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Evaluation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) Implementation into Practice

Olivia Wilson

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EVALUATION OF SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) IMPLEMENTATION INTO PRACTICE

by

Nicole Olivia Wilson, MS, PMH-APRN, DNP(c)
Bachelor of Science, University of North Dakota, 2006
Master of Science, University of North Dakota, 2010

A Doctor of Nursing Practice Project
Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Nursing Practice

Grand Forks, North Dakota

August
2017
This DNP project, submitted by Nicole O. Wilson in partial fulfillment of
the requirements for the Degree of Doctor of Nursing Practice from the
University of North Dakota, has been read by the Faculty Advisory
Committee under whom the work has been done and is hereby approved.

Kris Hendrickx, DNP, ACNP-BC, Clinical Associate Professor, Chairperson

Maridee Shogren, DNP, CNM, DNP Program Director, Member

This DNP project is being submitted by the appointed advisory committee
as having met all of the requirements of the University of North Dakota
and is hereby approved.

Gayle Roux, Ph.D, NP-C/FAAN, Dean, College of Nursing and Professional Disciplines
PERMISSION

Title Evaluation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) Implementation into Practice

Department College of Nursing

Degree Doctor of Nursing Practice

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Nicole O. Wilson

June 10, 2017
Screening, brief intervention, and referral to treatment (SBIRT) is a public health intervention designed to recognize, reduce, and prevent problematic substance use through the identification of high-risk individuals and delivery of interventions prior to the need for more intensive treatment. The SBIRT model has been in existence for almost thirty years and has demonstrated efficacy in terms of clinical outcomes and cost effectiveness. While efforts to train healthcare providers in this modality have improved, the implementation of the model into practice remains low. The purpose of this project was to evaluate whether a cohort of clinical social work (SW) and nurse practitioner (NP) clinicians who participated in a grant-funded, interprofessional SBIRT training during their graduate education at a Midwestern university are implementing the SBIRT model in clinical practice. Additionally, this project aimed to identify factors that have either facilitated or prevented SBIRT implementation among this population. Data was collected through a 21-item online, mixed-methods survey. Results indicated that this sample of providers are inconsistent in their SBIRT implementation in practice. Agencies’ lack of SBIRT adoption or staff training were cited as barriers. Recommendations regarding future directions for practice, educational efforts, research, and policy development are discussed.

*Key search terms: SBIRT, implementation, barriers & facilitators*
Evaluation of Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Implementation in Practice

Screening, brief intervention, and referral to treatment (SBIRT) is a public health intervention designed to recognize, reduce, and prevent problematic substance use through the identification of high-risk individuals and delivery of interventions prior to the need for more intensive treatment (Substance Abuse Mental Health Services Administration [SAMHSA], 2011). The SBIRT model has been in existence for almost thirty years and has demonstrated efficacy in terms of clinical outcomes and cost effectiveness. While efforts to train healthcare providers in this modality have improved, the implementation of the model into practice remains low (Nilsen, Aalto, Bendtsen, & Seppä, 2006). The purpose of this Doctor of Nursing Practice (DNP) project was to evaluate whether a cohort of clinical social work (SW) and nurse practitioner (NP) clinicians who participated in a grant-funded SBIRT training are implementing this model into their clinical practice.

Background & Significance

Substance abuse is a serious public health issue in the United States and has a significant impact on morbidity and mortality. Excessive alcohol use alone is responsible for 88,000 deaths in the U.S. annually (Centers for Disease Control & Prevention [CDC], 2016). It also accounts for 1 in 10 deaths among working-age adults and can shorten life expectancy by an average of 30 years. In a recent estimate compiled by The New York Times, deaths resulting from drug overdose increased by 19% in 2016 (Katz, 2017). They estimate drug-related overdoses likely exceeded 59,000, which is the largest increase ever recorded in the United States and attribute this dramatic rise to the opioid epidemic and influx of illicitly manufactured fentanyl and similar drugs. Drug overdoses are now the leading cause of death among Americans under the age of 50.
While these numbers are preliminary after surveying state health department and county coroner data, the final numbers will be calculated and certified by the CDC in December of this year.

While most individuals will not go on to develop a full-blown addiction or dependence to alcohol or drugs, even occasional, risky use can have a variety of health-related or societal consequences (SAMHSA, 2011). Excessive substance use is associated with elevated risk for chronic health conditions, such as liver and heart disease and various cancers, and can lead to risky sexual behavior, which may result in sexually transmitted infections or unintended pregnancy. Any alcohol use during pregnancy potentiates the risk for the development of fetal alcohol syndrome or fetal alcohol spectrum disorders. Both alcohol and drug use during pregnancy can be connected to other congenital anomalies and/or pregnancy loss. Substance use is also associated with an increase in violence and injuries, such as falls, drowning, motor vehicle accidents, assaults, homicides, and suicides. Excessive alcohol use alone cost the U.S. economy approximately $249 billion in 2010, with a significant percentage of these costs being paid by the public in terms of healthcare and public safety spending, in addition to lost productivity (CDC, 2016).

**Substance Use in the United States**

**Prevalence of Alcohol and Drug Use.** According to SAMHSA’s most recent National Survey on Drug Use and Health (NSDUH), approximately two-thirds of people 12 years of age or older in the U.S. reported drinking alcohol in the past year (Center for Behavioral Health Statistics & Quality [CBHSQ], 2016). About 6% of these individuals met diagnostic criteria for an alcohol use disorder. In 2015, almost 18% of individuals 12 years of age or older reported using an illicit drug in the past year, and 1 in 10 Americans reported using an illicit drug in the past thirty days, which has increased slightly over the past two years.
In 2015, approximately 20.8 million people 12 years of age or older met diagnostic criteria for a substance use disorder within the past year (CBHSQ, 2016). A slightly larger number of Americans, 21.7 million people, required substance abuse treatment within the past year. However, unfortunately, only about 10.8% of those people went on to receive the specialty treatment that they needed.

