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Barriers and Facilitators in Implementing “Prevention for Positives” Alcohol Reduction Support: The Perspectives of Directors and Providers in Hospital-Based HIV Care Centers

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Abstract

HIV-infected patients have considerable need for alcohol reduction support, and HIV care providers are strategically placed to implement a “prevention for positives” alcohol reduction approach through alcohol screening and brief interventions (SBIs). To facilitate this approach, we provided alcohol SBI education and training to HIV care providers in four hospital-based, New York City HIV Care Centers in 2007. Interviews with the medical directors and 14 of the HIV care providers who attended the training identified barriers to implementing alcohol SBIs. These included limited time for alcohol screening, patients’ incomplete disclosure of alcohol use, providers’ perceptions that alcohol use is not a major problem for their patients, and provider specialization that assigns patients with problematic alcohol use to specifically designated providers. Identified facilitators for alcohol SBI implementation included adequate time to conduct the SBI; availability of information, tools, and key points to emphasize with HIV-infected patients; and use of a brief alcohol screening tool.

Keywords

alcohol; barriers and facilitators; brief intervention; HIV; prevention for positives

In view of the large number of HIV-infected patients who use alcohol excessively (Chander et al., 2008; Conigliaro, Gordon, McGinnis, Rabeneck, & Justice, 2003), many patients with HIV have considerable need for alcohol reduction support in order to optimize their medication adherence, retard their disease progression, and limit their alcohol-associated sexual risk behaviors (Bryant, 2006). Unfortunately, many HIV care providers fail to detect alcohol use in their HIV and HIV/hepatitis C virus (HCV) co-infected patients, or counsel

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them concerning alcohol reduction (Conigliaro et al., 2003; Strauss et al., 2009). Importantly, because hundreds of thousands of HIV-infected patients receive regular primary care in clinical care settings, HIV care providers in these settings are in a strategic position to reach many patients and offer risk reduction support. Notably, however, patients and HIV care providers have come to expect that the provider will facilitate access to services and respond to the patient's expressed needs, rather than focus on the patient's potentially problematic alcohol use practices (Mitchell et al., 2005). In addition, providers often have limited education and training to address alcohol abuse issues, and limited skills, confidence, experience, and organizational support to incorporate addiction counseling into their interactions with patients (Bluespruce et al., 2001; Mitchell & Linsk, 2001; Mitchell et al., 2005).

Alcohol screening and brief interventions (SBIs) appear to be an optimal "prevention for positives" approach for HIV care providers to support the identification and reduction of patients' excess alcohol use. Screening typically involves using a psychometrically validated instrument such as the 10-item Alcohol Use Disorders Identification Test (AUDIT; Maisto & Saitz, 2003). Brief interventions (BIs) generally involve several 5–10 minute sessions that incorporate patient-centered, motivational, and interactive counseling techniques (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2005). Overall, BIs have been shown to be effective when delivered by providers - including nurses and/or physicians - who conduct them in diverse venues (e.g., primary care clinics and offices, college campuses, emergency departments), and that target alcohol reduction among individuals with various demographics (e.g., gender, race/ethnicity, geographic location, socioeconomic status) (Ballesteros, Gonzalez-Pinto, Querejeta, & Arino, 2004; Bazargan-Hejazi, et al., 2005; Borsari, & Carey, 2000; Fleming, Barry, Manwell, Johnson, & London, 1997; Moyer, Finney, Swearingen, & Vergun, 2002; Ockene, Adams, Hurley, Wheeler, & Hebert, 1999). Unfortunately, SBIs are used infrequently for HIV patients' alcohol reduction (Strauss et al., 2009).

