Resources to support SBIRT implementation: Theory-based case, course, & tool development

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Substance misuse and abuse represent a significant public health problem in the U.S. Public health providers are uniquely positioned to address these risky use behaviors through SBIRT (Screening, Brief Intervention, and Referral to Treatment). SBIRT adoption is gaining momentum; however, education and support lag behind endorsement, with few courses and tools available and none that address organization-wide implementation issues. We discuss the results of two independent, multi-year efforts to address this problem.

sbirt in action

SBIRT is Screening, Brief Intervention, and Referral to Treatment for substance abuse.

SBIRT is a clinical practice for rapidly identifying, intervening with, and referring patients with or at-risk for substance abuse. Originally implemented in emergency rooms, SBIRT has received attention by federal, state, and local entities as a potentially useful primary care provider (PCP) tool for increasing early, effective identification of substance abuse.

Background

Although SBIRT itself is a simple, short, easy to implement brief procedure, adopting, implementing and maintaining SBIRT at the organizational level is quite complex, even in the smallest medical practice environment. First, you have to have buy in from key stakeholders, then everyone has to develop a shared understanding of just exactly what SBIRT is and what it will look like in their particular health care environment, and everyone, from key leaders to front office staff, have to adopt and implement it.

That's a lot. And, as with any behavioral change, whether it be changing our patient's behavior or our own and that of our colleagues, there's information to desseminate, attitudes to change, skills to develop, and much more. Electronic resources, whether they be courses, videos, or simple FAQS, and paper-based tools, including the very forms you will need to administer and track SBIRT implementation, can help...but...you have to build them, and if they themselves aren't theory based and responsive to your audiences, then they more likely than not will be suboptimal.

So, that's what we've been up to across multiple projects: making tools, trying them out, changing them, and trying something new every once in a while.

The relevant projects include a web site and resource set for NIDA; the web, face to face, and paper courses and tools for a large scale resident training effort at a major midwestern university; training guides, face to face presentations, and forms for a state-wide SAMHSA initiative; and, for fun, a simulated SBIRT practice environment in a virtual environment.

Methods

It's tempting when developing learning and performance support tools to think "ah, I know this area, I'm an expert, I can just write it up/present it and all will be well." Well, no. Many of us assume because we know an area, we can teach it, but we've also all experienced learning environments where this clearly didn't work.

Our approach instead was to use established user-centered design processes, learning theories, and extensive expert and end-user involvement. That is, end users get to have a say in what is included and how its said, and they get to do so mulitple times, rather than just being the recipient of our 'knowledge.' It also means experts are, in fact, heavily involved--different stakeholders, with different types of expertise, all working together.

And, it means theory, design theory, that is, how to go about making things, and behavioral theory, or how to go about changing behavior, and that's because all professional development is, first and foremost, a *behavioral change effort*: it's about getting people to do the things you need them to do, to a certain level of performance, in specific situations.

Since SBIRT implementation is, therefore, about changing not just patient behavior but provider behavior as well, all materials should reinforce the sought behaviors, enhancing motivation, addressing barriers, and reinforcing positive beliefs. This is a theory based approach where factors that influence behavioral adoption and ongoing implementation are just as important, and need to be identified right up front and continually re-examined, as the simpler issues of awareness, knowledge, and skills.

Results

So, across the projects, we have iteratively developed five separate, media rich, web-based courses were developed, several with tailored versions for residents, primary care, pediatrics, and obgyn, and explored different technologies (Flash, video, CMS, javascript) for delivery, presentation, and interactivity. All courses have been well-received and led to measurable improvement in target outcomes; however, satisfaction, usability, and learning outcomes varied by technology, implying practical suggestions for when to use different technologies to support learning.

The efforts have produced many different SBIRT-related videos ranging from case studies to expert interviews, to real-world patient-provider interactions and clinic-wide adoption cases. Grounded in a simulated patient approach to case development, we have SBIRT video resources freely available on most aspects of SBIRT adoption and implementation, from screening to brief intervention, to treatment; from decision making when deciding whether and how to adopt, to issues encountered during adoption.

Over the years of our efforts, we've tried Flash, mobile friendly, and face to face training courses. Examining the outcomes showed that each have affordances useful for some environments and not so much in others. In the end, responsive, html based delivery through a CMS proved to be the most flexible, user friendly, and easy to implement. We developed modules to introduce SBIRT (Understanding SBIRT), to examine how SBIRT procedures and protocols intersect with other provider behaviors (Beyond SBIRT: SBIRT 2.0!), and on Organization Wide SBIRT Implementation.

And, we made forms, and Powerpoints, and protocol flows, and project information sheets, and patient information materials, all with a similar style and tone, so that the various efforts had a consistent, high quality, feel. Too often a project puts a lot of time and effort into, say a poster, or a website, then uses photocopied intake forms or assessments that, frankly, look terrible.

Conclusion

SBIRT can reduce adverse alcohol and substance misuse related public health outcomes. Adoption and implementation remains a challenge at the individual provider and organizational levels. The reported efforts address adoption, education, and support for specific target audiences and additional tailored courses and cases are merited for other specialties and practice environments.

Over the projects, we found three things to be well-received and effective in supporting the behavioral change underlying SBIRT implementation:

1. Establish an Identity and Be Consistent. That's one thing we found and can't stress enough: perceptions, and willingness to engage, are often in the details. Decide on a project identity and style right up front and stick with it! It's a prime driver.

2. Use a Narrative. Talk to the audience, whether by narrative case studies or through a more friendly narrative approach to course content. People understand and resonate to stories, and they like to be talked to, to learn with you, not be talked at or 'taught' a bunch of facts and figures. This approach can create tension between what experts think everyone should know and what end users really need to understand in order to do their job (and be willing to do them!). And, that's where a good instructional designer can help....

3. Incorporate Behavioral Change Elements. You use various behavioral change tools every day if you work with patients. You might check in on stage of change, or you might look at their willingness to modify a behavior and then you could use a little motivational interviewing to help move them along in making a change, even if you just leave them with "okay, and would you be willing to think about this some more and contact me?" So why wouldn't you use the same tools to help your colleagues decide to implement SBIRT (or any other changed practice)? You should. Not only does it work, but, if done overtly, it models good patient-provider practices!

Many courses and resources freely available at **SBIRTinAction.org**

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For More Information

Academic Edge, Inc. is a media research and development company specializing in state-of-the-art learning tools for children and adults. We target health related issues ranging from STD and conflict prevention among teens and tweens, to FASD, ADHD, and other disorder education for lay care providers, to disease prevention and medical assessment training for healthcare providers. We particularly focus on the social aspects of health care: why do people do the things they do and how can we help them live healthier, happier, or more productive lives? For more information about Academic Edge, including our many other public health related research efforts, visit **www.academicedge.com**.