**Substance Use in North Dakota**

North Dakota continues to have the highest reported rate of binge alcohol use among youth aged 12-20 in the nation (SAMHSA, 2015). About 20,000 youth in North Dakota, ages 12-20 years (23.3% of this age group) reported binge alcohol use within the last month of being surveyed between the years of 2009-2013. This is compared to the U.S. average of 16% of youths reporting a binge-drinking episode during the previous month. The reported rates of past-month heavy alcohol use and past-year alcohol dependence among adults in North Dakota has consistently been higher than the U.S. average. A little over 9% of adults ages 21 years and older reported heavy alcohol use over the past month between the years of 2009-2013, as opposed to the national average of 6.8%.

On the other hand, reported rates for illicit drug dependence or abuse during the past year were lower among those ages 12 years and older in North Dakota in 2009-2011 compared to the national average (SAMHSA, 2015). However, this rate has slowly climbed, and in 2012-2013, the reported North Dakota prevalence of illicit drug abuse/dependence was the same as the U.S. rate at 2.7%.

**SBIRT Model**

In response to the increasing impact of substance abuse issues around the world, the World Health Organization originally developed the SBIRT model as an intervention to reduce
and prevent harmful substance abuse. The model was readily adopted by SAMHSA (2011), which has served as a champion to disseminate this model within the United States. SAMHSA (2011, p.2) defines SBIRT as “a comprehensive, integrated, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, as well as the timely referral to more intensive substance abuse treatment for those who have substance use disorders.”

**Elements of SBIRT.** SBIRT is a public health model that can be delivered across a wide variety of settings including: mainstream healthcare, clinics, hospitals, trauma centers, public health, schools and campuses, tribal and military health, and dental offices (Office of National Drug Control Policy [ONDCP], 2012; SAMHSA, 2011). A key aspect of SBIRT is the integration of its components into a system of care. With the appropriate risk monitoring and support, the goal is to reduce the number of individuals who move from problematic substance use into addiction. SBIRT is a three-part process that includes:

- **Screening:** universal screening to assess substance use and identify risk level using an appropriate evidence-based screening tool.

- **Brief intervention:** brief sessions, typically 5-15 minutes, provided during a single visit or over the course of multiple sessions when moderate risk levels occur. Brief intervention uses motivational interviewing to raise clients’ awareness surrounding substance use and its consequences and enhance readiness toward positive behavior change.

- **Referral to treatment:** coordination of a referral to specialty care when clients are screened as high risk.
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**Evidence-base.** With nearly three decades of research, SBIRT has been validated as an efficacious, cost-effective, evidence-based model used across multiple settings and a variety of populations (Babor et al., 2007; Babor & Higgens-Biddle, 2001; SAMHSA, 2011). SBIRT has the strongest efficacy for alcohol and tobacco use, and evidence to support its efficacy with drug use is accumulating (SAMHSA, 2011). Additionally, emerging studies indicate SBIRT, or at least portions of the model, are effective in addressing mental health concerns such as depressive and anxiety disorders and trauma, particularly in the primary care setting. There are also indications that SBIRT may be effective at reducing other high-risk behaviors related to sexual activity or suicide/self-injury (SAMHSA, 2011).

**Clinical Outcomes.** When evaluating outcomes of SAMHSA grant-funded SBIRT programs, patients demonstrated a reduction in their reported drug and alcohol use from only 16% reporting abstinence at baseline compared to 41% reporting abstinence six months after receiving brief intervention (ONDCP, 2012). Patients have also reported enhanced quality of life after receiving SBIRT intervention, such as improved housing and employment/education status, and a decrease in 30-day arrest rates. Risky behaviors, such as unprotected sex or intravenous drug use, were also reduced with injection use decreasing from 3.2% at baseline to 1.5% at follow-up.

**Cost-effectiveness.** SBIRT can result in both reduced healthcare and societal costs. The use of SBIRT has demonstrated reductions in monthly Medicaid spending by $185-$192 per patient during a 30-day period (ONDCP, 2012). Patients admitted to the hospital after being seen in the emergency room experienced even greater reductions in spending, ranging from $238-$269 per month, after receiving SBIRT intervention. Finnell (2012) noted that for every dollar
invested in SBIRT, $3.80 could be saved in future emergency healthcare costs and $4.30 for primary care.

**Problem Statement**

SBIRT has the potential to impact health at the population level and reduce the dangers associated with high risk substance use. However, the degree of impact depends on the ability to achieve widespread implementation among settings that are positioned to reach the vast majority of the population. Despite recent national and statewide initiatives to increase provider training and system implementation of SBIRT, this model is not being widely adopted into practice (Nilsen et al., 2006). This research-practice gap served as an ideal opportunity for the DNP student to identify implementation barriers and develop strategies to translate and disseminate this evidence more widely into practice.

**Significance of the Problem**

The research to practice gap that is evident with the SBIRT model comes as little surprise considering it takes approximately 17 years for evidence to translate from research into the practice setting (Morris, Wooding, Grant, 2011). As it relates specifically to unhealthy alcohol use, the U.S. Preventive Services Task Force (USPTF, 2004) has had guidelines in place for over a decade recommending universal screening and behavioral interventions to prevent alcohol misuse for all adults in the primary care setting. However, it is one of the least commonly preventive services performed with only 10-20% of patients in primary care screened for alcohol misuse (Denny et al., 2003). Despite being ranked as one of the highest prevention priorities for adults, screening for harmful alcohol use has one of the lowest delivery rates (Solberg, Maciosek & Edwards, 2008; Williams et al., 2011), typically only occurring if a risk factor is present (Johnson, Jackson, Guillaume, Meier & Goyder, 2011).
Lack of SBIRT implementation is not only an issue among primary care settings but acute care as well. Approximately 60% of patients presenting to trauma centers are under the influence of either alcohol or drugs. However, a study conducted by the RAND Corporation found that only 15.5% of patients with traumatic injuries admitted to an inpatient setting had any information in the medical record that indicated substance use history had been assessed (McGlynn et al, 2006). Despite proving to be a cost-effective intervention (Barbosa, Cowell, Landwehr, Dowd, & Bray, 2016; Bray et al., 2014), there are many institutional and system barriers cited in the literature by clinicians and organizations that prevent widespread adoption of SBIRT into practice and will be examined below in the literature review section.