Background to the Study

Research suggests that training to improve providers' awareness, skills, attitudes, knowledge, and self-efficacy to support patients' alcohol reduction increases the use of SBIs (Babor, Higgins-Biddle, Higgins, Gassman, & Gould, 2004; Saitz, Horton, Sullivan, Moskowitz, & Samet, 2003). We therefore gave 3 hours of onsite SBI education and training in four HIV Care Centers in New York City that was tailored to the providers' specific needs. The education and training was an adaptation of the National Institute on Alcohol Abuse and Alcoholism's Clinician's Guide on a Brief Alcohol Intervention (NIAAA, 2005). It was theoretically guided by social cognitive theory in order to increase providers' knowledge and self-efficacy in implementing alcohol SBIs (Bandura, 1986) and emphasized the value of using motivational interviewing principles to enhance communication with patients (Miller & Rollnick, 2002). The first half of the education and training gave an overview of alcohol and HIV and HIV/HCV co-infection, the effectiveness of SBIs, and essential SBI elements. The second half focused on implementing alcohol SBIs and followed the NIAAA Clinician's Guide's four steps: (a) Ask about Alcohol Use, (b) Assess for Alcohol Use Disorders, (c) Advise and Assist, (d) At Follow-Up: Continue Support (NIAAA, 2005). The interactive nature of the training and its motivational approach were intended to generate positive attitudes about the techniques being modeled, greater skills learning, and subsequent use of these skills. Because it was offered onsite at the HIV Care Center, education and training attendance by HIV care providers was facilitated, enabling various disciplines (e.g., physicians, nurses, case managers, social workers) to interact while learning needed skills that could be used for the benefit of the Center's patients. Participating providers were encouraged to implement the approaches and skills taught.

Specifically, each Center was asked to have participating providers implement a total of 50 or more alcohol use screenings (using the AUDIT) and brief interventions with their patients in the month after being taught these processes.

Several weeks after the conclusion of the education and training in each of four HIV Care Centers, we conducted semi-structured qualitative interviews with a sub-sample of attendees. We sought to understand the training's impact on providers' subsequent actions in support of patients' alcohol reduction. We also conducted interviews with the medical directors in these four Centers that examined the impact on the Center as a whole. In this paper, we analyze data from these interviews with providers and administrators in order to describe their perspectives on the barriers and facilitators in implementing alcohol SBIs in HIV Care Centers.

Methods

Participating Programs

An examination of the barriers and facilitators in the implementation of alcohol SBIs was a component of a larger study funded by NIAAA that evaluated state-of-the-art education and training on alcohol reduction for HIV-infected patients. Four Designated AIDS Centers (DACs) in New York City participated in the research in 2007. DACs are comprehensive, hospital-based, state-licensed, HIV treatment centers providing both inpatient and outpatient care. They use interdisciplinary teams and provide or arrange for case management, emphasizing quality improvement in order to provide a high level of clinical and support services.

The four participating DACs each served between 800 and 1,100 patients yearly, with the proportion of male patients varying from 40% to 66%. At least 82% of the patient populations in each of these DACs were Black or Latino, and between 25% and 40% of the patients were co-infected with HIV and HCV. These patients were served by between 22 and 50 staff. Before the education and training, all four of the DACs screened patients for excess alcohol use at their annual examinations, and one of the DACs (DAC 3) used the CAGE instrument to do so (Ewing, 1984). Alcohol screening at the other three DACs was limited to several non-standardized questions concerning current drinking.

HIV Care Providers and Administrators

In each of the participating DACs, all HIV care providers were invited to attend the onsite alcohol reduction support education and training, and a total of 69 providers in the four DACs did so. Up to four providers in each DAC who attended the training were also invited to volunteer to participate in a 60-min, one-on-one, semi-structured interview to take place generally 1 month but up to 3 months after the training sessions. Volunteers included two providers in DAC 1 and four providers in each of DACs 2, 3, and 4. In all, these 14 providers included 2 nurses (one in each of DACs 2 and 3), 2 nurse managers (one in each of DACs 1 and 2), 3 physician assistants (one in each of DACs 1, 3, and 4), 2 health educators (one in each of DACs 3 and 4), 2 case managers (one in each of DACs 2 and 4), a counselor (in DAC 4), a psychotherapist (in DAC 3), and a clinical psychologist (in DAC 2). Each had worked at their respective DACs for an average of 9 years (median = 8 years; range = 4 months - 20 years). Interview topics included (a) their perceptions of the education and training, (b) the extent to which they were able to use the information and skills taught and any barriers that made it difficult to do so, (c) perceived organizational support for the implementation of alcohol SBIs, (d) perceived changes in alcohol reduction services and support offered at the DAC, and (e) any additional thoughts or recommendations they might have regarding the implementation of alcohol SBIs in DACs.

