to both screen and conduct brief interventions (6, 12). Overall, however, like physicians, generalist nurses are typically undertrained in SBIRT content and skills, have highly ambivalent attitudes about addressing alcohol misuse, and are likely to feel similar time and role constraints. Similarly, other health care professionals such as clinical psychologists and "health educators" could also implement SBIRT. We have every reason to believe that highly trained, motivated, compassionate professionals from all disciplines can be effective with SBIRT, and a small body of literature suggests that patients are receptive to receiving SBIRT outside the primary care setting and outside of the physician-patient relationship.

How can clinical and administrative stakeholders engage and utilize other health care professionals in SBIRT activities that are beneficial to the patient as well as professionally satisfying for providers? Engagement of providers from all disciplines is essential for (1) determining the most effective SBIRT delivery models for promoting patient-level outcomes; (2) maximizing resource utilization and reducing costs; and (3) reducing staff perceptions of burden and ambivalence about who on the health care team can and ought to be addressing alcohol misuse with patients. Regardless of discipline, engagement of other providers in SBIRT practice will mean ensuring clear expectations, clear responsibilities, and clear communication. SBIRT delivery needs to be shaped in such a way that providers find the its individual clinical elements meaningful, i.e., not simply tasks to be completed for institutional performance measurement, "scut work" passed from one set of professionals to another, or work that sets the stage for another provider to perform the more "substantial" or "important" elements. SBIRT delivery models should also explore what constitutes meaningful professional "feedback" for clinicians (i.e., knowing or seeing that they made a difference), particularly in care settings such as emergency or inpatient care where an ongoing relationship with patients is less likely, except in the negative case of "frequent flyers."

Several "next steps" could improve the interdisciplinary implementation of SBIRT outside of primary care settings. First, research agendas should explicitly seek and fund more effectiveness and SBIRT implementation research, specifically proposals with clear interdisciplinary roles and cross-setting elements. Second, the active, intentional creation of SBIRT "champions" and peer clinical role models in disciplines other than medicine should be promoted. These champions can be developed through inclusion (or mandate) of SBIRT content in undergraduate and graduate nursing, social work, and psychology curricula; designated scholarships for individuals focusing on addiction-related study; and the opening of unique addiction management training programs to nurse practitioners, and clinical social workers and psychologists. Finally, flexible SBIRT reimbursement models are needed that do not require *physician* delivery of SBIRT services or establish unnecessary reimbursement strata based on the individual providing brief intervention services.

Greater implementation of SBIRT has the promise of improving the health of patients with addiction diagnoses or with hazardous alcohol and drug use. Implementation and practice must move beyond physician-centric approaches. Although duplicating service delivery does not make common or fiscal sense, there is something to be said for patients receiving a consistent alcohol risk reduction message from providers of multiple disciplines along the continuum of care within a health care setting. A single set of health care providers, i.e., physicians, cannot and ought not bear the bulk of responsibility for addressing unhealthy alcohol and other drug use. The engagement and utilization of multiple disciplines is critical for sustainable SBIRT implementation and the field seems to be recognizing this early in the science of SBIRT implementation. SBIRT implementation is a perfect modality to make the rhetoric interdisciplinary approaches to the provision of health care a reality.

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