**Literature Review**

**Search Methods**

To examine the body of literature surrounding the implementation of SBIRT, a search was conducted using the CINAHL, MEDLINE, and Cochrane Library databases. Search terms used included “implementation of SBIRT”, “barriers AND SBIRT implementation”, and “facilitators AND SBIRT implementation”. Search parameters were limited to peer-reviewed articles published within the last five years written in the English language. Duplicate studies and those articles that were not original research but rather commentary or editorial remarks of other studies were also excluded. A Google Scholar search was also conducted to find any additional articles or practice/implementation guidelines from additional sources pertinent to SBIRT implementation not yielded in the search above.

**SBIRT Implementation**

Despite a sufficient evidence-base that supports both clinical efficacy and cost-effectiveness, widespread implementation of SBIRT into clinical practice has yet to occur
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(Nilsen et al., 2006; Williams et al., 2011). In part, the lack of evidence of implementation may be related to the amount of time and cost associated with evaluating a multi-faceted intervention such as SBIRT. Implementation and evaluation research in practice are incredibly complex, much like the healthcare systems where providers are attempting to integrate these best practices (Stetler et al., 2006). Therefore, it becomes difficult to report actual rates of overall SBIRT implementation as opposed to only one component of the model, such as rates of screening for substance abuse. The literature does contain data that identifies rates of screening among various patient or provider populations and organizational settings, as well as rates of patients seeking or receiving chemical dependency treatment, some of which were reviewed above in the background and significance section. However, there were no reports of overall rates of SBIRT implementation as an entire model available upon this literature search. One could argue that screening rates alone depict an estimation of overall SBIRT implementation rates because if the first step of screening has not been completed, SBIRT has not occurred.

**Barriers**

Barriers to SBIRT implementation have been primarily examined in the literature from the perspective of the clinician or the healthcare organization. From this viewpoint, barriers such as time, competing priorities, lack of consistent communication, workflow/logistical issues, lack of training and resources, and concerns regarding scope of practice as it relates to brief intervention/treatment were cited in multiple studies (Agley, Gassman, Vannerson, & Crabb, 2014; Broyles et al., 2012; Clemence et al., 2016; Kaiser & Karuntzos, 2016; Rahm, et al., 2015). A need for strong organizational leadership support and network of referral protocol and options were highlighted in the literature as well (Rahm, et al., 2015), and will be discussed below along with factors that facilitate SBIRT implementation.
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The patient’s perspective of barriers related to SBIRT implementation were also examined. In two separate qualitative studies of patient stakeholder groups, patients reported general acceptance of universal screening for substance abuse and confidence in their providers, as well as an interest in gaining knowledge regarding their risk levels (Field et al., 2014; Rahm et al, 2015). In one study, patients actually reported that making screening universal would help to normalize the process and make it less uncomfortable (Rahm et al., 2015). These researchers also concluded there were differences among cultural groups related to concerns of confidentiality and who might have access to information regarding substance use. One advantage of SBIRT is that it can be tailored to different cultures and settings. A randomized controlled trial among emergency room nurses in Poland determined that with the appropriate cultural and setting-specific adaptations, the SBIRT model was effective in this specific patient population (Cherpitel, Moskalewicz, Swiatkiewicz, Yeu, & Bond, 2009).

Facilitators

Several studies have noted leadership and organizational support are important when facilitating the implementation of SBIRT into practice. Specifically, having policies and systems in place for continuing education, performance feedback, and quality improvement for staff have demonstrated positive impact on implementation (D’Souza-Li & Harris, 2016; Rahm, et al., 2015). Utilizing an interprofessional team to implement the various components of SBIRT has been identified as a critical strategy to enhance adoption of SBIRT (D’Souza-Li & Harris, 2016; Mertens et al., 2015; Mitchell et al., 2016; Rahm et al., 2015). The type of interprofessional approach used may differ depending on the setting. However, one strategy addressed in multiple studies, particularly to enhance the delivery of brief interventions and treatment, is the integration of a behavioral health provider into primary care settings (D’Souza-Li & Harris,
Effective use of integrated health information technology can also be used to facilitate SBIRT implementation. Strategies may include: clinical decision support tools that embed screening tools with the appropriate intervention into the electronic health record, creating an integrated network for the sharing of health information, providing telehealth opportunities, and enhancing workflow and efficiency related to the various stages of SBIRT (D’Souza-Li & Harris, 2016; Gonzales et al., 2012; Kaiser & Karuntzos, 2016; Shanahan et al., 2014).

A five year study that evaluated a SAMHSA-funded program implemented across the state of New Mexico identified some unique strategies to enhance implementation at the state level (Gonzales et al., 2012). The researchers stressed the importance of providing clinical supervision to providers, which may be offered via teleconferencing options to serve a wide range of agencies at a distance. Supervision is critical to offering performance feedback, especially as it relates to providing culturally competent and geographically relevant care and ensuring privacy and comfort. Integrating SBIRT across the continuum of care and involving both behavioral health and primary care providers was critical. The researchers also felt that utilizing a non-profit organization with a state-wide presence allowed for flexibility in program implementation. Finally, utilizing federal Medicare and state Medicaid billing codes specific to SBIRT facilitated the cost-effectiveness of implementation.