Thirty minute, semi-structured, one-on-one interviews were also conducted with the medical directors of the DACs both before the education and training took place and 3 to 4 months later. The initial interview asked the directors to give some basic information about patients in their DACs (e.g., the number served each year, their gender, and race/ethnicity), the number of staff, and the alcohol reduction and elimination policies, procedures, and/or services that existed at the DACs before the education and training took place. The second interview asked the directors to (a) assess the impact of the education and training on staff approaches to providing alcohol SBIs to HIV-infected patients, (b) describe their support for alcohol SBI implementation, and (c) assess changes made at the organizational level as a result of the alcohol reduction education and training for HIV care providers.

Prior to their participation in the interviews, staff and directors gave informed consent to take part in the study and to allow for audio-taping of the interviews. The scientific plan and procedures for protecting the confidentiality of research data and for respecting the rights of human subjects were reviewed and approved by the institutional review boards of the National Development and Research Institutes, Inc. and New York University.

Data Analysis

All interviews with the HIV care providers and medical directors were audio-taped and transcribed verbatim. Project personnel agreed on a framework of initial codes and sub-codes that derived directly from the research questions and aims regarding a full description of barriers and facilitators of implementing alcohol SBIs. Transcripts were initially coded with a focus on this master coding scheme. The constant comparative method, interspersing immersion and distance, was then applied to the analysis of transcripts. Central to this method is a systematic classification process that groups text data into fewer content-related themes that share the same meaning (Downe-Wambolt, 1992). In particular, through the researchers' repeated readings of the transcripts throughout the study that enabled them to stay close to the data, and through the discovery and inductive development of recurring themes as a result of their comparing codes and challenging interpretations, these codes were subsequently examined and revised as necessary. After comprehensive discussion, consensus was reached among the study's key investigators regarding the most salient themes addressed in the interviews.

Results

Barriers to Implementing Alcohol SBIs

Interviews with providers and medical directors revealed a variety of barriers to routine implementation of alcohol SBIs by providers in hospital-based HIV Care Centers. These included limited time for alcohol screening, patients' lack of disclosure of alcohol use, providers' perceptions that alcohol use was not a major problem among their patients, and provider specialization that assigned patients with problematic alcohol use to certain specifically designated providers.

Limited time for alcohol screening—While many providers agreed that there was value in screening their patients for alcohol use, a recurrent theme was the lack of time to implement the screening during regular patient visits. A nurse in DAC 2 put it this way: "One patient one right after the other. And there's always five patients waiting to be seen when you're trying to get through what you need, the bare minimum, as quickly as possible . . .," while the medical director in DAC 4 indicated, "In the era of needing to see more patients as well as patients with multiple comorbidities, we don't have the time to do a proper screening." Several providers, including a social work case manager in DAC 2,

pointed out that many of their HIV-infected patients needed assistance to complete the 10-item AUDIT, a major factor in the time needed to perform the assessment:

It takes time to ask all these questions. Or have the patient [read and answer the questions], and some of them can't read. So you have to sit down and do it with them. I'm always surprised when I ask someone can they read and write in their language and they'll say no. Even if they can read and write in their language, some of them are not interested in sitting down and reading this and answering all these questions. And even if I say let me go over them with you and we'll talk about it together, there again, you know, in order to do it right and have them understand what the question is sometimes, it takes time.

Patients' lack of disclosure of alcohol use—Barriers to implementing routine alcohol screening also include providers' judgments that the value of this screening is considerably diminished if patients are not truthful about their use of alcohol. Thus, in addition to limited time to screen for alcohol use, some providers expressed concern that even if time is allocated for this screening, patients may not fully disclose their use. A physician assistant in DAC 1 put it this way:

Do people actually answer totally truthfully all the time? I'm not 100% sure about that. Because a lot of my patients will say, "No, I never drink. At all." And some, I mean, some I probably could figure they probably do. But others I sort of think, well, you know... I'll say, "Not even for Christmas or something like that?" And some will say, "Oh, yeah, well, occasionally." But some will say, "Nah, nah, I just don't do it at all." And maybe they don't. We certainly have people in recovery and I'm sure that those people in recovery don't drink at all. And I can sort of think that they don't. But there are other people that are not, so . . .

