

Improving/ Initiating a Working SBIRT Program

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Purpose: In the American College of Surgeons Committee on Trauma's Resources for Optimal Care of the Injured Patient, all verified trauma centers are instructed to screen all injured patients for alcohol use and document this screening. Additionally, Level I and II trauma centers are instructed to provide an intervention by appropriately trained staff to patients who screen positive and document the intervention. There is wide variability in how ACS verified centers meet these requirements. Erlanger Adult Trauma Services initiated the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process in April of 2015, using the AUDIT tool. At the time, our institution utilized paper charts. Trauma resuscitation nurses conducted the screenings as time permitted, in addition to the resuscitation and clinical care of patients. Trauma nurse practitioners completed the brief intervention and referrals to treatment, tracking the process by manual entry into a spreadsheet.

In 2017 we recognized the continual struggle to screen all patients admitted to the trauma service. The problem was further complicated by a non-surgical admission rate of approximately 35%. We also recognized that we were not screening patients who were admitted to services other than trauma, but who met trauma registry inclusion criteria and met the criteria to require screening. Overall, we screened approximately 63% of injured patients from April, 2016-October, 2017. From our SBIRT implementation in 2015 to April of 2016 we were not tracking the percentages of screenings completed and thus cannot identify the percentages from that time. In addition, we were not tracking missed referrals until September of 2016. Our challenge was to identify and screen patients who were not admitted to the trauma service, but who met registry inclusion criteria, as well as improve the number of screenings and interventions on patients admitted to the trauma service. With implementation of the electronic medical record system EPIC in October 2017, we recognized this time as an opportunity to improve the screening and referral process.

Resources: The only resources needed were FTEs to implement the program (which were all already in place).

Description: A multidisciplinary workgroup was created to review and revamp our screening and referral to treatment process for adult and pediatric trauma patients (pediatric patients were not being screened at all at this time). This workgroup included nursing leadership, educators, case management, trauma nurses, process improvement coordinators, the trauma nurse practitioner, information technology, and the trauma nurse navigator. The workgroup met weekly to develop the process. After a thorough literature review, it was agreed that screening all admitted patients offered the best opportunity to identify and screen all registry inclusion patients. Verified screening tools were reviewed and the AUDIT was chosen for patients age 20 and above and the more adolescent appropriate CRAFFT was selected for patients ages 12-19. Once the process was agreed upon, nursing administration approval was sought and obtained. The EPIC team built the AUDIT and CRAFFT tools, as well as reports to monitor the percent of patients screened and referred utilizing EPIC "dot phrases." Mandatory online education modules were developed for nursing and case management. The referral to treatment resource pamphlet featuring local and regional resources was updated, and placed into the hospital system for individual floors and units to reorder as needed. The new SBIRT process was implemented 12.1.17. Every admitted patient receives a nursing admission assessment which includes the alcohol screening. A case management consult is sent via EPIC for positive screenings. Case management completes the brief intervention on all identified patients. The trauma nurse navigator runs a daily report to oversee completion of screenings and referrals prior to discharge.

Effectiveness: As previously stated, it was estimated that only approximately 63% of injured patients were screened from April 2016 until October 2017. Additionally, brief interventions for patients who screened positive were not completed 100% of the time. Once the process was in place and being documented in EPIC, a custom field was created in the trauma registry allowing for monthly review and feedback. This registry report is discussed at our monthly systems meeting. Since implementation our percentages continued to increase. Last month we had screened 94% of all registry included patients and had completed referrals on 100% of all patients who screened positive.

Lessons Learned: To complete a whole hospital process improvement you need buy in from all stakeholders and areas. We did a good job creating our workgroup and this ultimately led to our success. We also assigned a staff member to monitor the SBIRT completions on a daily basis. This was crucial to our success. One con of implementing the SBIRT on all patients is that the staff member assigned to monitoring has to interact with areas that don't commonly admit trauma patients to try to improve their screenings. These areas also feel less compelled to assist with metrics for the trauma service. This causes a large portion of his time to have to be spent on improving SBIRT for areas that are often not reflected in our numbers.

Conclusions: Screening went from approximately not meeting the required 80% to continually (month by month) surpassing the requirement. We went from intermittently completing brief interventions on those who screened positive to most months being completed 100% of the time. In conclusion, I highly recommend moving the SBIRT screening process into the admission history especially for those centers with a high percentage of non-surgical or non-trauma service admissions. Standardizing the alcohol screenings throughout the hospital will improve compliance to the screenings. You will still see below; however, that we do have fall outs from time to time. We have been able to PI all of the fallouts and now will be following up with all patients missed for the brief intervention over the phone and with a mailed letter of references.