Local Data

There were no studies found reporting the rate of SBIRT implementation within the state of North Dakota. Prevalence rates of risky substance use, rates of screening in primary care, and rates of individuals receiving substance treatment were reviewed above. However, these only reflect partial components of the SBIRT model and do not integrate the practice as a whole.
A small survey ($N=54$) conducted by a Midwestern university evaluated the frequency and type of alcohol screening conducted by healthcare and social service providers in western North Dakota (Shogren, Harsell, Devries, Roberts, & Muhs, 2015). The majority of respondents were social workers (82%), followed by nurse practitioners (14%), physicians (2%), and other providers (2%). Fewer than half of the participants (49%) reported routinely assessing for alcohol use. Of the 49% of participants who indicated that they were routinely screening, only 18% reported using a formal screening tool, such as the Alcohol Use Disorder Identification Test (AUDIT).

Participants who reported they do not routinely screen for alcohol use were also asked to identify barriers to implementing screening in their practices and the following themes were identified: inappropriate for population or setting, screening is referred out or completed as needed, agency not involved in direct patient care, lack of time, no screening tools available, and one respondent reported screening for alcohol use but not for illicit substances (Shogren et al., 2015). While this study did not aim to identify the extent of SBIRT implementation as intended, these results do illustrate a lack of evidence-based practice, given current recommendations indicate alcohol use should be screened on a universal basis.

**Project Purpose**

The purpose of this DNP project was to evaluate whether a cohort of clinical SW and NP clinicians who participated in a grant-funded, interprofessional SBIRT training during their graduate education at a Midwestern university are implementing the model in their clinical practices, as well as to identify barriers and facilitators to their SBIRT implementation. The overall goal of this project was to use this data to inform recommendations to the grant team to improve practice, education, and policy efforts in achieving more widespread adoption of SBIRT.
as an evidence-based practice. The outcomes below were formulated in an effort to achieve this goal.

**Outcomes**

1. The DNP student will be able to describe the rate and degree of SBIRT implementation among the sample as evidenced by results from quantitative data analysis by May 1, 2017.

2. The DNP student will identify/descibe the barriers and/or facilitators participants encountered when implementing SBIRT as evidenced by the analysis of themes that emerge from qualitative survey questions by May 1, 2017.

3. The DNP student will present survey findings and recommendations to improve SBIRT implementation to the interprofessional grant team by May 16, 2017.

**Theoretical Framework**

A portion of the Reach, Efficacy, Adoption, Implementation, and Maintenance (RE-AIM) framework was used to conceptualize the development of this project. The RE-AIM framework was designed to improve the generalizability of evidence and measure the ability to translate or disseminate this evidence into practice (Glasgow, Vogt & Boles, 1999; Polit & Beck, 2017). Outcomes within the framework can be evaluated at both the individual and organizational level. The framework was developed in the late 1990s to measure the five dimensions of: reach, efficacy, adoption, implementation, and maintenance of an effective clinical intervention into practice. While the researchers’ original intent was to examine the widespread adoption of interventions into practice, the RE-AIM framework has also been used during the planning and evaluation phases of program research and behavioral, policy, systems, and environmental changes.
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While efficacy trials are critical to identify evidence-based interventions, they often lack generalizability to “real-world” clinical practice considering they are often conducted in tightly controlled, manualized environments and often utilize highly motivated subjects. The goal of the RE-AIM framework is to evaluate how well a program or intervention works in a busy, possibly under-staffed setting with real-life patients (Glasgow, Vogt & Boles, 1999). To adequately analyze a program across all five dimensions would require multiple stages or evaluation cycles and a significant length of time that is outside the scope of this project. For the purpose of this project, the DNP student focused on the Implementation dimension at the individual clinician level as it relates to the extent to which an intervention is delivered in practice as it was intended during efficacy trials.

Design and Methods

Study Design

This project utilized a mixed-methods online survey to evaluate a cohort of clinical SW and NP clinicians who received interprofessional grant-funded SBIRT training regarding their implementation of SBIRT into clinical practice. Both quantitative and qualitative questions were used to analyze whether participants implemented the various components of the SBIRT model and to identify barriers and facilitators to implementation encountered in practice. An in-depth description of the survey instrument is provided below. This design was selected for practical purposes given the limited timeframe to collect data, but also was chosen with the intention of adding anecdotal information to primarily quantitative data.

Study Population and Sampling

The population for this project consisted of a cohort of nurse practitioner (NP) and clinical social work (SW) graduates (N =160) who completed an interprofessional, grant-funded
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SBIRT training during their graduate education at a Midwestern university who are now in clinical practice. Purposive sampling and recruitment strategies were used for this project to include the aforementioned criteria. Students who had completed the SBIRT training but had yet to graduate from their respective programs were excluded from this study. Participants were recruited through an email invitation sent by the grant team to the trainee listserv with the survey link embedded.

**Project Setting**

This project was conducted at a public Midwestern, research university in collaboration with the university’s interprofessional SBIRT grant team. The grant team consists of faculty from across three different health disciplines including: three advanced practice nursing faculty, two clinical social work faculty, one clinical psychology faculty, and one clinical psychology graduate research assistant. An administrative assistant from the nursing department works with the team as well. The team was formed in 2012 upon receiving grant-funding from SAMHSA. The grant team continues to meet consistently and is in year three of the grant award.

**Process for Implementation**

Upon approval from the university’s Institutional Review Board (IRB), the *Qualtrics* survey was emailed to the trainee listserv by the SBIRT grant team for distribution on February 8, 2017. The email included an invitation from the investigator (see Appendix C) with instructions regarding consent (see Appendix B), survey completion, and the embedded *Qualtrics* link to participate. Two reminder emails were sent through the same process to encourage completion prior to survey closure on March 31, 2017. Participation was voluntary with an incentive offered to win one of five *Amazon* gift cards valued at $25 each.
Participants’ confidentiality was protected using an anonymous, online Qualtrics survey. Additionally, anonymity was maintained by the DNP student forwarding the initial email invitation and subsequent monthly reminders to the grant team who were responsible for dispersing the email to the trainee listserv. This eliminated the need for the investigator to have access to participants’ email addresses. No identifying information, such as names, dates of birth or addresses were recorded.