Providers articulated a number of possible reasons for patients' lack of truthfulness about their drinking. Most frequent among these reasons was the fact that patients knew that they would be detained at the DAC for further questioning if they indicated that they drank. A nurse in DAC 2 indicated:

Once the patients get to us, because we are the last in the chain, they just want to get out. They want to have their blood drawn. They're ready to leave. They've sometimes been here 2 hours or more already. They don't want to sit for half an hour and fill out more forms, especially if they don't see it as anything helpful to them. It's not their priority.

This sentiment was echoed by the medical director in DAC 2:

I think the patients want to be done with it. So nobody has sex; nobody drinks; nobody does drugs. They're all in monasteries when they're not in their SROs [Single Room Occupancies]. You want to be done. And why are you asking me the same thing every visit? You're gonna ask me five more questions. And I need to get my bloods and pick up my kids.

In addition to not wanting to be detained at the program, structural conditions, such as lack of privacy, are likely to contribute to limited patient disclosure. A nurse in DAC 2 put it this way:

As far as the nurses go, we don't have privacy with our patients. So getting them to be open and honest about alcohol and drug use is a very difficult thing. We have two to three nurses working in one room. So that means two to three patients. Doctors opening the doors, everyone opening the doors. It's not a private area. You can have three patients sitting in the chairs, two patients in the next room, which is

the blood room, having their blood drawn with the door open in between and, you know, doctors walking in.

Providers' perceptions that most patients don't meet the threshold of "problem drinking"—Although several of the providers interviewed, such as those cited above, expressed their perceptions that some patients do not fully disclose their level of current alcohol use, it was the view of some of the participating providers that this use may have been a problem in some patients' past histories, but that their current drinking was likely to be social. A physician assistant in DAC 4 put it this way: "Most of my patients say, 'I don't drink at all.' Some of them just very, like socially. And I really don't think it's a problem for the majority of my patients." Similarly, a nurse in DAC 2 indicated, "Very few of our patients admit to drinking. Those who do admit say that it's social."

Provider specialization—As is the case with many specific needs of patients receiving care in the DACs, those whose alcohol use is problematic are generally referred to certain staff designated to support these needs. Thus, a patient identified as needing support to address alcohol reduction is generally referred to the "specialist" who deals with alcohol problems, such as a social worker or addiction counselor. A nurse in DAC 3 said:

We have a health educator who basically deals with educating patients about medications and side effects and that type of thing. We have a nutritionist and then we have the therapists who basically deal with the alcohol and stuff like that. So basically when I notice anyone with any problem like that, I just refer them to the specific person. So I don't really deal with that.

A combination of limited self-efficacy to effectively address this issue, combined with limited time to address alcohol reduction in a system that requires many patients to be seen over the course of a day, has contributed to this specialization model. Nonetheless, some providers expressed a concern that some patients may not be well served by this system, suggesting that provider specialization is not always an optimal approach. The medical director in DAC 4 indicated:

How effective am I imparting the message with the patient to stop or cut down alcohol? Maybe I wouldn't be that confident or my self-efficacy would not be that high. That is one of the other reasons why maybe we don't want to pursue that or go into it, rather just refer them to the substance use counselor. And especially when you know that there are many other patients waiting. You are aware like with HIV and Hep C patients, and Hep C already has an impact on the liver, alcohol is going to be even more of an issue. And the flip side of this is also some of the patients may not go to the substance use counselor. They may not go because they don't want to address the issue.

Additional synopsized participant responses regarding barriers to the implementation of alcohol reduction SBIs are provided in Table 1.

Facilitators in Implementing Alcohol SBIs

Feedback collected after the alcohol reduction support education and training illuminated a variety of existing or desired facilitators to support HIV care providers' implementation of alcohol SBIs. These included implementing the screening when adequate time was available; having information, tools, and key points that could be emphasized with HIV-infected patients; and having an abbreviated screening tool that would take less provider and patient time.