After the data collection period, analysis and evaluation of the results were conducted during April 2017. Coded data were maintained using Excel spreadsheets and SPSS software that was kept in password protected files stored on an external hard drive located with the DNP student.

**Instrument**

The DNP student, along with feedback from the SBIRT grant team, developed a 21-item, mixed-methods online survey using the Qualtrics program. The survey (see Appendix D) consisted of: six demographic questions related to the participant and his or her practice area, nine questions regarding SBIRT implementation using a 4-point Likert scale, four multiple choice questions regarding implementation, and finally two open-ended questions to gather qualitative data regarding barriers and facilitators to SBIRT implementation. The survey was estimated to take no more than 15 minutes to complete.

This instrument was not tested for reliability or validity but was adapted from the SBIRT Short-Form Proficiency Checklist-Clinical Version, which has demonstrated moderate to high levels of internal consistency and reliability for all SBIRT components and was rated highly in terms of clinician satisfaction (Pringle, Seale, & Bray, 2014). The final survey was approved by the university IRB and SBIRT grant team.
Data Analysis and Interpretation

Quantitative data obtained from the survey were entered into an Excel spreadsheet and analyzed using SPSS software with assistance from the departmental statistician. Descriptive statistics were used to calculate the mean and frequency for each item. Qualitative survey questions were evaluated for themes related to identifying the primary barriers and facilitators participants encounter when attempting to implement SBIRT into practice. These data were compared against the literature and local/national data to provide specific recommendations to key stakeholders.

Results

Data was collected through the distribution of an online survey to the sample of NP and SW clinicians (N =160) over a period of 7.5 weeks. A total of (N =7) participants responded to the survey representing a 4% response rate with three participants completing the open-ended questions. Descriptive statistics were used to analyze the characteristics of the sample and the participants reported use of the SBIRT model. The two qualitative responses were analyzed for themes, which given the limited number of responses, was quite straight-forward.

Demographic Characteristics. The majority of sample participants were advanced practice registered nurses (APRNs) (71%) with one clinical social worker (14%) and one manager/supervisor (14%). Most of the respondents were women (71%) with two males (29%) participating. The majority of participants (57%) were between the ages of 25-35, with 29% between the ages of 36-45. The remaining participant (14%) was between the ages of 46-55. The racial distribution was 86% white (6/7) and 14% Black/African American (1/7). Three participants indicated they primarily practice in North Dakota followed by two participants from Minnesota, and one participant each from Montana and Idaho, respectively. The participants
were distributed evenly across practice locations with two from the primary care setting and one participant each from: private practice, hospital, behavioral health, and the social service settings, respectively. Finally, one participant identified practicing in three separate locations including: primary care, public health, and behavioral health.

Table 1. Demographic Characteristics of Sample:

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**Screening.** The majority of participants (71%) reported assessing the quantity and frequency of alcohol and/or drug use and using an evidence-based screening tool at least sometimes or often in their practices. However, none of the participants reported screening universally for alcohol or drug use. Two participants, one NP and one SW, reported never screening for alcohol or drug use. Three participants reported using the AUDIT tool, two used the CAGE tool, and one reported using the ASSIST tool.

**Brief Intervention.** This step of the SBIRT model overall was the least likely to be regularly implemented by participants. Looking at the individual survey questions regarding specific brief interventions, participants were most likely to assess a client’s readiness to cut down or quit their substance use, with 29% who reported always performing this step and 43% often performing the step. Participants were least likely to negotiate a goal with their patients, with 29% reporting they sometimes performed this step and 29% reporting never using this intervention. Participants were also less likely to provide feedback about risks and consequences associated with substance use, with 43% providing this feedback sometimes and 14% never provide this type of feedback. (See Table 2 below.)

**Referral to Treatment.** The majority of participants reported sometimes recognizing a client’s need for referral to treatment (43%) and arranging follow-up when necessary (57%). One participant (14%) reported never performing this step. When referring clients to community and specialty resources, 100% of the six participants who performed this step of the SBIRT model recommended counseling or psychotherapy. Two-thirds recommended a chemical dependency (CD) evaluation or support from family and friends. Half of the participants suggested either 12-step programs, clergy or spiritual support, or outpatient CD treatment. Only one participant recommended medication-assisted treatment or inpatient CD treatment.
Table 2. SBIRT Survey Responses:

<table>
<thead>
<tr>
<th>SBIRT Survey Question</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. How often do you assess the quantity and frequency of alcohol and/or drug use?</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Q8. How often do you use evidence-based screening instruments?</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Q10. How often do you ask permission before providing feedback about a client’s substance use?</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Q11. How often do you use reflection and/or open-ended questions when implementing SBIRT?</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Q12. How often do you provide feedback about risks and consequences associated with clients’ substance use?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Q13. How often do you assess a client’s readiness to cut down or quit?</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Q14. How often do you negotiate a goal with a client?</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Q15. How often do you recognize a client’s need for referral to treatment based on their screening score?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Q16. How often do you arrange follow-up for your clients?</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

**Overall Implementation.** None of the participants reported receiving third-party reimbursement for SBIRT within their organization; however, almost half of the respondents were unsure whether any reimbursement was received for SBIRT implementation. In terms of
system-wide issues related to SBIRT implementation, only one participant from Montana who practiced in a hospital setting reported the organization had a specific SBIRT program or policies and another participant from an outpatient facility in North Dakota reported that his or her organization evaluated provider use of SBIRT through quality improvement monitoring. Two-thirds of the participants indicated that none of the system or organizational supports listed were in place.

**Barriers & Facilitators.** Three participants responded to the survey’s open-ended questions regarding barriers and facilitators that impacted their implementation of SBIRT. Barriers to SBIRT implementation included: the lack of adoption of the model by the agency or clinician, agency staff lack training in SBIRT, little opportunity to screen among their patient population, and one participant felt SBIRT was not the “main focus in my professional role”. There were fewer responses regarding facilitators, with one participant indicating he or she had yet to implement SBIRT. One respondent noted that the SBIRT “process aligns well with social work practice”.