Implementing the screening when adequate time was available—As the nurse manager in DAC 1 indicated, HIV-infected patients are accustomed to being asked questions about a variety of topics, many of them sensitive: “You know, we ask our patients a lot of things. About adherence to treatment. About adherence to appointments, about using condoms, about other substance use. They’re used to that.” Ways to facilitate the implementation of alcohol SBIs, therefore, seem to have less to do with concerns about patient discomfort in raising the issue of alcohol use than with finding the time to implement them. Many acknowledged limited time to conduct alcohol screening during regular, ongoing patient care visits. Some providers suggested that the additional time allocated at intake and at the annual comprehensive visit offered the most reasonable opportunity for this screening and facilitated its implementation. In fact, after he and his staff participated in the alcohol reduction education and training, the medical director at DAC 1 incorporated screening with the 10-item AUDIT as a routine part of a patient’s annual visit. Regarding its feasibility, he indicated:

I think it’s absolutely feasible to implement. In patients who are stable with no complex medical issues, if excessive alcohol intake would be an issue, you have plenty of time to do it. In an unstable population of patients in treatment, you certainly would look at factors which would be affecting their treatment. I don’t understand why somebody would not find the time to spend.

A physician assistant at the same DAC who has also implemented the AUDIT many times since the education and training at patients’ annual examinations put it this way:

[The screening with the AUDIT] doesn’t interfere a lot with providing medical care. I mean, as far as time goes. Except if you find out information. For me it means something because then I have to take time with that. It doesn’t necessarily mean that it has to, because you then can just refer, I’m sure. But just for me, then I have to talk a little bit about it because that’s the relationship I have with my patients. I think it’s a good method to bring up the subject because of its brevity, and it definitely gets to the points that are salient to what is gonna be what you’re looking for.

Having information, tools, and key points that could be emphasized with HIV-infected patients—Assuming that there is adequate time to implement alcohol SBIs, interviews with providers after the education and training suggested the importance to them of being able to raise a variety of HIV-specific issues concerning the negative effects of alcohol use as a way of facilitating alcohol-related conversations with patients. The medical director at DAC 4 indicated:

As a clinician, I was able to convey those three important points, which from the medical or HIV point of view, saying that drinking is going to affect your adherence. Your CD4 count is going to drop down. You may have high triglyceride reading levels. And you are at risk of transmitting the infection to others because of uninhibited like, unprotected sexual practice. So patients seem to hone in on those very easily.

Other providers found it useful to have concrete tools and facts that they could use in alcohol reduction support conversations with patients. These included a set of pictures that illustrated a standard drink, and concrete information concerning the number of drinks per week that were considered hazardous to health. In fact, in identifying the most helpful part of the education and training, a nurse manager in DAC 2 indicated: “Where you really did our homework for us, or whoever, but you set up this is what excessive drinking is. It’s very black and white. There is a standard. That really helps you cut to the chase.” The health

educator in DAC 4 referred to these guidelines, and to the standard drink guide as being especially useful in discussions with patients:

I didn't know that there were specific guidelines as to....if you drink this amount during the day, times a week, you know, that's a little too much. It was good to learn that, especially the pictures that you have on the ounce or the beer. Because a picture, I think showing the patients a picture is a lot easier for them to understand than telling them one ounce or two ounces.

Also helpful for some providers is using the AUDIT screener as a tool to conduct a conversation about alcohol that a patient initiates. For example, the clinical psychologist in DAC 2 indicated:

If I have a person who is actively using, comes in and says I'm concerned about my drinking, and I said, look, I have this that I have in my hand. And why don't we go through it together? I'll ask you some questions; let's see what we can come up with. It might be helpful. It will give you some information about yourself and some feedback.

An abbreviated screening tool—A very common theme in the interviews we conducted with providers was the need for a briefer alcohol screening tool to make it more likely that it would be used routinely. In responding to a question concerning whether the 10-item AUDIT was appropriate for use in the HIV care setting, a physician assistant in DAC 3 said:

I think an abbreviated tool with the option to go further if it's an issue. Like if you have one or two drinks once a month, I don't think we need to do the whole tool. I think it should be used at the discretion of the providers, how far they need to go on it.

Additional synopsized participant responses regarding facilitators in implementing alcohol reduction SBIs are provided in Table 1.

Discussion

Because patient rosters at hospital-based HIV Care Centers often number 1,000 or more, these centers need to formulate an efficient approach to patient care that expertly addresses the many needs and issues of the patient populations that they serve. Screening for alcohol use and intervening, however briefly, to assist patients to reduce their excess alcohol use is only one of many priorities. Nonetheless, it is of considerable concern that even after specialized HIV care provider education and training that emphasizes that excess alcohol use and its related harms are common among HIV-infected patients, some providers persist in their perceptions that patients' hazardous alcohol use is rare and is therefore of relatively low priority. Screening for alcohol use is often limited in these hospital-based settings, suggesting that providers' perceptions concerning the extent of patients' hazardous drinking may be based on incorrect assumptions about their patients' drinking. As a result, sorely needed alcohol reduction support may not be provided to patients. In addition, after the education and training, some providers remained concerned that even if the short time that they had to interact with patients was used to screen for alcohol use, those patients who did have alcohol problems might not disclose their excess drinking. Notably, even if their answers are not "truthful," having providers ask patients questions concerning their drinking might raise patients' consciousness about alcohol's harmful effects. This awareness might enable patients to address their alcohol use at a later point in time.

Because screening patients for alcohol use is so infrequent among HIV care providers, the education and training instructed participants on the use of the AUDIT and encouraged them to implement it with their patients. Our interviews revealed that providers had various approaches to incorporating alcohol screening and subsequent alcohol reduction efforts. These approaches included being a collaborator with the patient by conducting patient counseling to personally help her/him in risk reduction practices, or being part of a multidisciplinary team that sees risk assessment, prevention, and counseling as a shared responsibility (Gerbert et al., 1999; Morin et al., 2005). Notably, most of the providers in our study saw themselves as specialists who might conduct an occasional initial risk assessment but who would generally refer patients with alcohol problems to other providers (Gerbert et al., 1999; Morin et al., 2005). This latter self-perception is understandable, in view of the high patient load and many competing demands on providers' time. Unfortunately, with this approach, some patients in need of alcohol reduction support may "slip through the cracks," especially if those with alcohol reduction needs were consistently referred elsewhere and if there was no consistent follow-through. Nonetheless, the reality of limited provider time at patient visits may require especially busy clinics to sometimes address patients' alcohol reduction needs through a referral system (Drainoni, Dekker, Lee-Hood, Boehmer, & Relf, 2009). To prevent patients' alcohol reduction needs from remaining unaddressed, this system should incorporate communication between providers who refer patients and providers to whom the patients are referred.

In addition to the challenges inherent in implementing screening and brief interventions in HIV Care Centers, interviews with providers and administrators also revealed a variety of approaches that could facilitate greater support for HIV-infected patients' alcohol reduction needs. Acknowledging the constraints of time during regular patient visits, it may be possible to implement SBIs with new patients, as intake visits are often lengthier than subsequent ones. Alcohol screening could also be implemented on a regular basis at annual comprehensive examinations, another opportunity when more time is allocated for the visit. As was the experience in DAC 1, with encouragement at the administrative level from the medical director, the AUDIT can be routinely implemented with all patients at these annual visits. Recognizing that the implementation of the AUDIT may require providers' assistance rather than self-administration by patients, completing it may take some additional patient and provider time. In addition, if the AUDIT screen were positive, some initial brief intervention might be warranted, and the time involved would be further increased. From many providers' perspectives, however, this is time well spent in view of the potential negative effect of excess alcohol use on medication adherence and disease progression. Nonetheless, a more abbreviated tool, perhaps with additional questions for patients with a positive screen as a follow-up to a preliminary set of questions, may be especially helpful in order to more efficiently use the limited time available for this purpose. In this regard, the AUDIT-C (the first 3 items on the AUDIT) has been shown to be appropriate for use with HIV-infected patients (Strauss & Rindskopf, 2009).

Having good "talking points" regarding the harmful effects of alcohol also facilitated providers' implementation of alcohol screening and brief intervention. This enabled some providers to use a targeted approach to support patients' alcohol reduction. Concrete tools, such as having charts with pictures to show patients what would define and illustrate a standard drink, and being able to cite guidelines that identified the amount of alcohol that constituted harmful drinking, were also found to be helpful by participating providers.