**Discussion**

Results from this project were used to formulate recommendations for future grant-related activities, policy, education, and practice and were disseminated to the grant team in the form of a written executive summary and an audiovisual presentation via Skype for Business. Initial dissemination of DNP project results occurred in May and June of 2017.

Results from this project suggest that the intended goal of implementing universal screening for alcohol use among patients has yet to be achieved by this sample. This could relate to the system-related barriers that participants described, such as the lack of organizational adoption and staff training. One participant also reported little opportunity to screen, which could
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speak to the number of competing priorities providers must screen for during an average visit or session. Without policies and organizational support in place to assist providers to obtain information quickly and seamlessly, it is more difficult to achieve the goal of universal screening. Providers in the primary care setting may face even more difficulty achieving this goal, where the pressure to see more patients in a shorter timeframe and maintain unrealistic productivity standards could compromise the delivery of SBIRT interventions.

Another noteworthy finding was that it was more common for this sample to use tools that screen for alcohol than for drug use. The SBIRT training that participants received during their graduate education placed greater emphasis on alcohol use than drug use, which may explain the discrepancy. However, this finding is also supported in the literature in terms of healthcare providers screening less often for drug use compared to alcohol (CBHSQ, 2016). Some sources point to the stigma that surrounds drug use, whereas alcohol use is often viewed as being more socially acceptable (Rahm, 2015).

It was not surprising to see that brief intervention and referral to treatment were the steps of the SBIRT model with the lowest implementation rate as this was also confirmed in the literature (Kaiser & Karuntzos, 2016; Mertens et al., 2015; Rahm et al., 2015). There was one question related to brief intervention that participants were much more likely to implement, which was assessing a client’s readiness to quit or cut down on his or her substance use. This was an interesting finding which may relate back to the SBIRT training participants received. The training included the use of a tool known as the “Readiness Ruler”, which provides a tangible way to assess a patient’s willingness or readiness to cut down on his or her use on a scale of 1-10. This may highlight the importance of continued use of this teaching technique.
While it is often the perception that there are very limited resources available to patients for issues with substance use which can affect providers’ ability to refer to treatment, it was reassuring to see that none of the participants felt their communities lacked these resources. Despite the research available to support the use of medication-assisted treatment (MAT) and 12-step programs (Heinzerling, Ober, Lam, De Vries, & Watkins, 2016), these resources were not heavily utilized. The use of MAT requires specialized training and a waiver from the Drug Enforcement Agency, which could explain the limited use of this intervention. MAT is also typically reserved for individuals with a full-blown substance use disorder, which is a smaller percentage of patients than those engaging in risky substance use (SAMHSA, 2011). However, any provider would be equipped to facilitate referral to a 12-step program in the patient’s community, and given the strength of evidence to support this intervention, it could be used more readily. It was also surprising to note that the support of family and friends were not enlisted more often. However, this could speak to the sensitive nature and continued stigma surrounding substance abuse.

As it relates to the implementation portion of the RE-AIM theoretical framework used to conceptualize this study, it was evident from the results that most participants are not implementing the SBIRT model as an integrated system of care as it was intended, which is the intent of the model. Many participants were implementing pieces of the model but none implemented the full model. This again could be due to a lack of organizational support. For example, no one reported that they or their organization received third-party reimbursement for SBIRT, and without financial incentive, this practice is less likely to be utilized. In addition to lack of financial incentive, there were only two participants who reported having organizational support in the form of SBIRT-specific policies and quality improvement monitoring. While the
focus of this project was individual provider implementation vs. organizational implementation, this certainly would be an area of interest for further study.

**Strengths and Limitations**

**Strengths**

The strengths of this project included the ability to obtain both quantitative and qualitative data that enriched the description of the issues clinicians face when implementing SBIRT into practice. While the qualitative responses were somewhat sparse, the mixed methods data provided additional clarity and a more pragmatic view of the problem when designing potential recommendations and solutions. Additionally, despite the overall response rate being low making it difficult to generalize the study results, the information gleaned was consistent with the issues uncovered in the literature related to SBIRT implementation. While the survey instrument used for this project was an adaptation and not yet tested for reliability and validity, the design of this study would be very easy and cost-effective to replicate for future projects and could be further adapted to gain clarity and insight into the issue of SBIRT implementation.

**Limitations**

There are several limitations surrounding this SBIRT implementation project. First and most significant was the small sample size that prevents the ability to generalize these results to a larger population of clinicians. The low response rate may have resulted from the brief timeframe allotted for data collection. Participants were novice clinicians who may not have sufficient time in their schedule to complete additional tasks outside of their required clinical work. There is also the potential that participants’ email addresses may have changed since their participation in the SBIRT training, so it is unclear as to how many received the actual survey email. Another significant limitation was that the survey instrument utilized has not been tested
as valid or reliable. Given participants’ implementation of SBIRT was evaluated through self-report methods as opposed to actual clinical observation or chart review, the responses, in particular the Likert-scale questions, are subject to potential self-report bias. Finally, seeking qualitative data in a survey format as opposed to in-person interviews posed a limitation given the inability to ask clarifying questions or provide further structure to the interview.

**Implications and Future Directions**

**Grant-funding**

Despite the small sample size, some interesting findings surfaced from this project that have implications for future grant-related activities as well as academic policies, clinical partnerships, curricular development, and further research. A lack of organizational support and staff training were the main barriers participants identified to SBIRT implementation. While the initial phase of grant-funding was earmarked for interprofessional SBIRT curricular development, future grant-funding may be better directed toward clinical or community agencies to address barriers to SBIRT implementation at the systems level as opposed to directing the majority of funding toward academic institutions responsible for educating future healthcare professionals.

**Practice**

While enhancing interprofessional education through grant-funded initiatives may certainly help to enhance SBIRT implementation, clinical organizations must also do their part to utilize this model. Academic-clinical partnerships may assist in bridging this gap and provide students, faculty, and clinicians from a variety of disciplines the opportunity to provide training, supervision and case consultation, and quality improvement both at the individual and organizational level. Organizations that do not have access to behavioral healthcare, such as rural
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communities could be reached more readily through use of telehealth and other health information technologies.

Another practice concern relates to the results that indicated none of the NPs have been consistently screening for substance abuse in terms of safe prescribing practices. While the survey did not look specifically at whether the NPs within the sample were prescribing medications or controlled substances in their practices, this activity does fall within the scope of an NP. It becomes a safety issue when prescribing a medication that may potentially interact with alcohol or illicit drugs and is essential to assess and document a patient’s typical pattern of use. Assessing a patient’s risk levels regarding their substance use also plays an important role in preventing abuse of controlled medications and guides safe decision-making, an issue of utmost importance amid the current opioid epidemic in the United States.

Education

The continued education of health professionals during their academic training remains an important component when enhancing SBIRT implementation. The literature supports the use of interprofessional teams to enhance SBIRT implementation, particularly the use of nurses or unlicensed personnel to assist with screening and the use of behavioral health providers to provide brief intervention and assist with referral to treatment (Rahm et al., 2015). Therefore, integrating SBIRT content into the curriculum across the interprofessional disciplines could provide an opportunity for students to practice their skills as a team using simulation or case studies. While this project involved clinical social workers and nurse practitioners, future training could also incorporate pre-licensure nursing students, clinical and counseling psychology students, and medical students to create a more inclusive team dynamic.
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Given the infrequent reported use of tools to screen for drug use, the grant team might consider placing increased emphasis on this content area. For example, incorporating additional role play scenarios that involve drug use may be of benefit. Considering the safety issues described above that exist for providers whose role might include prescribing medication, particularly controlled substances, this issue may also require emphasis in those discipline-specific curriculums.

Research

The information gathered from students previously trained in SBIRT who are now in practice will help to inform the grant team in terms of whether they would like to continue to survey cohorts of students after graduation and if so, which questions produced the most valuable data. This survey could also be adapted to use as a tool to gain information from preceptors and agencies across the state that are used for student clinical rotations. An additional component that could be added to the survey would be to assess more long-term satisfaction with the training and feedback on how methods could be improved. The utilization of additional research methods would also provide valuable information to enhance SBIRT implementation. For example, gaining further qualitative data through the use of telephone interviews or focus groups, done either individually or in teams. Organizational evaluation would also provide valuable data and could be obtained through chart review and/or direct or recorded observation.

Conclusion

SBIRT is an effective public health strategy to address a continuum of substance use issues across a multitude of care setting. While grant-funded initiatives have improved the number of future healthcare providers trained in this model, widespread implementation of SBIRT into clinical practice has yet to occur. This DNP project was aimed at identifying the
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degree to which healthcare providers have implemented SBIRT into their practice following interprofessional training and the barriers and facilitators encountered. Results were disseminated to the university SBIRT grant team with recommendations to enhance widespread SBIRT implementation.
## Project Timeline

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<td>Survey Development</td>
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<td>IRB Approval</td>
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<td>Email Recruitment/</td>
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<tr>
<td>Survey Distribution</td>
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<tr>
<td>Data Entry &amp; Analysis</td>
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<tr>
<td>Dissemination of Results</td>
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<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
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Appendix B
Consent Form

UNIVERSITY OF NORTH DAKOTA
Institutional Review Board
Informed Consent Statement

Title of Project: Evaluating Screening, Brief Intervention, and Referral to Treatment (SBIRT) Implementation in Clinical Practice

Principal Investigator: Nicole Wilson, 701-739-3094, nicole.o.wilson@und.edu

Advisor: Dr. Kris Hendrickx, 701-360-3656, kris.hendrickx@und.edu

Purpose of the Study:
The purpose of this study is to explore whether nurse practitioners and clinical social workers who have gone through a grant-funded SBIRT training program during their education are now implementing the model in their practice as well as to identify factors that have facilitated or prevented SBIRT implementation.

Procedures to be followed:
To gather this data, participants are asked to complete a survey using an anonymous, online link. The survey can be accessed on a computer, tablet, or smartphone device. You will be asked to answer a total of 21 questions, 19 of which are multiple choice, including demographic information and questions related to your use of SBIRT. The final 2 questions are open-ended questions. It will take approximately 15 minutes to complete this survey.

Risks:
There are no risks in participating in this research beyond those experienced in everyday life.

Benefits:
- You may develop a better understanding of your use of SBIRT in your clinical practice and identify potential areas for improvement. You might learn that colleagues have had similar experiences that you have.
- Your responses will assist in providing a better understanding of which components of SBIRT clinicians are implementing and what factors assist or prevent them from using this model in practice. This information will support efforts toward future educational, policy, and program development.

Statement of Confidentiality:
This survey is anonymous therefore does not ask for any information that would identify who the responses belong to. If this research is published, no information that would identify you will be included since your name is in no way linked to your responses.

All survey responses received will be treated confidentially and stored on a password-protected hard drive. However, given that the surveys can be completed from any computer (e.g., personal, work, school), we are unable to guarantee the security of the computer on which you choose to
enter your responses. As a participant in our study, we want you to be aware that certain "key logging" software programs exist that can be used to track or capture data that you enter and/or websites that you visit.

**Right to Ask Questions:**
The researcher conducting this study is Nicole Wilson. If you have questions, concerns, or complaints about the research, please contact Nicole at: 701-739-3094 during the day, or you may contact the researcher’s advisor, Dr. Kris Hendrickx at: 701-360-3656.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at: 701-777-4279. You may also call this number with problems, complaints, or concerns about the research. Please call this number if you cannot reach research staff, or you wish to talk with someone who is an informed individual who is independent of the research team.