We acknowledge a number of limitations to the study. The research was conducted in four hospital-based DACs in New York City, and may not be representative of other large, hospital-based HIV Care Centers in other geographic locations, or those that are community-based. In addition, although respondents included providers in a variety of clinical and non-

clinical roles, their responses may not be entirely representative of the larger group of providers at the DACs. In spite of these limitations, our study highlighted many of the barriers and facilitators in implementing alcohol SBIs in busy hospital-based HIV Care Centers. While the challenges in addressing HIV-infected patients' excess alcohol use are formidable, alcohol SBI implementation can be facilitated by administrative advocacy, useful tools and talking points, and routine implementation when adequate time is available.

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Table 1

Codes, Sub-codes, and Synopsized Participant Responses Regarding Barriers and Facilitators in Implementing Alcohol SBIs

Code/Theme	Sub-code	Illustrative Additional Synopsized Participant Responses
Barriers to Implementing Alcohol SBIs	Limited time	A lot of our patients have very low literacy, and they need our help and our time to complete the alcohol screening (Nurse, DAC 2). HIV-infected patients have compromised health systems, so you need to address illegal substances, tobacco and alcohol. But we do not have the luxury of that much time to address just alcohol issues (Nurse Manager, DAC 2). We need to see more and more patients and many with multiple co-morbidities, and don't have time to do a proper screening, assessment, and follow up (Medical Director, DAC 4).
	Patients may not disclose	Some people say two or three different stories at the same time. They never drink, but when they drink, they drink two drinks. Or a lot of people drank, but long ago. That may be accurate or it may not be (Health Educator, DAC 3). I don't know if they're always being totally honest with me about their drinking (Psychotherapist, DAC 3). Sometimes you're talking to patients about alcohol reduction. But they can tell you one thing, and they're doing the opposite (Case Manager, DAC 4).
	Patients not seen as problem drinkers	Many of our patients drink socially, and we really don't have that big of an issue with it (PA, DAC 3). Most of my patients either say they don't drink at all, and some of them say they just drink socially. I don't think alcohol is a problem for most of my patients. (PA, DAC 4). There's a climate of functional drinking that's perceived as less worrisome than other alternatives like illicit drugs; alcohol doesn't seem to be a problem. I don't think a huge number of our population have a serious drinking problem (Case Manager, DAC 2).
	Provider specialization	If we assess that drinking might be an issue, we bring our concerns to the social worker assigned to the case (Nurse, DAC 2). I usually send patients with alcohol problems to the social worker. Maybe if I didn't have someone to refer them to, I would have to more address it more (Nurse, DAC 3). If a person is drinking a lot, we refer him to the substance abuse counselor. But some patients may not go (Medical Director, DAC 4).
Facilitators in Implementing Alcohol SBIs	Having adequate time	I could do a whole session just to assess a patient's substance use. I have that flexibility (Clinical Psychologist, DAC 2). During their initial visit, we ask patients about their alcohol use, and at the annual visit, we revisit what they've already told us (Case Manager, DAC 2). At the annual visit, we do a survey about alcohol use, and we can do the screening in a systematic way at that time (Case Manager, DAC 4).
	Having talking points and concrete tools and facts	Before conducting the screening, I said, "we're doing a systematic evaluation to see how much people are drinking. I'm going to go over these questions with you" (Medical Director, DAC 1). The guidelines for what constitutes hazardous drinking that were presented at the training were very helpful. It gave me a way to quantify it and present it to people (Physician Assistant, DAC 3). It is very helpful to be able to tell patients that according to specific studies and research that has been done, your drinking is really harmful (Psychotherapist, DAC 3).
	Having a brief screening tool	In a medical visit, when you have 15 minutes to do the history, the physical, and everything else, the screening needs to take one or two minutes to make it routine (Medical Director, DAC 2). I need something that would give me a good idea of what's going on, but in a much shorter time (Clinical Psychologist, DAC 2). For most people, once they answer the first couple of questions, it becomes unnecessary to ask more (Physician Assistant, DAC 4).

Note: SBI = screening and brief interventions; DAC = Designated AIDS Centers; PA = Physician Assistant