General information about being a research subject can be found on the Institutional Review Board website “Information for Research Participants” [http://und.edu/research/resources/human-subjects/research-participants.cfm](http://und.edu/research/resources/human-subjects/research-participants.cfm)

**Compensation:**
In exchange for your participation, participants who complete the survey will be entered in a drawing to win one of five $25 Amazon gift cards.

**Voluntary Participation:**
You do not have to participate in this research and may stop your participation at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age older to consent to participate in this research study.

Completion and return of the survey implies that you have read the information in this form and consent to participate in the research.

Please keep this form for your records or future reference.
Appendix C
Recruitment & Reminder Emails

Dear colleagues,

You are invited to participate in an online survey regarding your clinical experience with implementing the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model into practice. Your feedback is important, so in exchange for your participation, you will be entered in a drawing to win 1 of 5 -- $25 Amazon gift cards. Completing the survey will take about 15 minutes, and it will be available until approximately March 31, 2017. To complete the online survey, simply click on the link below:

Qualtrics link: https://und.qualtrics.com/jfe/form/SV_1OikKuk4zq1oNF3

Additional questions can be directed to the principal investigator at nicole.o.wilson@und.edu or 701-739-3094.

Thank you for your consideration,

Nicole O. Wilson, MS, PMHNP, DNP Student
University of North Dakota
College of Nursing & Professional Disciplines

Reminder email:

Dear colleagues,

Just a friendly reminder that if you haven’t already done so, please consider participating in the online survey below regarding your experience with implementing SBIRT model into your practice. Your feedback is incredibly valuable. Your participation will allow you to be entered into a drawing to win 1 of 5 -- $25 Amazon gift cards. The survey will close on March 31, 2017. To participate, click on the link below:

Qualtrics link: https://und.qualtrics.com/jfe/form/SV_1OikKuk4zq1oNF3

Thank you!
Nicole O. Wilson, MS, PMHNP, DNP Student
nicole.o.wilson@und.edu
701-739-3094
University of North Dakota
College of Nursing & Professional Disciplines
Appendix D
SBIRT Implementation Survey

If you would like your name to be entered into a drawing to win one of five $25 Amazon gift cards upon completion of the survey, please enter your name and email address below. Your contact information cannot be connected to your survey responses.

Name (1)
Email (2)

Q1 Where do you currently practice? Select all that apply.

☐ Primary care (1)
☐ Hospital (2)
☐ Long-term care (3)
☐ Emergency Room/Urgent care (4)
☐ Behavioral health setting (5)
☐ Public/community health (6)
☐ Social service setting (7)
☐ Correctional facility (8)
☐ Government agency (9)
☐ School (10)
☐ Private practice (11)
☐ Other (Please specify) (12) ____________________

Q2 Which state do you primarily practice in?

Q3 What is your professional role?

☐ Advanced Practice Nurse (1)
☐ Clinical Social Worker (2)
☐ Addictions Counselor (3)
☐ Manager/Director/Supervisor (4)
☐ Other (Please specify) (5) ____________________

Q4 Gender

☐ Male (1)
☐ Female (2)
☐ Other (3)
Q5 Race
- White (1)
- Black or African American (2)
- American Indian or Alaska Native (3)
- Asian (4)
- Native Hawaiian or Pacific Islander (5)
- Other (6)

Q6 Age
- 18-24 (1)
- 25-35 (2)
- 36-45 (3)
- 46-55 (4)
- 56-65 (5)
- Over 65 (6)

Q7 How often do you assess the quantity and frequency of alcohol and/or drug use, for example by asking about the number of standard drinks in ounces?
- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q8 How often do you use evidence-based screening instruments to identify a client's level of risk related to alcohol or drug use?
- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)
Q9 Which of the following screening tools have you used when screening clients? Select all that apply.

- AUDIT (1)
- ASSIST (2)
- DAST (3)
- CAGE (4)
- CRAFFT (5)
- Other (Please specify) (6) ____________________

Q10 How often do you ask permission before providing feedback about a client's substance use?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q11 How often do you use reflection and/or open-ended questions when implementing SBIRT?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q12 How often do you provide feedback about risks and consequences associated with clients' substance use behavior?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q13 How often do you assess a client's readiness to cut down or quit?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)
Q14 How often do you negotiate a goal with a client based on steps he/she is willing to take?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q15 How often do you recognize a client's need for referral to treatment for substance use based on their screening score?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q16 How often do you arrange follow-up (specialist, counseling, referral to treatment, medications, etc.) for your clients?

- Always (1)
- Often (2)
- Sometimes (3)
- Never (4)

Q17 Which of the following community and specialty resources have you suggested to your clients? Select all that apply.

- 12-step programs, such as Alcoholics Anonymous (1)
- Counseling or psychotherapy (2)
- Chemical dependency evaluation (3)
- Outpatient chemical dependency treatment (4)
- Inpatient chemical dependency treatment (5)
- Medication-assisted treatment, such as Naltrexone or Suboxone (6)
- Family & friend support (7)
- Clergy, religious or spiritual support (8)
- Other (Please specify) (9) _________________
- There are no specialty resources available in my community. (10)
Q18 Do you receive third-party reimbursement for SBIRT?
- Yes (1)
- No (2)
- Unsure (3)

Q19 Which of the following pertain to your experience with SBIRT implementation? Select all that apply.
- I have received performance feedback re: SBIRT use. (1)
- I have sought out supervision re: SBIRT. (2)
- I have mentored someone to implement SBIRT. (3)
- My organization has a specific SBIRT program or policies. (4)
- My organization offers continuing SBIRT education. (5)
- My organization evaluates provider use of SBIRT through quality improvement monitoring. (6)
- None of these apply to my practice. (7)

Q20 What are the top three barriers that have either prevented or limited your use of SBIRT?

Q21 What are the top three factors that have helped you to implement SBIRT?
REFERENCES


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Preventative Medicine, 34, 143-152.


